NHS
Shropshire, Telford and Wrekin

NHS Shropshire, Telford and Wrekin Integrated Care Board

Annual Report 2025/26

Contents

Welcome 2
A statement from the Chief Executive Officer 3
About us 5
Purpose and activities of the organisation 7
Our objectives and strategies 7
Our population 12
Performance Report 13
Performance overview 14
Performance analysis 21
Children and young people's services 22
Safeguarding, child deaths and looked after children 25
Maternity and neonatal services 28
Quality and patient safety assurance, and improvement 30
Mental health 32
Learning disabilities and autism 34
Planned care (includes elective, cancer and diagnostics) 36
Community transformation 40
Urgent and emergency care 42
Primary care 43
Pharmacy and medicines optimisation 45
Improving population health 47
Environmental matters 57
Emergency Preparedness, Resilience and Response (EPRR) position 60
Digital 61
Patient experience and complaints 62
Engaging people and communities 64
Accountability Report 65
Corporate Governance Report 66
Governance statement 89
Finance, governance and control 97
Remuneration and Staff Report 103
Staff Report 116
Parliamentary Accountability and Audit Report 131
Annual Accounts 132

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Call 01952 580 300

or email

stw.generalenquiries@nhs.net

Alternatively, use the Next Generation Text Service for deaf and hard-of-hearing patients, carers and staff: www.ngts.org.uk

We want our patients, carers, staff and partner organisations to be able to understand our information in the format that is most accessible to their individual needs. This includes identifying and reasonably removing barriers for people accessing our information, services, premises, and any employment or engagement opportunities.

Welcome

A statement from the Chief Executive Officer

Welcome to our annual report for 2025/26. This past year has been significantly challenging for the NHS in Shropshire, Telford and Wrekin and across the country. Against a backdrop of organisational change, colleagues in our health and care system have worked exceptionally hard to continue improving outcomes for the population we serve. The performance overview in this report offers detailed insight into our achievements during this period.

In March 2025, the UK government announced far-reaching changes to the NHS in England. As part of the reset, the government asked all integrated care boards (ICBs) in England to reduce running costs by an average of 50%.

To meet these requirements, Shropshire, Telford and Wrekin ICB agreed to 'cluster' with Staffordshire and Stoke-on-Trent ICB. This arrangement enables the two organisations to work closely, share best practice and develop joint strategies to improve healthcare for our residents.

For now, both ICBs remain separate statutory bodies, but will increasingly operate under a single management structure.

Having served as Chief Executive Officer (CEO) of Shropshire, Telford and Wrekin ICB since 2022, I was appointed CEO of the new ICB cluster in October 2025.

I would like to acknowledge the work that has continued over the last year to strengthen relationships between Shropshire, Telford and Wrekin partners – including NHS organisations, local authorities and groups from the voluntary, community and social enterprise sector.

These robust relationships allow us to tackle challenges collaboratively and provide the broader perspectives that help keep the needs of our residents at the centre of our improvement work. Thousands of people have been engaged in shaping improvements including mental health services, healthy ageing, cancer care, primary care and community services.

This report is also a testament to the real achievements made in 2025/26:

- Opened new community-based hubs such as the Highley Health and Wellbeing Centre, bringing GP, women's health, health visiting, sexual health, and prevention services together in one place.
- Improved patient flow with initiatives such as the Care Transfer Hub, Integrated Community Front Door, extended urgent community response opening hours, additional acute bed capacity, and enhanced frailty and Same Day Emergency Care services.
- Huge progress in prevention through blood pressure checks, community diagnostic tests, lung health checks and community eye care.
- Strengthened inclusion through the 'Everyone Belongs Here' campaign and targeted programmes supporting migrant communities, people with learning disabilities, and underserved groups.

Looking ahead, one of our key priorities will be to develop the neighbourhood model of care. Shifting appropriate care from hospitals into communities is a core ambition of the NHS 10 Year Plan, and we will focus on delivering integrated neighbourhood services that are more personalised, accessible

and closer to home. This will help ensure hospital services can concentrate on providing expert specialist care where it is most needed.

We will continue to strengthen our relationships with providers to drive improvements in areas such as urgent and emergency care and elective waiting times. Investment and support for mental health services for all ages will remain a priority, recognising the crucial role these services play in supporting wellbeing and tackling health inequalities.

Despite the challenges we face, I believe the future holds exciting opportunities for our ICB cluster. Existing links – such as those between the University Hospitals of North Midlands and the Shrewsbury and Telford Hospital NHS Trusts, and the work of Midlands Partnership University NHS Foundation Trust, which operates in both regions – provide a strong platform to build on.

We can look forward to exploring new ways to collaborate, share our expertise, and tackle health inequalities in our communities, by improving the services offered and the integration and connectivity of those services.

Finally, I would like to thank staff across the ICB for their unwavering commitment during a time of considerable change, and the clinicians and professionals who deliver amazing care, day in, day out, to the residents of Shropshire, Telford and Wrekin.

Simon Whitehouse
Accountable Officer
17th June 2026

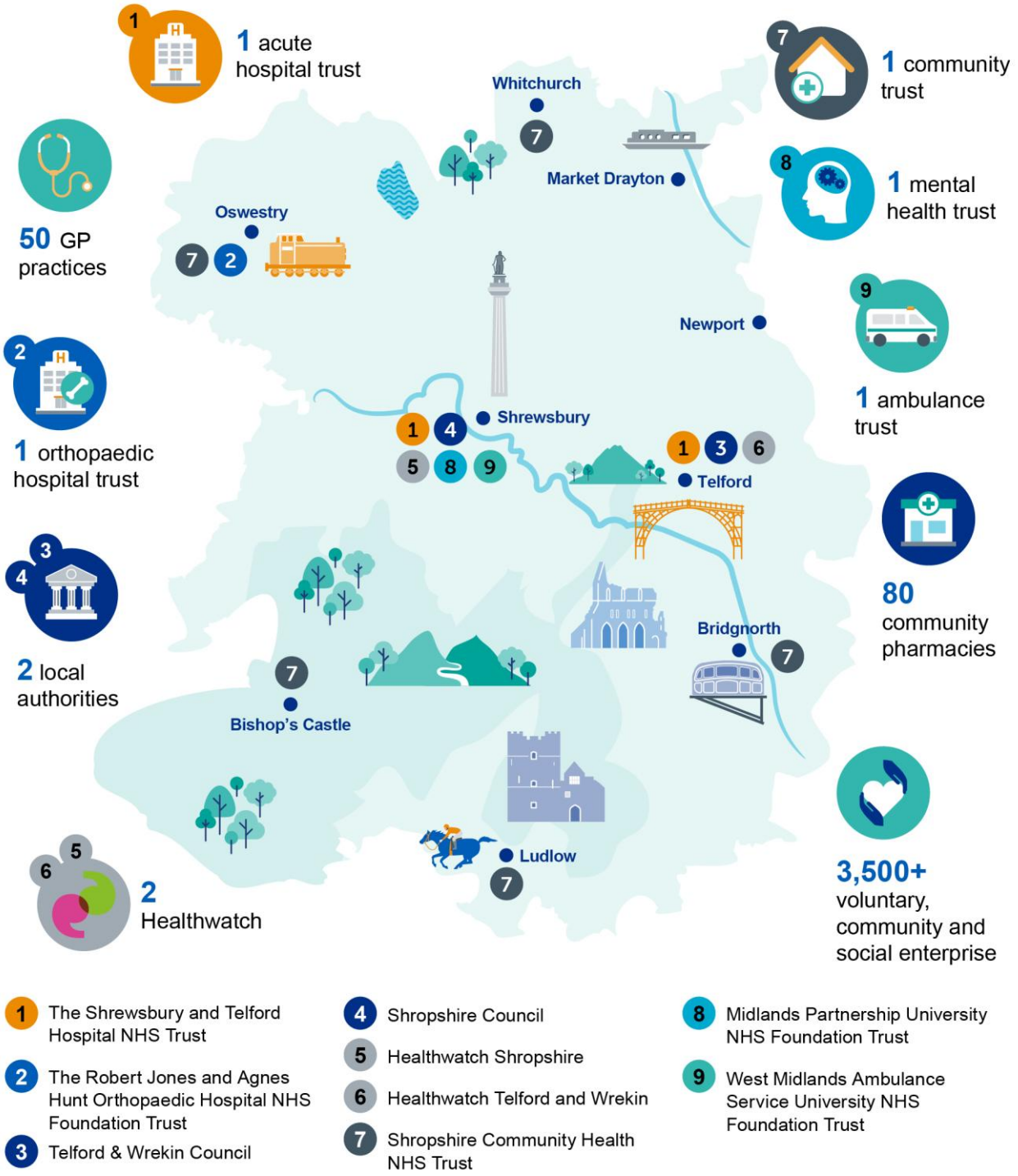
About us

Shropshire, Telford and Wrekin Integrated Care Board (ICB) is responsible for the health and care of around 520,000 people (190,000 in Telford and Wrekin and 330,000 in Shropshire), across a geographical area of 1,347 square miles. While Telford and Wrekin is a largely urban geographic area, Shropshire is predominantly rural. We plan and buy a wide range of health and care services for the whole of Shropshire, Telford and Wrekin. These include general practice and primary care services such as optometry, pharmacy and dentistry, hospital care, community healthcare and mental health services.

Integrated Care System

Our uniquely positioned partnership between local people and communities, the NHS, local authorities and the voluntary and community sector enables us to improve all aspects of health and care – including the wider determinants of health and preventing ill-health.

Our Integrated Care System spans two Places – Shropshire, and Telford and Wrekin.



1. The Shrewsbury and Telford Hospital NHS Trust
2. The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
3. Telford & Wrekin Council
4. Shropshire Council
5. Healthwatch Shropshire
6. Healthwatch Telford and Wrekin
7. Shropshire Community Health NHS Trust
8. Midlands Partnership University NHS Foundation Trust
9. West Midlands Ambulance Service University NHS Foundation Trust

Purpose and activities of the organisation

The purpose of ICSs is to bring partner organisations together to achieve the following:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

The Integrated Care Partnership (ICP) has representation from all the system partners.

The ICP produced an Integrated Care Strategy to deliver a joined-up approach to care that improves the health, wealth, happiness, and wellbeing of our local population. We are committed to leading and supporting the delivery of the four ICS aims, which include:

- Improving outcomes in population health and healthcare
- Tackling inequalities in outcomes, experience, and access
- Enhancing productivity and delivering value for money
- Helping the NHS to support broader social and economic development.

Local communities have identified the following priorities:

- Access and timely intervention to health and wellbeing services
- Tackling isolation and loneliness, especially for people in rural areas
- Consistent and reliable information and education for all ages
- Services working together, including information sharing and flexible working
- Building strong communities and investment in local people.

Our objectives and strategies

This Integrated Care Strategy development through the ICP is a key step in setting out the high-level needs assessment and long-term health and wellbeing priorities for Shropshire, Telford and Wrekin. A clear governance, planning, and delivery cycle exists to support partnership working across the system. This development cycle will be complemented by a comprehensive consultation and engagement process to ensure co-design.

Given what we know about our population's health and care needs and the feedback from residents, the ICS strategy will:

- Improve safety and quality
- Integrate services at place and neighbourhood level
- Tackle the problems of ill health, health inequalities and access to health care
- Deliver improvements in mental health, learning disability and autism provision
- Support economic regeneration to help improve the health and wellbeing of our population
- Respond to the threat of climate change
- Strengthen our leadership and governance
- Increase our engagement and accountability
- Create a financially sustainable system
- Make our ICS a great place to work so that we can attract and keep the very best workforce.

Our challenges and opportunities

During 2025/26, we continued to operate in a period of significant change for the NHS, both locally and nationally. We were required to respond to sustained demand pressures, deliver major transformation programmes and support our workforce through organisational change, while continuing to improve outcomes for our population.

The following section outlines the key challenges we have faced during the year and the opportunities these have created to strengthen our system and shape our future direction.

Our challenges

We have continued to operate in a highly pressured and complex environment this year. Demand for services remained high, particularly across urgent and emergency care, with system flow and timely access continuing to require sustained focus and close collaboration with partners. While progress has been made, these pressures underline the need for whole-system approaches that balance immediate operational delivery with longer-term transformation.

The year was also marked by significant organisational change. The introduction of voluntary redundancy schemes and wider Management of Change processes, alongside the development of new cluster arrangements, created uncertainty for staff and placed additional pressure on organisational capacity. Supporting colleagues through this period, maintaining morale, and ensuring continuity of delivery remained a priority, while recognising the risk of skills gaps and loss of corporate knowledge.

Financial constraints continued to present a challenge. Although the system has strengthened its financial grip and control, rising demand and increasing service complexity mean that difficult decisions are required to balance affordability with quality and access. Delivering recovery and transformation at pace, within a constrained financial envelope, has required strong governance, disciplined prioritisation and close partnership working.

Variation in provider performance also remained a challenge. While system oversight has matured and overall performance has improved, not all partners have progressed at the same rate. Supporting providers facing ongoing quality or regulatory challenges, while maintaining momentum across the wider system, has required sustained leadership attention.

Finally, the pace of national policy change has added complexity. Changes arising from the NHS Reset, evolving planning guidance, and commissioning expectations have required rapid adaptation, often alongside existing transformation programmes. Maintaining strategic clarity and stability for partners during this period has been an ongoing challenge.

Our opportunities

Alongside these challenges, 2025/26 has also presented significant opportunities for us. A major milestone during the year was the system's successful exit from the NHS England Recovery Support Programme. This represents recognition of the progress made in governance, leadership, financial management, and delivery, and marks an important shift from recovery towards greater system autonomy and confidence. While continued improvement is required, this transition provides a stronger platform for future development.

The development of cluster working with Staffordshire and Stoke-on-Trent has created opportunities to strengthen leadership capacity, share learning and align approaches to risk, planning and delivery. Working at scale enables greater resilience, more consistent governance and the ability to draw on a broader range of expertise, while retaining a strong focus on local place-based priorities.

Progress in developing integrated neighbourhood and place-based models of care has also been a key opportunity. These models support prevention, early intervention and more coordinated care, helping to improve outcomes for residents while reducing reliance on acute services. Strengthening neighbourhood working remains central to our ambition to deliver care closer to home and improve system flow.

Digital and data-enabled improvement continues to offer significant potential. Enhanced use of shared data, digital tools and intelligence supports better quality surveillance, more informed decision-making and more targeted improvement activity. Continued investment in digital capability will be critical to improving productivity and reducing unwarranted variation.

Shropshire

- 139,000 households – predicted to increase 28% by 2043
- 23% of the population are aged 65 and over – higher than the England average
- 26% increase in 'Looked After Children' from 2019/20 to 2020/21
- 44,969 people are 30 minutes or more by public transport to the closest GP
- An estimated 3,740 people are currently living in care home settings – a figure likely to increase in the future
- The relatively affluent county masks pockets of deprivation, growing food poverty, health inequalities and rural isolation, with the county overall having a low earning rate
- Life expectancy at birth is 79.8 for men and 83.9 for women compared to 78.9 and 82.8 for England (2020 to 2022) – approximately one year longer than the national averages
- Healthy life expectancy at birth is 62.8 for men and 67.1 for women compared to 63.1 and 63.9 for England (2018 to 2020) – slightly below the national average for men, but significantly above the national average for women.

Finally, the year has seen continued progress in strengthening governance and strategic commissioning. A clearer focus on strategic, outcomes-based commissioning, underpinned by robust risk management and assurance, provides the opportunity to move away from short-term transactional approaches and towards longer-term population health improvement.

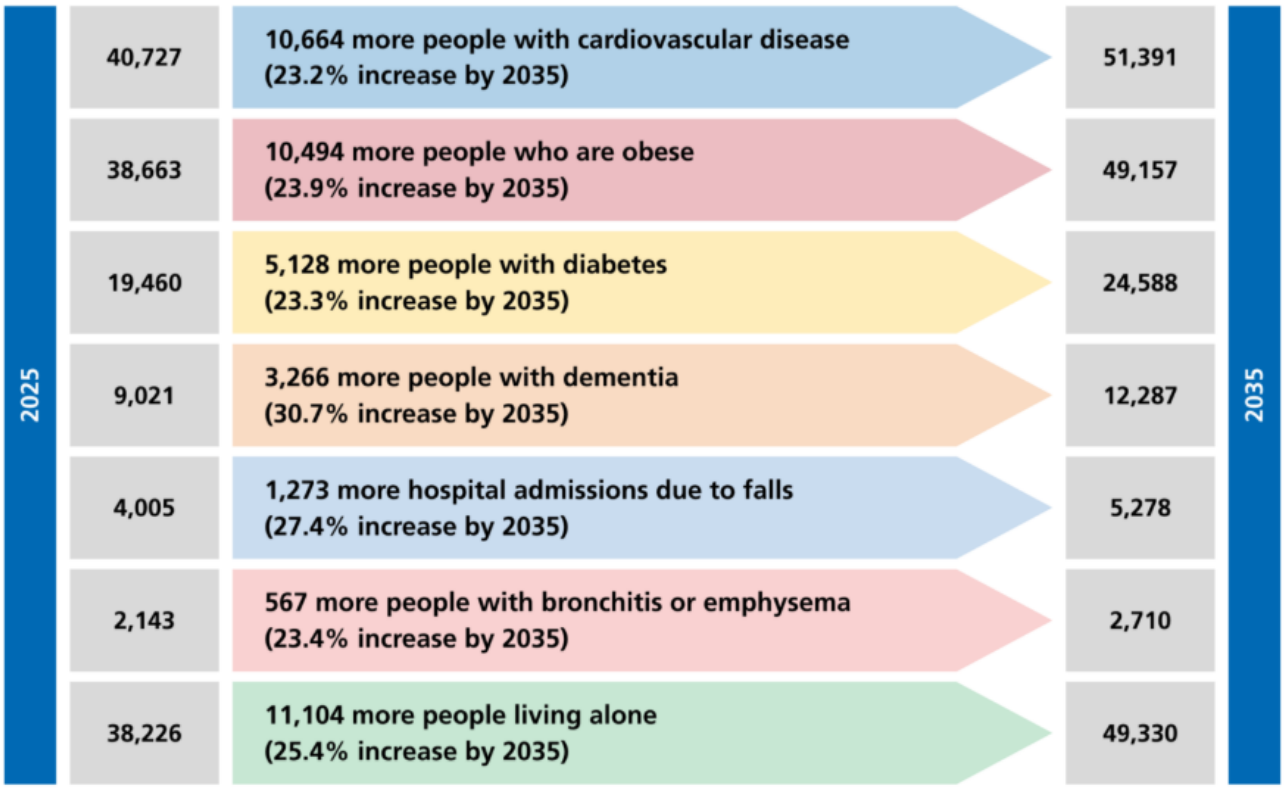
Telford and Wrekin

- Fastest population growth in the West Midlands (2011–202 = 11.4% growth) and second fastest growth nationally in the over-65 population (35.7%)
- Population changing – becoming more diverse and ageing (median age now same as West Midlands at 39.6 years)
- More than a quarter (27%) live in the 20% most deprived areas in England – significantly higher than the England average
- Just over a fifth (21%) of children and young people are living in poverty
- Life expectancy at birth is 78.0 for men and 82.1 for women compared to 78.9 and 82.8 for England (2020 to 2022) – similar to the national averages, but two years shorter than Shropshire
- Healthy life expectancy at birth is 57.6 for men and 60.3 for women compared to 63.1 and 63.9 for England (2018 to 2020) – significantly below the national averages and several years shorter than Shropshire.

Long-term conditions

The number of people with long-term conditions is increasing, with just over half of over-65s having two or more long-term conditions. The diagram below shows the levels of common long-term conditions in 2025 and how this is expected to grow by 2035 if the current trends persist.

Long-term condition projections in Shropshire, Telford and Wrekin for over-65s



POPPI, www.poppi.org.uk.
Data sources: Office for National Statistics licensed under the Open Government Licence v3.0.

Shropshire, Telford and Wrekin

Geography

Overall Shropshire, Telford and Wrekin comprise of **66.8%** urban geographic areas and **34.2%** rural – Telford and Wrekin is mostly urban, while Shropshire is predominantly rural.

Population Age

Both areas have ageing populations, with a rising number of retirees and fewer young people. Shropshire has one of the UK's oldest populations, with the average age increasing from 44 in 2011 to 48 in 2021. In Telford, the 50–64 age group grew by **20%,** while the 35–49 group declined by **3.4%.**

Disabilities

In 2021, **9.1%** of Telford and Wrekin residents reported being disabled, which is a reduction from 10.8% in 2011. Shropshire saw a similar decrease, from **8%** in 2011 to **6.7%** in 2021. However, Telford and Wrekin continues to have a higher proportion of disabled residents than both the UK and West Midlands.

Diversity and Religion

Shropshire remains one of the least diverse areas in the UK, with **97%** identifying as White in 2021 (a slight decrease from 2011). Meanwhile, **1.3%** identified as Asian, Asian British, or Asian Welsh, and **1.2%** as Mixed. In contrast, Telford and Wrekin is more diverse – **88%** identify as White (down **5%** in 10 years), **5.4%** as Asian, and **3%** as Black, Black British, Black Welsh, Caribbean, or African.

Religious affiliation is declining in both areas. In 2021, **48%** of Telford and Wrekin residents identified as Christian (down from **62%),** while 56% in Shropshire identified as religious (down from **69%**). Christianity remains the largest single group, with Muslims making up **2.7%** and Sikhs 1.5% of Telford's population. No other religion exceeds **1%** in Shropshire.

In 2021, there were 6,161 pregnancies across Shropshire, Telford and Wrekin. Both counties recorded rates below the West Midlands average, with Shropshire reporting one of the lowest in England and Wales. Nationally, conception rates rose for the first time in six years, with the West Midlands leading at 78.1 conceptions per 1,000 women aged 15–44.

In 2021, a total of 10,429 residents across Shropshire, Telford and Wrekin identified as LGBTQ+. This equates to **2.8%** of Telford's population and **2.3%** of Shropshire's.

Other characteristics

The gap in life expectancy is driven by deaths caused by cardiovascular disease, followed by cancers, with Telford and Wrekin found to have significantly higher rates of premature (under-75) deaths from cardiovascular diseases and cancers considered preventable than the national average.

Excess weight is the most significant lifestyle risk factor in the population, with over two thirds of adults living within both areas estimated to be overweight. Telford and Wrekin has significantly high levels of childhood excess weight and obesity.

The level of alcohol-related hospital admissions in both areas is significantly above the national average. Adult smoking rates are a key driver of inequalities, and smoking in pregnancy is a particular issue for STW. The highest levels are seen amongst younger mothers and those living in deprived communities.

Mental health is a key cause of poor health amongst our communities, with levels of poor mental health in children and younger people increasing. The physical health of adults with serious mental illness is also a cause for concern across Shropshire, Telford and Wrekin.

NHS Government Reset Programme

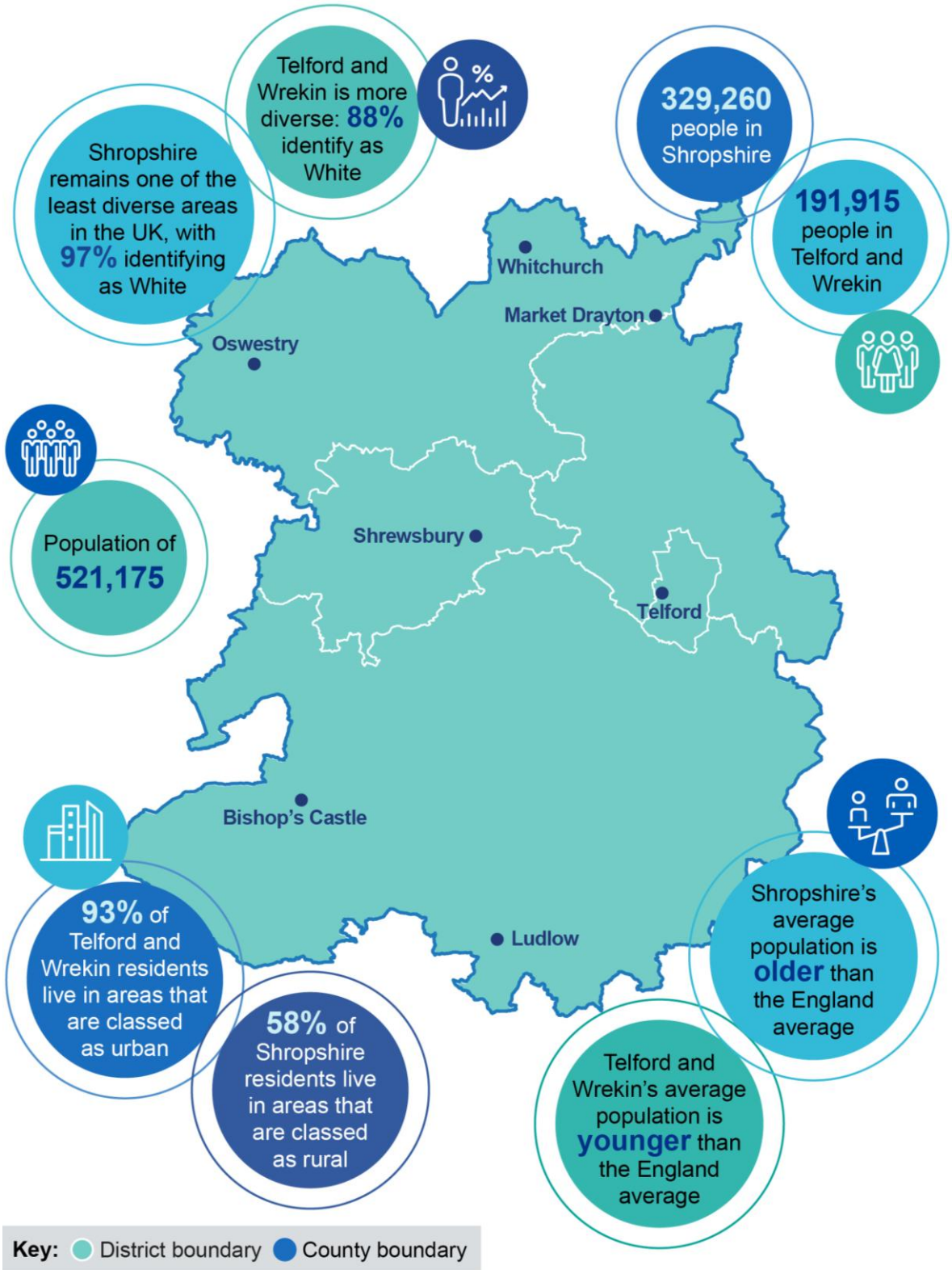
The Government NHS Reset Programme continues to progress as planned, supported by strengthened governance arrangements across both NHS Shropshire, Telford and Wrekin (STW) and NHS Staffordshire and Stoke-on-Trent (SSOT) Integrated Care Boards (ICBs).

During the year, the Management of Change (MOC) consultations for senior leadership and clinical roles were completed, and consultation commenced with the wider workforce.

The organisation continues to navigate a complex period of change in a structured and well-managed way, with a strong emphasis on supporting colleagues and maintaining long-term organisational stability.

Our population

Shropshire, Telford and Wrekin has a diverse healthcare system, comprising both urban and rural areas, as well as being one of the least diverse areas in the UK.



Performance Report

Performance overview

As a statutory body, we recognise the importance of providing assurance to our stakeholders and the public so that they have confidence in our ability to plan and deliver safe, high-quality and sustainable services within the resources that we have available.

Oversight and assessment

For more information on the NHS Oversight Framework, see NHS England's website.

Key issues and risks

See the Governance Statement for information about how the ICB manages key issues and risks.

Finance review

Performance Analysis of Our Key Statutory Duties

Duty to develop a joint capital resource use plan

As part of the Health and Care Act 2022 (the 2006 Act), Integrated Care Boards, partner NHS trusts and NHS foundation trusts are required to prepare joint capital resource use plans. The plans are intended to ensure there is transparency for local residents, patients, NHS health workers and other NHS stakeholders on how the capital funding provided to Integrated Care Boards is being prioritised and spent to achieve the Integrated Care Board's strategic aims. This aligns with Integrated Care Board's financial duty to ensure that their allocated capital is not overspent and their obligation to report annually on their use of resources.

In 2025/26 the ICB set a Joint Capital Resource Use Plan with system partners compliant with capital expenditure depreciation limits (CDEL) for operational capital and included funding confirmed for national capital programmes such as the Hospital Transformation Programme and Estates Safety. A Shropshire, Telford and Wrekin Capital Prioritisation and Oversight Group oversaw monitoring of the system capital programme against the capital envelope, gained assurance that the estates and digital plans are built into system financial plans and to ensure effective oversight of future prioritisation and capital funding bids.

The Joint Capital Resource Use Plan can be viewed on our website Joint Resource Capital Plans - NHS Shropshire, Telford and Wrekin (shropshiretelfordandwrekin.nhs.uk)

Financial duty as to resource use limits

For 2025/26, the reported financial outturn is a favourable position which is £2.1m favourable against the planned £2.0m deficit. There are a small number of key drivers of increased expenditure for the organisation which have continued throughout the year:

- Increases in acute elective recovery fund costs, non-contract expenditure and excluded drugs and devices costs.

- Increases in mental health out of area non-contract activity.
- Increases in volume and value of individual commissioning continuing healthcare packages.

These costs were mitigated through delivery of efficiency in excess of target (£6.2m) and the application of the balance of funds not spent for delegated Pharmacy and Specialised Commissioning which supported upstream investment in other programme areas.

The full year financial position includes £41.4m total efficiencies delivered in year; this is an increase in total savings of £3.4m from 2024/25. Significant efficiencies were delivered in Individual Commissioning and Medicines Management, and of the total efficiency delivered £35.0m (84.7%) was recurrent.

In summary, 2025/26 represents a year of genuine financial recovery and a platform from which the ICB and the wider ICS can continue to develop a sustainable financial footing for the future.

NHS Shropshire, Telford and Wrekin has an established Budgetary Control Framework which is a key element of its internal control environment and is designed to assist budget holders and managers in the discharge of their responsibilities. It sets out the rules for the financial year within which the budgets are to be operated, clarifies roles and responsibilities, and ensures that budgetary processes form part of the overall assurance framework. This guide has been prepared to help all budget holders fulfil their financial and corporate responsibilities and is intended as a supplement to the support and advice available from the Finance Department within NHS Shropshire, Telford and Wrekin.

NHS Shropshire, Telford and Wrekin commenced the year as part of the National Recovery Support Programme. As an organisation we were subject to significant scrutiny around finances and financial decisions. A System Integrated Improvement Plan was developed and Undertakings were in place across a number of areas Leadership & Governance, urgent and emergency care, workforce and finance. The finance key deliverables were to develop a recovery plan through a Medium-Term Financial Plan and multi-year efficiency plan, to deliver the capital and revenue plans over the year and to improve grip and control. In year, the ICB submitted evidence of delivery against these deliverables and in early September 2025 exited the National Recovery Support Programme and Undertakings were removed.

The System Finance Strategy[1] was approved by the board in June 2025 alongside the Medium-Term Financial Plan. The Medium-Term Financial Plan was refreshed in March 2026 as part of the latest 3-year plan submission process.

To ensure that all decision-making is transparent and that changes are understood and approved by all, the system has implemented a Strategic Decision-Making Framework[2] which aligns to the Integrated Care System core aims. This ensures that the value is maximised in terms of outcomes for patients alongside value for money (efficiency and productivity), reducing health inequalities and broader social and economic benefits. The framework provides a fair, equitable and transparent process under which investment is removed where value is not demonstrated, the framework also provides a basis for prioritisation of investment and disinvestment under the 'hard decisions' process.

Duty as to effectiveness, efficiency and economy

Throughout 2025/26, NHS Shropshire, Telford and Wrekin has maintained a clear focus on delivering its statutory duty to operate effectively, efficiently, and economically. Recognising the significant challenges faced across the health and care system, we have worked in close

[1] STW-ICS-Financial-Strategy-Final-.pdf

[2] STW-Strategic-Decision-Making-Framework-Final-Nov-2024-COM005.pdf

partnership with our providers, stakeholders, and NHS England to ensure our actions align with our statutory responsibilities and support the delivery of sustainable, high-quality care.

A key area of focus has been the development of a robust system-wide Financial Strategy to form the basis of our Financial Recovery Plan, which underpins our Medium-Term Financial Plan. This plan sets a challenging trajectory to breakeven and targets significant productivity and efficiency gains. In addition, our improvement programmes focus on high-cost areas including Continuing Healthcare, Temporary Staffing, Urgent and Emergency Care, Corporate Back Office, and Elective Care pathways. By prioritising these areas, we are working to maximise value from every pound spent, reduce unnecessary expenditure, and reinvest savings into frontline care.

During the year, we strengthened our financial governance and grip across the system. A comprehensive self-assessment against NHS England's financial control checklist was completed and externally reviewed, with key recommendations implemented. Further system-wide controls, including strengthening vacancy management processes and the establishment of a Programme Management Office (PMO), have been embedded to enhance financial oversight, ensure robust decision-making, and track delivery of transformational programmes.

Our focus on effectiveness is evident through the delivery of the system-wide Urgent and Emergency Care Improvement Plan. This has resulted in measurable improvements in key areas such as reduced Emergency Department attendances, increased use of community-based alternatives, and better patient flow through hospital sites. Notably, increased use of Same Day Emergency Care and community Minor Injury Units has provided patients with more appropriate and timely care options while reducing pressure on hospital services.

We recognise that challenges remain, particularly around ambulance handovers and Emergency Department wait times, as well as financial deficits driven by high temporary staffing costs. Addressing these areas remains a priority, and we continue to work collaboratively across the system to implement mitigations, improve performance, and reduce reliance on temporary staff.

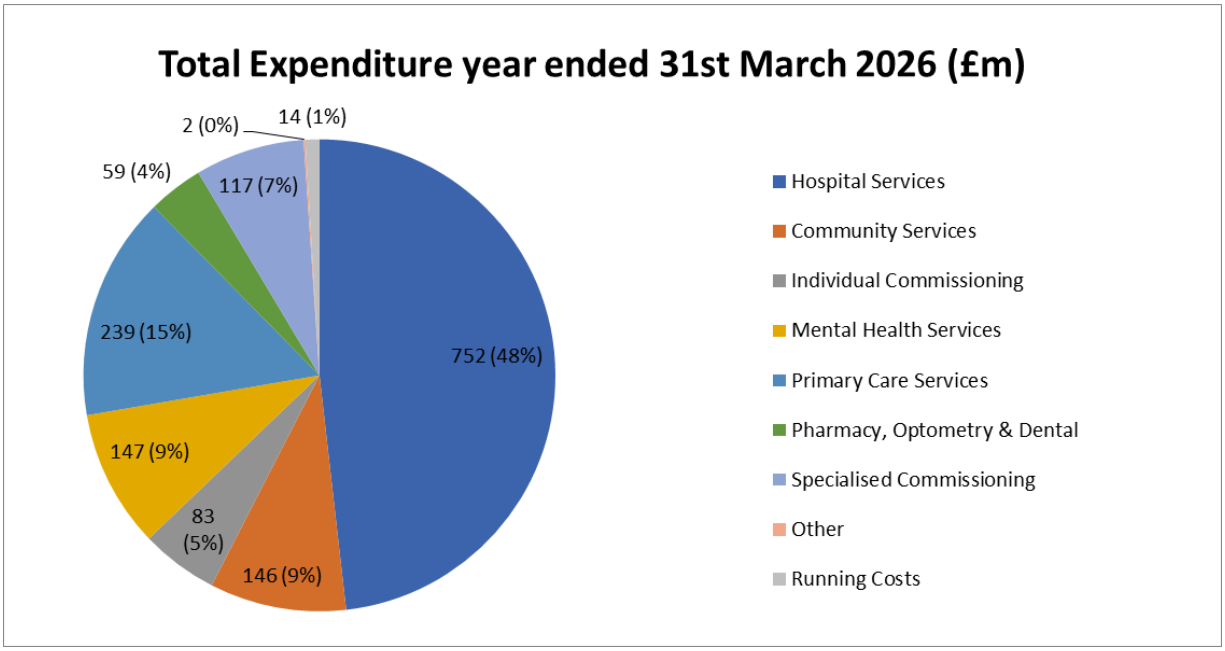
Our approach to delivering economy has been strengthened by the leadership of system Chief Executives in our transformation programmes and the establishment of the System PMO, ensuring alignment of resources, streamlined governance, and a collective focus on delivering system-wide improvements. By targeting areas of greatest inefficiency and aligning transformation initiatives to national productivity expectations, we are laying the foundations for sustainable improvement.

Overall, NHS Shropshire, Telford and Wrekin remains committed to delivering its statutory duty. While significant challenges persist, the plans, actions, and improvements implemented this year demonstrate our clear focus on driving effectiveness, efficiency, and economy in the use of public resources to improve outcomes for our population.

Financial position

In the year ended 31 March 2026 NHS Shropshire, Telford and Wrekin received a total allocation of £1,559 million to spend on the healthcare of its residents. Figure 3 below shows a breakdown of the organisation's expenditure for the period by spend type totalling £1,559 million.

Breakdown of the organisation's expenditure for the period by spend type



Further analysis of expenditure, by type for the year ended 31 March 2026

Expenditure	Current year (2025/26) Total (£'000)	Prior year (2024/25) Total (£'000)
Pay	26,491	18,730
-	-	-
Purchase of goods and services		
Services from other ICBs and NHS England	6,171	4,518
Services from foundation trusts	266,348	229,100
Services from other NHS trusts	778,447	730,399
Purchase of healthcare from non-NHS bodies	200,140	118,513
General dental services and personal dental services	36,451	33,596
Prescribing costs	103,786	100,320
Pharmaceutical services	38,502	16,163
General ophthalmic services	12,214	13,809
GPMS/APMS and PCTMS	118,900	112,309
Supplies and services – clinical	2,116	2,456
Supplies and services – general	262	4,848

Consultancy services	(6)	1,603
Establishment	2,043	2,999
Transport	914	887
Premises	118	505
Audit fees	132	150
Other non-statutory audit expenditure: Other services	-	40
Other professional fees	816	916
Legal fees	412	424
Education, training and conferences	709	258
Total purchase of goods and services	**1,550,539**	**1,443,813**
Depreciation and impairment charges	-	-
Depreciation	115	115
Total of depreciation and impairment charges	**115**	**115**
Provision expense	-	-
Provisions	(1,346)	(9)
Total provision expense	**(1,346)**	**(9)**
Other operating expenditure	-	-
Chair and Non-Executive Members	140	134
Grants to other bodies	-	34
Expected credit loss on receivables	256	890
Other expenditure	6	(3)
Total other operating expenditure	**402**	**1,055**
-	-	-
Total expenditure	**1,576,201**	**1,463,704**

An analysis of the Statement of Financial Position, detailing assets and liability balances

Expenditure	Current year (2025/26) Total (£'000)	Prior year (2024/25) Total (£'000)
Total non-current assets	823	938
Current assets		
Trade and other receivables	9,410	13,214
Cash and cash equivalents	840	660
Total current assets	**9,890**	**13,874**
Total assets	**10,713**	**14,812**
Current liabilities	-	-
Trade and other payables	(84,574)	(81,129)
Lease liabilities	(111)	(107)
Provisions	(1,941)	(3,353)
Total current liabilities	**(86,626)**	**(84,589)**
Non-current assets plus/less net current assets/liabilities	**(75,913)**	**(69,777)**
Non-current liabilities	(814)	(926)
Assets less liabilities	**(76,727)**	**(70,703)**
Financed by taxpayers' equity		-
General fund	(76,727)	(70,703)
Total taxpayers' equity	**(76,727)**	**(70,703)**

Mental health expenditure

Amount and proportion of expenditure incurred in relation to mental health

Financial years	Current year (2025/26) £'000	Prior year (2024/25) £'000
Mental Health Spend	147,289	127,030
ICB Programme Allocation	1,247,319	1,182,632
Mental Health Spend as a proportion of ICB Programme Allocation	11.87%	10.74%

Going concern

NHS Shropshire, Telford and Wrekin's accounts have been prepared on a going concern basis. In the year ended 31 March 2026 NHS Shropshire, Telford and Wrekin NHS System reported a £10.5m surplus in the year ended 31 March 2026 post deficit support funding, within this the ICB reported a £65k surplus.

It is important to note that the ICS financial position has been achieved with the support of £90m of Deficit Support Funding, which is released by NHS England predicated on the system achieving its agreed financial plan. The delivery of that plan is therefore not only a financial imperative but a condition of accessing the support that underpins the system's overall position. This underscores the significance of the performance achieved and the importance of maintaining the financial discipline that has made it possible.

At the end of the financial period, it was judged that the going concern status of the organisation remained unchanged on the following basis:

NHS Shropshire, Telford and Wrekin has taken steps to maintain business continuity for the finance function throughout the period in order that payments and collection of debt are not materially impacted. These steps include continuing with secure remote access to financial systems for all finance staff and budget holders and working with our third-party providers (Midlands and Lancashire Commissioning Support Unit and Shared Business Services), to ensure transactional processing is not adversely affected. This is evidenced in the low value of NHS Shropshire, Telford and Wrekin's aged debt and its continued high achievement against the Better Payment Practice Code.

There is a presumption that Integrated Care Boards are deemed to be a going concern because there is a statutory requirement to perform the commissioning function by a public body – and this determines the requirement to apply the going concern principle – not whether the specific Integrated Care Board will be doing the function in future.

The Governing Body, having made appropriate enquiries, have reasonable expectations that NHS Shropshire, Telford and Wrekin will have adequate resources to continue in operational existence for the foreseeable future.

Further, NHS Shropshire, Telford and Wrekin submitted its 2026/27 financial plan covering the 12-month period for the organisation on the 12th February 2026 and again on the 18th March 2026, both submissions are compliant with the Revenue Financial Plan Resource Limit and Capital Depreciation Expenditure Limit. This plan was based on the allocations notified by NHS England for the full financial year of 2026/27. On the 7th April 2026 the ICB received an official plan close down letter from NHS England to confirm compliance with conditions related to performance trajectories.

NHS Shropshire, Telford and Wrekin has therefore adopted the going concern basis for preparing the financial statements and has not included any adjustments that would result if it was unable to continue as a going concern.

Performance analysis

Children and young people's services

This year, we have worked collaboratively with local authorities, education partners, voluntary and community organisations, and service providers to ensure every child has the best possible start in life. Areas of focus have included earlier intervention and prevention, reducing health inequalities and improving health outcomes, improving access to specialist support, and ensuring services meet the diverse needs of local families.

Health services for children and young people (CYP) remained under significant and sustained pressure this year. In particular, we faced challenges with mental health access, workforce capacity and waiting lists – compounded further by significant growth in demand. As of February 2026, in excess of 3,000 children and young people were waiting for autism and ADHD assessments.

Despite these challenges, significant progress was achieved across elective care, community services, asthma and epilepsy pathways, safeguarding, Special Educational Needs and Disabilities (SEND), and multiagency governance.

Key achievements

- Shrewsbury and Telford Hospital NHS Trust has eliminated all CYP waits of more than 52 weeks for elective care, while Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and Shropshire Community Health NHS Trust have reduced long waits across most specialties
- Significant reductions have been reported for waits of more than 52 weeks across most children's community services
- Mental health crisis services are consistently meeting the four-hour response standards
- Strong progress has been made in delivering the national CYP asthma and epilepsy care bundles, including pathways, training, and enhanced specialist roles. The Asthma Friendly Schools scheme was relaunched and expanded this year
- Uptake of routine immunisations has increased through strengthened communication campaigns and improved access to flexible appointments
- We strengthened system-wide safeguarding arrangements for vulnerable and Looked After Children, including enhanced training and rapid learning reviews, Child Death service development, and focusing on those most at risk of poor health outcomes
- A memorandum of understanding has been drawn up to secure specialist, consultant-led palliative and end-of-life support for CYP until 31 March 2026, and a long-term contract to provide the service on a permanent basis from 1 April 2026.

Communication and neurodiversity support in schools

The Early Language Support for Every Child (ELSEC) initiative has supported young children with speech, language, and communication needs in 59 primary schools and nursery settings across Shropshire, Telford and Wrekin. The cross-discipline team has delivered training, coaching, and support to education staff and parent carers.

As well as improving the speech and language skills of the children, education staff are now more confident in supporting children to develop their communication skills. The local Speech and Language Therapy service is piloting delivering care in schools rather than clinics, and providing link therapists to all mainstream schools. The approach has also supported a reduction in waiting lists.

The Partnership for Inclusion of Neurodiversity in Schools (PINS) initiative has supported 70 primary schools in the area to better meet the needs of neurodiverse children. Coaching, training and support has been delivered by a range of local partners including NHS Occupational Therapy and Speech and Language Therapy services. Funding has also been allocated to local SEND Parent Carer Forums to establish a peer support network for parents of children with neurodiversity attending the selected schools. Both local authorities are moving forward with providing similar elements of support for secondary schools.

Central to our service transformation work this year has been empowering children, young people, and their parents to influence decision making, co-produce our plans, and share their lived experiences. Highlights include:

- We engaged extensively with service users to complete a whole-system review, redesign and recommissioning of child and adolescent mental health services (CAMHS). A new contract was awarded to Midlands Partnership University NHS Foundation Trust, and will launch in April 2026. The new model will focus on better education, early help and prevention, with improved access, joint working and person-centred care. Many future improvements are planned over the longer term.
- A robust review of current autism and ADHD pathways and services concluded this year, including considerable public and professional engagement. Evaluation is underway, and the findings will inform future design and commissioning plans.
- We established a Learning Disabilities and Neurodiversity (LD&ND) P artnership Group in May 2025 – strengthening oversight, sharing learning and bringing partners together to identify trends and solve problems together.
- A three-year project is underway to transform adult mental health inpatient services, which will also explore how children transition to adult services.
- Engagement with clinicians, partners, and lived-experience voices has shaped the design of a dedicated ARFID (Avoidant/Restrictive Food Intake Disorder) pathway. Improved collaboration across paediatrics, mental health, dietetics, and education will improve early identification, assessment, and support for CYP with complex feeding needs.
- A comprehensive review of local services for myalgic encephalomyelitis / chronic fatigue syndrome (ME/CFS), long COVID, and community neuro-rehab services is currently underway. This work is bringing together clinical teams, commissioners, and lived-experience voices to map current provision and identify what is needed to deliver more consistent, effective, and accessible support. The findings will ensure that services meet the needs of the local population, and provide high-quality, evidence-based care.
- We have started to redesign and recommission children's continence, constipation, and enuresis pathways to streamline referral routes, standardise clinical practice, and reduce unwarranted variation across the system.

Our work this year demonstrates a sustained commitment to improving health outcomes for children and young people across Shropshire, Telford and Wrekin. Significant progress has been made through strong partnership working, targeted investment, and a focus on prevention and early intervention.

Our future priorities aim to build on these foundations to create a more integrated, equitable, and responsive system where every child can thrive:

- Further strengthening and aligning of early help services across health, education, and social care, and expanding family hubs and community-based support models.
- Continuing to redesign the autism and ADHD pathways, and increasing capacity i n the neurodevelopmental pathway through new workforce roles and digital assessment tools.
- Supporting more schools and colleges through our Mental Health Support Teams, and improving transitions to adult services by developing a 0–25 emotional wellbeing and mental health offer.
- Expanding use of digital apps, remote therapy, online resources, and self-help tools designed for children and families.
- Continuing initiatives to improve recruitment and retention of paediatric and CYP mental health roles, and training staff around trauma-informed practice, neurodiversity, and safeguarding.
- Expanding youth engagement programmes and strengthening partnerships with parent-carer forums to ensure lived experiences shape our commissioning and quality improvement work.

Safeguarding, child deaths and looked after children

Ensuring the welfare of babies, children, and young people remains a priority across our system. This year, we have fulfilled our statutory duties by maintaining strong strategic leadership, governance, and assurance processes.

We have promoted safeguarding and early intervention through our commissioning and partnership work, and strengthened relationships with Special Educational Needs and Disabilities (SEND) partners and the Child Death Service. Our safeguarding arrangements have been developed to comply with Working Together to Safeguard Children (2023) – with our CEO being the Lead Safeguarding Partner and the Chief Nursing Officer being the Delegated Safeguarding Partner. This has further strengthened our partnership working within both local authorities, police, and partner agencies.

Prevention and early intervention

During the last year, we have worked closely with our partners to begin implementing the Families First Partnership Programme, which will improve how all agencies work with families to ensure they receive help at the earliest opportunity, from the right teams.

This has funded the recruitment of a Families First Partnership Health Coordinator, who we hope will be in post early in 2026/27.

We continue to deliver recommendations from the Independent Inquiry into Telford Child Sexual Exploitation (IITCSE). Safeguarding and contract review meetings are an opportunity to monitor progress of CSE-specific training.

The Child Protection Information Sharing (CP-IS) system alerts practitioners when a child protection plan is in place, or a child is in the care of the local authority. We are working with providers on the next phase, which affects multiple areas across the system, including 0–19 services, outpatient clinics and GP practices. Our Designated Doctor for Safeguarding Children is leading this work – ensuring oversight and strategic support for providers.

Meeting NHS England's requirements and delivering the NHS Safeguarding Commissioning Assurance Toolkit (SCAT) has also involved working closely with providers. We have completed our Section 11 audit to comply with the Children Act (2004) and give assurance regarding our statutory requirements. Furthermore, the ICB have maintained oversight of actions and identified learning as part of the Joint Targeted Area Inspection undertaken in Telford and Wrekin.

Female genital mutilation (FGM) has been one key aspect our safeguarding activity this year – ensuring providers are using the FGM Information Sharing alert system, and working with the regional NHS England team to ensure FGM is being identified and appropriate support services offered.

Another focus is unaccompanied asylum-seeking children (UASC) which continues to be included in the safeguarding assurance process by providers. We also participate in the West Midlands Strategic Migration Partnership which is an opportunity to share current challenges and good practice across the region.

Both Shropshire and Telford and Wrekin are part of the Devolved Decision-Making National Referral Mechanism pilot for which both Designated Safeguarding Children's Nurses are involved. We have worked collaboratively with our statutory safeguarding partners, local authorities, and police, in line with Working Together to Safeguard Children (2023).

We remain active members of both the Shropshire and Telford and Wrekin Safeguarding Partnerships – contributing to joint leadership, quality assurance, and shared learning. We also ensure learning from rapid review and Child Safeguarding Practice Reviews (CSPRs) are embedded across the system.

The designated nurses continue to identify local learning from national reviews and reports, and to ensure that embedded learning is shared through safeguarding committee meetings. We are a key partner within the Safeguarding Partnership Learning and Development teams – ensuring recommendations from reviews such as the IITCSE and the CSPR Panel's Annual Report are incorporated into subgroup work plans. In addition, we have identified local learning which is being embedded through the system following rapid reviews and local safeguarding practice reviews. Themes and trends identified through these have included neglect, young carers, mental health challenges, professional curiosity, and cross-border challenges.

We contribute to annual safeguarding reports produced by each partnership – which detail activity, learning from reviews, and effectiveness of local safeguarding arrangements. The ICB publishes its own Safeguarding Annual Report and Child Deaths Overview Panel (CDOP) Report each year. The CDOP Report sets out the arrangements for reviewing child deaths and learning with implementation.

Details of these safeguarding arrangements, annual reports and key priorities are available online:

- Shropshire Safeguarding Partnership
- Telford and Wrekin Safeguarding Partnership
- STW ICB Safeguarding Annual Report
- STW ICB Child Death Overview Panel Annual Report

We hear the child's voice through our involvement in procurement and commissioning processes, safeguarding partnership reviews, and the child death process. Families are included in local safeguarding practice and child death reviews so that we can hear their insights into how we can work differently to meet their needs.

We assure safeguarding quality through contractual arrangements with all NHS and independent providers, maintaining oversight of safeguarding practice and continuous improvement. We confirm that the ICB has followed the statutory processes set out in the NHS Safeguarding Accountability and Assurance Framework (SAAF) during 2025/26 which ensures effective safeguarding leadership, quality assurance, and a system-wide focus on the welfare of children and young people across our population.

Special Educational Needs and Disability (SEND)

The Children and Families Act (2014) places a statutory duty on the NHS to work with local authorities to support children and young people aged 0–25 with Special Educational Needs and Disabilities (SEND).

We have continued to play an active role in our two SEND partnerships with Shropshire Council and Telford & Wrekin Council. During this period, we contributed to SEND annual engagement meetings in both local authorities and regular monitoring meetings with the Department for Education (DFE) and NHS England. In Shropshire, we contributed to the six-monthly monitoring of the SEND Accelerated Progress Plan and a Local Government Association SEND Peer Review. Neither area underwent a joint local area inspection from the Care Quality Commission and Ofsted this year.

SEND Change programme

This year, we continued to take part in the national SEND Change programme. Developing Local SEND Reform Plans is an important first step for local areas to set out how they will lay the foundation for reform, and design an approach tailored to their local context. A shared plan which focuses on co-designing the local approach as system partners and with children, young people and families will help foster collective responsibility for delivering the reforms. Most notably for health, this programme has enabled continued delivery of the Early Language Support for Every Child (ELSEC) in Shropshire Telford and Wrekin. This has supported more than 50 schools and early years settings, and the Partnership for Inclusion of Neurodiversity in Schools (PINS), which has supported 70 schools to date. The positive impact of both initiatives has been recognised nationally and is informing future service planning across the system. The ICB continues to work in partnership with local authorities on the governance, assurance and commissioning of services to support families and children and young people with SEND.

The local population is increasingly needing SEND support, with social, emotional, and mental health needs being most needed. We acknowledge the importance of early intervention and continue to support the roll out of services such as the Mental Health in Schools Teams and the newly established 0–5 Child and Adolescent Mental Health Service (CAMHS) offer to enable support to be accessed at the earliest opportunity.

Progress with the early intervention approach can also be seen as services become more accessible, with reduced waiting times and a growth in accessing telephone advice lines to enable tailored, needs-led support. As a system, we have continued to improve the information available to describe our full offer of support related to neurodiversity and speech, language and communication needs, as well as more general support while waiting. The resources held on the Healthier Together website have received high numbers of views throughout the year, with positive impact reported by our SEND Parent Carer Forums. This work has supported a graduated response and better enabled the right support at the right time.

The SEND priorities for 2026/27 align with national priorities as set out in the pending White Paper focusing on early, local, fair, effective, and shared services. Our local priorities are to promote inclusive practice across health services through a systematic, data-informed approach in collaboration with our partners in local authority and education settings. In line with the Five-Tear Strategic Commissioning Plan, we have ambitions to support care closer to home through joint commissioning and delivery with local authority partners. We also endeavour to support the prevention agenda through early identification, appropriate diagnostic pathways, further consideration of school nursing delivery models, and ensuring a skilled children and young person's workforce across agencies.

To continue to improve the experience of children and young people with SEND and their families, it is essential that we work in synergy with the Families First Partnership and Best Start in Life programmes and other priority agendas. We plan to respond to the pending Schools White Paper, while continuing to engage regularly with our parent carer forums.

Maternity and neonatal services

This portfolio provides strategic leadership, assurance and improvement across the perinatal pathway – ensuring women, birthing people, babies and families receive safe, equitable and high-quality care.

By working with provider trusts, neonatal networks, public health, primary care and community partners, we support the delivery of national programmes including Saving Babies' Lives v3, the Three-Year Delivery Plan for Maternity and Neonatal Services, the Women's Health Strategy and the NHS Long Term Plan. The portfolio also leads commissioning, contracting, quality oversight, workforce planning and digital readiness, alongside the development of integrated, prevention-focused pathways designed to reduce inequalities and improve outcomes.

This year has been marked by strengthened safety oversight and closer partnership working across maternity and neonatal services. The Local Maternity and Neonatal System (LMNS) Quality and Safety workstream continues to provide a forum for partners to identify barriers, share learning and agree system-wide improvements.

Safety across the perinatal pathway has remained stable, supported by strong clinical practice, effective escalation processes and robust governance arrangements and well-established neonatal optimisation pathways that continue to reduce unnecessary transfers to the neonatal unit. We have made significant progress against national investigation recommendations – including actions from the Ockenden Report – with the majority now complete.

We have also strengthened our understanding of perinatal equity. A comprehensive perinatal equity analysis brought together data from system partners to understand variation in outcomes and experiences across our population. Working together, our partners have used this analysis to identify our key priorities and develop a population health management approach. This work will enable improvement efforts to be targeted more effectively and ensure that services respond to the needs of our diverse communities.

Workforce across maternity and neonatal services has remained broadly stable throughout the year. Midwifery staffing supports consistent, safe care and the ongoing delivery of one-to-one support in labour, while neonatal teams have maintained safe staffing and continued to progress Family Integrated Care models. Core training compliance remains strong across most staff groups – underpinning the wider safety and quality agenda and supporting preparation for forthcoming national requirements.

Although there has been some pressure within the obstetric education function, interim arrangements and focused planning are in place to ensure continuity of essential training activity as part of a wider commitment to strengthening education, development and resilience across the perinatal workforce.

Commissioning and contracting activity has centred on preparing for substantial national requirements beginning in 2026/27, including the Maternal Care Bundle, the ABC Programme, the national maternity triage specification, and bereavement care standards. Progress has continued on the cluster-wide maternity specification with Staffordshire and Stoke-on-Trent ICB, which is designed to harmonise pathways, standards and contractual expectations across the wider geography.

Digital maturity remains a key area of focus, with current limitations within BadgerNet relating to national deterioration tool requirements driving targeted improvement work to strengthen capability and support forthcoming national standards.

Strong partnership working continues to underpin improvement. Collaboration across maternity, neonatal services, primary care, 0–19 services, public health, the Maternity and Neonatal Voices Partnership (MNVP) and the voluntary sector is enhancing prevention, service improvements, early identification of risk and personalised care planning. A key focus for 2026 will be developing integrated community midwifery models and exploring models of enhanced continuity of carer and prioritising women who are evidenced to be at highest risk of poorer outcomes.

Preconception care

This has been a significant area of growth this year. Through funding from the Burdett Trust for Nursing, we established a proof-of-concept partnership between the LMNS, 0–19 nursing service and subject matter experts at Balance Fertility. This work aims to improve reproductive health literacy among young people and communities experiencing deprivation – whether conception is planned or not.

Planned evidence sessions and cross-sector training for professionals across maternity, fertility, primary care and community services will strengthen early intervention, enhance pre-pregnancy optimisation and promote a deliberate left shift. This will help individuals enter pregnancy in the best possible health and reduce avoidable risk.

Through sustained focus on safety, equity, prevention and partnership, we remain committed to delivering high-quality, compassionate maternity and neonatal care for every family.

Quality and patient safety assurance, and improvement

During 2025/26, we have continued to strengthen our role as a system leader for quality, safety and population health outcomes. We focused our efforts on improving assurance, reducing unwarranted variation, and embedding a culture of learning across all providers and pathways.

Our statutory responsibilities under the Health and Care Act (2022) have shaped a renewed emphasis on evidence-led decision making and proactive quality surveillance – particularly in urgent and emergency care and perinatal care. Assurance is provided to the ICB Quality and Performance Committee, and the System Quality Group's terms of reference align to the National Guidance on System Quality Groups (National Quality Board, 2022).

National and local performance and quality insights come from national datasets, regulatory intelligence, patient experience feedback and local clinical indicators. These have underpinned our system quality priorities, including targeted work on maternity safety, urgent and emergency care pressures, elective recovery, community care, communicable disease resilience, and frailty.

Throughout 2025/26, we triangulated evidence to identify variation, commission targeted improvement actions, and support providers to respond to both immediate quality concerns and long-term system challenges. Evidence has come from:

- Specialty treatment data (such as elective outcomes, mental health outcomes, cancer pathways, maternity indicators) published on the MyNHS platform
- Service-level performance data including access, safety outcomes, and patient-reported experience. This has included the piloting of the Maternity and Neonatal Senior Independent Advocate (MNISA) and strengthening our Maternity and Neonatal Voices Partnership (MNVP) with strategic leadership
- Health and wellbeing population indicators, informing prevention and early intervention priorities across the ICS. This has informed a newly-commissioned 24/7 response to communicable disease and infection control.

We have reviewed system quality governance, and fully implemented the recommendations. We have enhanced our thematic review capability and our quality visits programme, and fostered greater alignment across providers through shared learning and joint improvement plans. We have supported organisations facing quality challenges while promoting prevention and early intervention to reduce future harm.

Our commitment to patient voice and co-production has deepened, ensuring that services are not only clinically safe but reflective of the lived experiences and diverse needs of our communities. Our improved MNVP leadership has significantly improved diverse voice into our perinatal pathways and oversight, and the MNISA pilot has shown earlier engagement with families and providers and feedback directly into boards.

Workforce campaigns

Workforce culture has remained a central priority, with increased focus on human factors, safety thinking, leadership capability, and psychological safety. Our work on equality, diversity and inclusion has focussed on a system-wide campaign to drive the message of 'no quality without equality'. A supporting communication campaign 'Everyone Belongs Here' has been co-designed with the workforce.

We have supported the deterioration pathways, with 100% of care homes offering deterioration training to their staff. Martha's Rule is now being implemented in both of our commissioned inpatient

providers, and monthly assurance indicators on quality of care in the energy departments have improved month-on-month despite operational challenges.

System quality focus has resulted in no services being overall rated as 'inadequate', however medicine and emergency care at Princess Royal Hospital remain inadequate.

Table: Regulatory oversight

Service	CQC ratings (as at 21 February 2026)
Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	Good
Shrewsbury and Telford Hospital NHS Trust	Requires improvement • Maternity – Good • Services for children and young people – Good
Shropshire Community Healthcare NHS Trust	Good
GP practices	Outstanding 3 Good 47 Requires improvement 0 Inadequate 0
Care homes including nursing, residential and specialist learning disability and mental health	Outstanding 5 Good 114 Requires improvement 28 Inadequate 0 Not inspected 8

Looking ahead, we will further evolve our digital quality surveillance and use of shared care record, develop provider-collaborative-led quality assurance models, and elevate system-wide improvement capability.

Our ambition remains consistent and clear – to deliver high-quality, safe and compassionate care for every resident of Shropshire, Telford and Wrekin and beyond, as we move into a new clustered model in 2026/27.

As the ICB moves to a strategic commissioning model next year, the focus will be on:

- Strengthening integrated quality oversight across the Provider Collaborative Model and at Place
- Enhancing digital quality surveillance – enabling earlier detection of unwarranted variation
- Deepening partnership working with local authorities and the voluntary sector to address wider determinants of quality and wellbeing
- Expanding capability in safety-critical areas such as early warning detection, human factors, and system resilience
- Deepening the understanding of patient and public voice.

Mental health

We remain committed to an integrated, collaborative approach across the Shropshire, Telford and Wrekin system to ensure mental health is given equal priority to physical health. Our ambition is for all residents to receive timely, compassionate and effective mental health support as close to home as possible, with care that strengthens families, promotes independence and improves long-term wellbeing.

System oversight continues to be provided through the Shropshire, Telford and Wrekin Mental Health, Learning Disability and Autism (MHLDA) Portfolio Board, which brings together partners from across the ICS, including VCSE colleagues and lived experience representatives. The Board is sponsored by Neil Carr, CEO of MPFT, and is operationally led by Cathy Riley, Managing Director at MPFT, as the Senior Responsible Officer.

Children and Adolescent Mental Health Services (CAMHS)

In 2025/26, we completed the re-procurement of CAMHS and introduced a redesigned model that places co-production and participation at the centre of service development. This ensures that children, young people, parents and carers directly shape improvements to the service. While workforce challenges have continued to impact access, targeted recruitment is improving waiting times and service responsiveness.

During 2026/27, we will continue to deliver the Three-Year Transition Plan, focusing on:

- Embedding prevention-focused, needs-led and trauma-informed practice
- Establishing a single point of access
- Strengthening pathways and improving service navigation
- Expanding digital support and early help resources
- Fully embedding the iThrive framework

Through this programme, we expect to reduce crisis presentations, A&E attendances and avoidable admissions, while improving resilience, early intervention and outcomes for children, young people and their families. We will maintain a continued focus on Core20PLUS5 to reduce inequalities in access, experience and outcomes for underserved groups aged 0–17.

Mental Health Support Teams (MHSTs)

Mental Health Support Teams remain a vital component of our early intervention offer, helping to reduce waiting times and improve emotional well-being in education settings. Current coverage stands at approximately 68% of schools and colleges across Shropshire, Telford and Wrekin, with teams delivering evidence-based interventions and embedding whole school approaches to mental health.

In line with NHS England's 2025/26 planning guidance, we will continue to expand MHST provision, contributing to the national ambition of 100% coverage by 2029/30. This expansion will strengthen prevention, reduce stigma, and help ensure children and young people can access mental health support as early and as easily as possible.

Talking Therapies

MPFT's Talking Therapies service continues to provide targeted support for people experiencing depression, anxiety, stress, low mood, phobias and emotional difficulties, including those with long-term physical health conditions. In 2025/26, the service received 11,501 referrals and supported 5,814 people in line with NICE recommended practice.

In 2026/27, we will focus on expanding access, improving waiting times and strengthening performance against national indicators, including Reliable Recovery, Reliable Improvement and treatment completion. Our ambition is for people to receive the right therapeutic support at the earliest opportunity, reducing escalation and improving long-term outcomes.

Inpatient Quality Transformation Programme (IQTP)

Working with system partners, we continue to deliver the Inpatient Quality Transformation Programme, which aims to ensure that inpatient mental health care is:

- Personalised, therapeutic and safe
- Delivered through timely and clinically appropriate admissions
- Underpinned by effective therapeutic engagement and high-quality care planning
- Better coordinated with community services
- Continuously improved and responsive to inequalities

Through this programme, we aim to reduce unwarranted variation and ensure people receive the right support in the least restrictive environment.

Dementia

During 2025/26, we strengthened our post-diagnostic dementia offer to ensure people with dementia and their carers receive proactive support, including specialist nursing and dedicated link workers. This approach aims to prevent crisis, support independence and improve quality of life.

In 2026/27, we will embed dementia care pathways within our emerging neighbourhood models, rolling out the successful Dementia Multi-Disciplinary Team model piloted in Southeast Shropshire across all neighbourhoods. This model focuses on proactive identification, assessment, multi-agency coordination and ongoing case management to reduce deterioration and crisis episodes.

24/7 Text Crisis Service

The all-age 24/7 Crisis Text Service, launched in Autumn 2025, provides immediate, confidential support for people experiencing mental health distress. The service enables individuals to seek help discreetly at any time, offering an alternative for those who may feel unable to talk on the phone or who require privacy and anonymity. It is particularly valuable for people who find verbal communication challenging or overwhelming. By offering round-the-clock support, the service aims to reduce the likelihood of crisis escalation, self-harm or suicide, and to improve overall mental health outcomes.

Review of Intensive and Assertive Community Mental Healthcare

NHS England has asked all ICBs to review intensive and assertive community mental health services to ensure they adequately meet the needs of people with severe and complex mental health conditions. This includes evaluating the capacity, quality and coordination of existing provision to identify gaps and ensure care is person-centred, accessible and aligned to individuals' needs.

This review will support improvements across the community mental health pathway, reduce unnecessary hospital admissions, promote recovery-focused care and address inequalities in access and outcomes. It will also inform future commissioning and workforce planning as we strengthen our neighbourhood-based mental health models.

Learning disabilities and autism

Our ambition for Learning Disability (LD) and Autism services is to ensure timely, equitable and high-quality support across the whole pathway, with a strong emphasis on prevention, early intervention and reducing avoidable hospital admissions. Our approach continues to be shaped by the following priorities.

We have undertaken a comprehensive assessment of the actions required to improve access, experience and outcomes for adults with a learning disability and autistic adults. This work has involved significant engagement with local people and will underpin clear commissioning and delivery plans from 2026/27 onwards. Successful delivery will depend on a close partnership with Local Authorities and mental health providers, particularly in relation to housing, social care, community support and specialist health provision.

Working collectively with system partners during 2025/26, we have also focused on reducing the need for inpatient admissions for children under 18. Current admission numbers remain very low, and our ambition is for any admission to be an absolute exception. This will be achieved through strengthened early help, enhanced crisis support, and the development of effective, multi-agency wraparound care, led jointly with Local Authorities and mental health providers.

Alongside this, we have strengthened systemwide partnership working to ensure timely, safe and person-centred discharge for individuals who require an inpatient stay. This includes coordinated working between inpatient teams, Community Learning Disability Teams, Local Authorities and the Transforming Care Team. Our aim is to prevent unnecessary delays, avoid deterioration, and ensure that people return to the least restrictive, most appropriate setting as soon as clinically safe.

We have continued to increase uptake of Annual Health Checks (AHCs) among people aged 14 and over with a learning disability and to improve completion rates for Health Action Plans (HAPs). Our ambition is to exceed the current forecast of 81% HAP completion for 2025/26. Strengthening AHC and HAP delivery supports earlier identification of health needs, reduces avoidable illness and improves communication and outcomes — aligning with national expectations to reduce premature mortality and improve physical health outcomes for people with a learning disability.

Across all age groups, for neurodiversity (autism and ADHD), we completed a full pathway review in 2025/26 in response to national and local challenges related to capacity and access. This review, co-produced with service users, carers and professionals, will inform a redesigned needs-led pathway from 2026/27, including improved pre- and post-diagnostic support. Recommendations from the national ADHD Taskforce and any future national guidance will be incorporated into the design and delivery of neurodiversity services.

We have also continued to work with commissioned providers to improve access to autism and ADHD assessments for children and adults, recognising that current demand continues to exceed capacity, which is a challenge both locally and nationally, with the service redesign planned being key to reducing waiting times.

We remain committed to ensuring that autistic people and people with a learning disability receive high-quality, person-centred mental health inpatient care when required. National evidence highlights the higher likelihood of mental health challenges in these groups, making it essential that services provide appropriate, reasonable adjustments, personalised care planning and trauma-informed approaches. Continued involvement of people with lived experience in service design and quality improvement will support the development of accessible, recovery-focused and efficient inpatient pathways.

Finally, we have continued to embed improvements to our Learning from Lives and Deaths (LeDeR) processes, ensuring that learning is acted upon and inequalities are addressed across the system. This ongoing work will play a central role in shaping safer, more responsive and more equitable services for people with a learning disability and autistic people.

Planned care (includes elective, cancer and diagnostics)

In Shropshire, Telford and Wrekin, we are proud of the progress made during 2025/26. We recognise that some patients are still waiting too long for treatment. Reducing elective waits remains a core organisational priority as we move into 2026/27. We will also continue with our highly successful engagement events with our patients and the public, particularly for cancer awareness.

Cancer

During 2025/26, NHS Shropshire, Telford and Wrekin continued to deliver its Cancer Transformation Programme, aligned to the National Cancer standards and NHS Cancer Operational Planning Guidance. The programme focuses on improving outcomes across the entire cancer pathway, from early detection to diagnosis, treatment, and personalised care. In 2025/26, non-recurrent funding from the West Midlands Cancer Alliance continued to support the provision of an NHS Shropshire, Telford and Wrekin Cancer Programme Team to drive this work.

In 2025/26, The Shrewsbury and Telford Hospital NHS Trust, the main cancer care provider in Shropshire Telford and Wrekin, made significant and consistent progress against key national cancer targets. Focus on improvements at the front end of the Cancer pathway, from referral to patients receiving either a definitive cancer diagnosis or have cancer ruled out, has seen the national Faster Diagnostic standard being met and exceeded over the second half of the year. The referral to treatment standard, which requires patients to receive first treatment within 62 days of urgent referral, has also seen steady improvement against national standards, with plans in place to further improve performance in 2026/27.

Lung Cancer is one of the most common types of Cancer in the UK; however, it has historically had one of the lowest early-stage detection rates. The Lung Cancer Screening Programme was launched in Shropshire, Telford and Wrekin in December 2025, screening smokers and previous smokers aged 55-74. The programme has tailored the delivery of Lung Health Checks and Low-dose CT scans to help address barriers faced by those with protected characteristics and other groups at risk of health inequalities, in order to improve access to the service.

A pathway to support the management of unexplained bleeding whilst on Hormone Replacement Therapy (HRT) was launched in 2025/26. This pathway supports careful management of these patients in Primary Care by clinicians with additional training from the British Menopause Society. This ensures that only those who require Urgent Suspected Cancer investigation are referred on to secondary care, reducing unnecessary worry for patients.

As part of the Shropshire Telford and Wrekin early cancer diagnosis programme, and supported by the West Midlands Cancer Alliance, a cancer bus tour was run in 2025/26 to raise awareness of cancer screening programmes (including the Lung Cancer Screening Programme), educate the population on early signs and symptoms of cancer and encourage individuals to seek support from their GP if they were concerned about their health. Working with key stakeholders from the ICS, 6 events were held in towns across Shropshire and Telford and Wrekin, plus an event at the Oswestry Livestock Market.

A further element of the Early Diagnosis Programme is a Young People's Cancer Awareness initiative that delivers flexible engagement in sixth forms and colleges across Shropshire and Telford & Wrekin to boost young people's understanding of cancer signs, screening, and prevention. Events are being provided by Local Authorities and the Lingen Davies Cancer Charity in schools and colleges, offering information and support to young people and their educators.

Elective Care

During 2025/26, all providers across the system have worked hard to reduce waiting times for patients requiring planned care. For the vast majority of patients, across all specialities, the wait for treatment is now under 52 weeks.

Key achievements include:

- The number of patients waiting over 65 weeks has reduced significantly—from 1,438 in June 2024 to 47 in January 2026.
- Patients waiting over 52 weeks have been reduced to 596, with continued progress toward full elimination.
- No children or young people are currently waiting over 52 weeks for treatment.
- Referral to Treatment (RTT) performance has improved to 64.2%, up from 50.7% in 2024/25.

These improvements have been delivered through a combination of additional capacity via internal extra activity, insourcing and outsourcing; and productivity gains. The system has also benefited from increased surgical capacity at the Surgical Hub at the Princess Royal Hospital, providing ring-fenced day-case capacity dedicated to elective care. In-year elective recovery funding has been effectively used to expand short-term capacity in specialities with the longest waits, including evening and weekend clinics.

Alongside reducing waiting times, we have also focused on supporting people while they wait. In partnership with Public Health, we have strengthened proactive outreach for those awaiting musculoskeletal appointments, offering holistic and lifestyle-based support to improve wellbeing during the wait. We have also seen increased use of digital support tools such as My Recovery and tinnitus management apps.

Looking ahead to 2026/27, we are confident that waiting times will continue to fall, with the next system milestone being to ensure all patients wait less than 40 weeks. We will also continue to expand the use of AI where evidence shows it improves patient experience and outcomes.

Although we are proud of the progress made, we recognise that some patients are still waiting too long for treatment. Reducing elective waits remains a core organisational priority as we move into 2026/27

Diagnostics

In 2025/26, the Shropshire, Telford and Wrekin (STW) system continued to deliver against the NHS Long Term Plan and the NHS Elective Reform Plan (January 2025), maintaining a strong focus on improving equitable and timely access to diagnostic services as a key enabler of earlier diagnosis and improved population health outcomes.

The development and optimisation of Community Diagnostic Centres (CDC) have remained central to this approach. The Telford Community Diagnostic Centre delivered over 134,000 diagnostic tests in 2025/26, a significant increase from 85,000 in 2024/25. Extended operating hours have improved accessibility for patients, particularly those who may face barriers to accessing acute hospital services. The continued expansion of clinical pathways within the CDC supports the system's ambition to deliver more care closer to home, improving patient experience while reducing pressure on acute settings

Plans to drive innovation, standardisation, and service improvement across the system are in progress. In parallel, plans for an additional Community Diagnostic Centre are being progressed, subject to national approval and funding, to further increase capacity and improve geographical equity of access.

Workforce sustainability remains a key priority. The system has strengthened collaborative working through enabling more flexible deployment of staff and improved resilience across services. Targeted recruitment and training initiatives continue to address workforce shortages and support the delivery of safe and sustainable services. A continued focus on workforce retention and developing advanced practice within the radiographic workforce.

Demand for diagnostic services continues to grow year on year. In response, the system has adopted a whole-system approach to pathway transformation and capacity optimisation. This includes a comprehensive review of diagnostic capacity, the introduction of a digital performance dashboard to support real-time operational oversight, and continued work to streamline pathways and reduce unwarranted variation.

Reducing health inequalities remains a core focus. Targeted efforts have been made to improve access for underserved and vulnerable populations, including those in rural communities and patients on cancer pathways, ensuring timely access to diagnostics and supporting earlier intervention and improved outcomes.

The system remains committed to achieving the six-week diagnostic standard and delivering sustainable improvements in access, experience, and outcomes for the population.

Key Achievements 2025/26

- Performance against the six-week diagnostic standard improved to 86.5% (February 2026), compared to 58.4% (December 2024).
- The number of patients waiting over 13 weeks reduced significantly from 2,955 to 140
- A greater proportion of patients are receiving diagnostics within six weeks, supporting earlier diagnosis and improved outcomes.

Risks and Challenges

- Continued growth in demand for diagnostic services may outpace capacity if further expansion is not secured.
- Workforce shortages, particularly in specialist diagnostic roles, remain a constraint to sustained delivery, and reliance on the independent sector
- Dependency on national approval and funding for additional CDC infrastructure presents a risk to future capacity expansion.

Priorities for 2026/27

- Progress development and delivery of an additional Community Diagnostic Centre to increase capacity and improve geographical access.
- Further expand CDC clinical pathways to support care closer to home and reduce reliance on acute services.
- Strengthen workforce models through continued collaboration, recruitment, and skill mix optimisation.
- Enhance use of digital tools and data to support proactive performance management and pathway improvement.
- Maintain a focus on reducing health inequalities by targeting underserved populations and improving equitable access to diagnostics.

Community transformation

Cardiovascular disease (CVD)

Around 62% of people locally are living with one or more conditions affecting the heart, kidney, or metabolism – such as diabetes. These conditions, including high blood pressure, are closely linked and can significantly affect people's health, quality of life and independence if not managed early.

This year, we developed a key strategy (due to be implemented in 2026/27) to improve how these conditions are prevented, identified, and managed across our communities. The focus is on earlier detection, proactive prevention, and ensuring people receive the right personalised care, treatment, and support at the right time. This includes improving access to services closer to home, using data and technology to identify those at greatest risk, and supporting healthier lifestyles to reduce the likelihood of developing complications.

Diabetes

A new National Diabetes Prevention Programme (NDPP) referral pathway for women with gestational diabetes (during pregnancy) was introduced – supporting earlier prevention and enabling referral at the point of diagnosis. This has helped increase maternity care and strengthen joined-up care.

We have harnessed opportunities to promote preventative services in local communities through having a presence in community hubs, supporting opportunistic conversations, improving access and reach, and helping people connect to the right programme in a familiar setting. We have also boarded the Telford and Wrekin CVD Bus and provided resources in several languages to reach more communities.

Good-quality foot care is key to effective diabetes care. With support from acute hospital colleagues, we developed an educational foot care video for healthcare professionals. NHS England have expressed an interest in sharing this work more widely as an example of good practice.

Finally, a dedicated diabetes website is due to be launched in 2026/27. Service users have been involved in its development to ensure the content is clear and consistent.

Children and young people's asthma

A significant programme of work has been undertaken to support local schools to implement the new national approach to asthma training for children and young people (CYP). Alongside this, the CYP Asthma School Policy Advisory Guidance was updated and published, and the refreshed CYP Asthma Friendly School Scheme was launched.

We have delivered several online support sessions to schools – helping to strengthen confidence, consistency, and best practice in managing asthma in school settings. The impact of this work is clear, with Tier 1 training increasing from 601 in April 2025 to 3,732 in January 2026. Since the Asthma Friendly School scheme launched in November 2025, one in five schools in Shropshire, Telford and Wrekin are now accredited. Funding for this provision has now also been allocated recurrently, which is also a huge achievement for the local population.

Integrated neighbourhood teams

In September 2025, Shropshire was chosen as one of 43 sites to participate in the national neighbourhood implementation accelerator programme. Building on this, we have continued to work with our partners to establish integrated multi-disciplinary teams in each of our nine neighbourhoods.

The aim is to proactively target patients with moderate frailty and/or long-term conditions at risk of acute deterioration and consequent need for urgent and emergency services. Multi-provider assessment and wrap-around holistic support is arranged to address their health and wellbeing needs – keeping them well for as long as possible in their community.

A key priority is for GP practices, community services, hospitals, local authorities, and the voluntary sector to work in a more integrated way, improve coordination between services, and support people to better manage their conditions. This will help reduce avoidable hospital admissions, improve long-term outcomes, and help people to live longer, healthier, and more independent lives.

Urgent and emergency care

Our Urgent & Emergency Care Delivery Group has representatives from all system partners, which is accountable via Committees to the Integrated Care Board for the delivery of quality of care and operational performance. Our system-wide improvement programme agreed with the NHS England Midlands region has built upon progress last year.

This year it has comprised of four workstreams areas of focus were:

1. Providing Community alternatives to our Emergency Department and alternatives to Admission to our hospitals.
2. Improving Acute Flow through our Emergency Departments.
3. Improving System Discharge processes.
4. Winter Planning to ensure our System was prepared – early, and in good order – for the increased demands in the winter period.

Key achievements in delivery of this improvement programme include:

- An Integrated Out of Hospital model of care has expanded capacity of services such as Virtual Ward and Urgent Community Response, supported by streaming away from our Emergency Departments and extended operation of our Care Transfer Hub that facilitates discharges for patients that require additional support.
- A 56 bed modular build has been opened at the Royal Shrewsbury Hospital. This enabled an ambitious reconfiguration of the bed base there that has resulted in better overall flow through the hospital with patients in more optimal locations, giving much needed capacity to key service specialities.
- At The Princess Royal Hospital a similar reconfiguration of use of space has resulted in 40 additional beds or Assessment spaces providing significant enhancements to patient flow out of our Emergency Departments.
- Further improved to working across system partners has mitigated risks and improve care for our population.
- The progress made has been recognised by NHSE as the ICB being now being compliant with and having fulfilled the Legal Undertakings placed upon us for UEC improvement. And further recognition has been the ICB being released from the national Recovery Support Programme for UEC.

Key risks remain regarding the crowding experience at times within our Emergency Departments resulting in excessive waits in ambulance handover, performance to the four-hour standard and the number of patients waiting over 12 hours for a hospital bed.

Our UEC Improvement Programme for the year ahead will be a two year programme with a headmark of preparation for the Hospital Transformation Programme at our acute hospital sites from early 2028. It will continue to focus on supporting our patients to receive the most appropriate care in the right setting, ensuring patients who need emergency services receive these in a timely manner.

Primary care

General practice

There are 50 GP practices in Shropshire, Telford and Wrekin – across nine Primary Care Networks (PCNs). Over the past year, PCNs have continued to deliver national requirements under the Directed Enhanced Service contract. PCNs have a key role in improving access including extended hours on evenings and weekends, initiatives such as winter illness clinics, and services to support and improve outcomes for people with long-term conditions.

This year, our PCNs have been central to developing our growing neighbourhood working models by collaborating with our two local authorities, community pharmacy, other NHS providers, and the voluntary sector. Reducing health inequalities remained central to delivery, with programmes to identify patients most at risk of needing hospital care. Action has been taken to reduce this across a number of areas including frailty, cardiovascular disease, diabetes, and respiratory disease.

Improving patient experience and access to general practice has been a key priority both nationally and locally during 2025/26. Changes to the general practice contract have resulted in patients at all practices having access to GPs via walk-in, phone, and online methods. More practices are moving to a total triage model to support access, ensure patients are prioritised appropriately, and that urgent appointments are offered quickly. It also allows patients with long-term conditions to book necessary appointments in advance.

We are seeing growing use of digital routes of access to general practice, with 358,050 online consultations delivered between April and November 2025. Figures from 31 January 2026 show that 69% (324,325) of patients aged 13 and over were registered on the NHS App. The NHS App will increasingly be used to inform patients and help them manage their own conditions more effectively.

Between April and December 2025, a total of 2,338,301 GP appointments were delivered – an increase of 0.5% compared to 2024/25.

Through feedback and surveys, we continue to hear positive experiences regarding access to primary care. General practice access and performance across Shropshire, Telford and Wrekin continues to measure positively against national measures and targets.

Community pharmacy

Our network of 80 community pharmacies provides vital clinical services – supporting prevention, self-care, and neighbourhood health delivery. This year we celebrated the second anniversary of Pharmacy First, which has delivered almost 160,000 consultations since launch. This figure includes 103,017 clinical pathway, minor illness, and urgent medicines consultations, 47,430 blood pressure checks, and 8,617 oral contraception consultations.

These essential neighbourhood services have seen growth of 31% year-on-year across all arms of the service. We continue to engage with neighbourhood partners to ensure community pharmacy remains an integrated partner through raising awareness, expanding service provision, and integrating pathways.

Through the Community Pharmacy Independent Prescribing Programme, three community pharmacies in Shropshire, Telford and Wrekin delivered more than 500 consultations related to acute on-the-day care, women's health, deprescribing, long-term condition management, and medicines shortage management. Although successful, the national programme has concluded. We are currently exploring how to embed prescribing services into more of our community pharmacies from 2026/27.

Optometry

Local optometry services continue to provide accessible, high-quality eye care through 58 NHS-contracted practice sites. Services are delivered through the General Ophthalmic Services contract and enhanced community pathways including Optometry First, which now has participation from more than 70% of practices.

The Community Urgent Eyecare Service (CUES) supports rapid access for urgent eye conditions, with around 83% of patients fully managed within community optometry. Additional pathways such as cataract refinement, glaucoma repeat readings and children's eyecare are well embedded, and have received positive patient feedback.

The Local Eye Health Network continues to strengthen collaboration across optometry, ophthalmology, orthoptics and sight loss services, supporting integrated care and shared learning. Workforce development remains a priority, with ongoing uptake of higher qualifications including Independent Prescribing, Glaucoma and Medical Retina.

Digital improvements continue through the Electronic Eyecare Referral System (EeRS), ensuring faster, more efficient communication and referrals. Work is progressing on commissioning annual sight tests for children and young people in special educational settings, with strong local engagement ahead of the planned 2026 procurement timeline.

Dentistry

This year we have focused on improving performance, access, and resilience of dental services across Shropshire, Telford and Wrekin. Improving access to dental care is a priority both nationally and locally. Although access for children and adults across Shropshire, Telford and Wrekin is above the England average, it remains below pre-pandemic levels. Improving access to both routine and urgent dental care has been a priority in 2025/26 and will continue to be so in the coming year.

Urgent Dental Care

We have commissioned 7,408 additional urgent appointments this year, representing a 24.7% increase on last year. Commissioned services generally see patients within 24 to 48 hours.

Key investments for 2025/26:

- We commissioned additional activity to improve access – focused on highest-need areas across Telford, Shrewsbury, Oswestry, Ludlow, Bridgnorth, Church Stretton, and Market Drayton
- We expanded the Shropshire and Staffordshire Oral Health Improvement Team – hosted by Shropshire Community Healthcare NHS Trust – to undertake more targeted preventative work
- We began offering dental checks in special educational settings
- We launched the multi-disciplinary dental 'Golden Hello' scheme to support local recruitment and retention of dentists, therapists and nurses
- We addressed waiting lists for orthodontic care for children and young people.

While work remains to be done, these initiatives are showing improvements in dental access for our residents, including:

- Increased availability of routine and urgent NHS dental appointments
- Reduced waiting times for adults, children and families
- Strengthened prevention through community programmes
- A more resilient and sustainable dental workforce.

Pharmacy and medicines optimisation

Medicines value and financial recovery

The Medicines Value Programme continues to deliver strong financial performance, achieving £4.2 million savings this year (as of January 2026) against a plan of £4.0 million, and forecasting £4.9 million by year-end. This reflects effective system-wide prescribing optimisation and supports our overall financial recovery plan.

Promoting Pharmacy First

The Pharmacy First programme has delivered 159,064 consultations (February 2024 to January 2026) covering minor illness, urgent medicines, blood pressure checks and contraception. This continues to reduce pressure on general practice and urgent care and aligns with national access priorities.

Investing in our workforce

Delivering the Integrated Pharmacy Workforce Strategy has resulted in significant improvements in recruitment and capacity. The fill-up rate for the Foundation Trainee Pharmacist is 93%, up from 54% at the start of the year. We have recruited eight community pharmacy apprenticeships, and expanded the independent prescriber workforce with four community pharmacists supported into training. These improvements contribute directly to the sustainability of our workforce and our capacity for future service development.

Using antibiotics appropriately

Antimicrobial stewardship is a national priority ensuring antibiotics are used appropriately, in order to get the best patient outcomes, reduce resistance, and minimise side effects.

Through targeted activity, we have substantially reduced antibiotic prescribing in children under 10 from 36.6% to 27.9% – bringing the system close to national targets and improving consistency across practices. This is a significant quality and safety achievement aligned with the UK Antimicrobial Resistance strategy.

Improving patient safety

Shropshire, Telford and Wrekin benchmarks as one of the highest-performing systems nationally using the Eclipse Radar risk stratification service. More than 98% of all critical and significant medicines-related risk alerts have been reviewed, and more than 14,000 patients identified as being at potential risk of avoidable harm. We have demonstrated a reduction in emergency care risk and improved assurance for high-risk medicines.

Transformational clinical pathways

Two major national policy roll-outs have been delivered safely and consistently. Aligning with NICE guidance, we phased the implementation of hybrid closed-loop technology (automated insulin management) for Type 1 diabetes to support equitable access.

We introduced Tirzepatide weight-loss injections for patients with a Body Mass Index (BMI) of 40 or above using a PCN collaborative model. This ensured robust governance, demand management and the integration of behavioural support services.

These programmes improve long-term population health outcomes and support wider cardiovascular disease and diabetes ambitions.

Reducing medicines waste

More than 400,000 digital engagements have been recorded through the Think Twice, Order Right (TTOR) system-wide behaviour change

campaign. This has demonstrated changes in patient behaviour – for example, increased checking before ordering, and increased returns.

We have also seen a measurable reduction in medicines waste costs over five consecutive months. This contributes to financial sustainability, patient safety and environmental goals.

Strengthening system governance

We have implemented improved governance across several areas, including:

- A transparent, evidence-based formulary framework.
- Strengthened shared care guidance between primary and secondary care.
- Consistent interpretation and application of national policy relating to gender-affirming hormone therapy.

These actions enhance clinical consistency, professional assurance and system-wide safety.

Prescription Ordering Direct service

Following a strategic review, we decided to phase out the Prescription Ordering Direct (POD) service. This also aligns with national priorities to improve digital access through the NHS App.

Introduced in 2016/17 as a phone and email system to support repeat prescription ordering, this service now duplicates functions routinely provided by GP practices and the NHS App. The review also identified persistent access challenges, increasing staffing costs and limited value for money, with operating costs exceeding £1 million per year.

A comprehensive communications and engagement plan is in place to support patients through the transition, with a particular focus on helping people move to digital channels where appropriate and ensuring continuity of access for those unable to use digital tools.

To ensure equity and safe implementation, we are prioritising:

- **Maintaining non-digital access:** Ensuring all GP practices continue to provide repeat prescription ordering and clear communication routes (paper and phone) for patients who cannot use digital tools – including those with visual impairments, dementia, low literacy, language barriers, safeguarding needs, or no internet or smartphone access.
- **Ensuring clear communication and continuity of care:** Providing clear messaging and processes to ensure uninterrupted medication access for patients unable to transition to the NHS App, including transparent information on what services are available digitally and what alternatives exist.
- **Targeting support for vulnerable groups:** Delivering short-term, targeted support for carers (including proxy access), digitally-excluded populations, inclusion health groups, and minority ethnic communities, with accessible, translated, and Easy Read materials where needed.
- **Strengthening digital support and literacy:** Ensuring digital literacy training is widely available and well-publicised across urban and rural areas, and supporting GP practices to identify and engage patients most likely to need help.

This planned transition supports digital transformation ambitions, improves service sustainability and maintains patient safety and access for all groups.

Improving population health

Health and Wellbeing Boards

Our Chief Executive Officer, Simon Whitehouse, sits on the Health and Wellbeing Boards of both Shropshire Council and Telford & Wrekin Council, and is co-chair for both Health and Wellbeing Boards. The Health and Wellbeing Boards also form part of the organisation's governance structure to ensure that partnership working is truly at the centre of the delivery of the ICS Strategy.

Both Health and Wellbeing Boards have a Health and Wellbeing Strategy in place, and this underpins the development work on the Joint Forward Plan. NHS Shropshire, Telford and Wrekin has consulted each lead officer of the relevant Health and Wellbeing Boards in preparing this Annual Report.

Duty of co-operation between NHS bodies and local authorities

We are committed to fostering strong partnerships between NHS bodies and local authorities to enhance health and social care outcomes for our communities. In fulfilling this duty, we have undertaken a range of collaborative initiatives to ensure that services are effectively integrated and responsive to the needs of our population.

We have worked closely with local authorities in the development and implementation of our Joint Strategic Needs Assessment (JSNA) and each local authority's Health and Wellbeing Strategy. This collaborative approach ensures that commissioning decisions align with local health priorities and social care needs, promoting a seamless and person-centred care experience.

Bringing together health, social care, and community support

The Highley Community Hub delivers a range of services from the leisure centre including the GP practice being relocated into the hub, drop-in health visiting services, women's health services, and dementia multi-disciplinary team meetings.

This approach jointly delivers person-centred care with social care, voluntary and community sector services, the primary care network and therapy services. The hub also offers a range of primary prevention services such as blood pressure measuring to identify undiagnosed high blood pressure. This has been replicated across our community and family hubs.

We continue to work closely and collaboratively on neighbourhood health across our area, and in 2025 became part of the National Neighbourhood Health Implementation Programme (NNHIP) which aims to transform health services by integrating care at the community level – focusing on health equity and personalised car e. We have also agreed a system-wide Prevention Framework and Health Protection Strategy including our immunisation and vaccination improvement plan.

Recognising the importance of a cohesive workforce, we have partnered with local authorities to deliver joint training programmes for NHS and social care staff. As part of this effort, the Oliver McGowan mandatory training for system partners has been led by Shropshire Council. As of the end of February 2026, a total of 4,894 NHS staff had been trained across Shropshire, Telford and Wrekin. Through the ICB-funded training which ran until 30 May 2025, Tier 1 was completed by 297 non-NHS learners, and Tier 2 was completed by 420 non-NHS learners. A further 209 non-NHS staff received Tier 2 joint training – bringing the total to 926.

Our commitment to co-operation extends to engaging with service users, carers, and voluntary sector partners. Through our two jointly-chaired Health and Wellbeing Boards, we have coproduced service improvements such as the community and family hubs, women's health services, neighbourhood working, inequalities and Weight Management Strategy. Both Health and Wellbeing boards have engaged the public on the Joint Strategic Needs Assessment to understand the needs of the population.

By embedding collaboration at every level of our work, we continue to uphold our duty of cooperation between NHS bodies and local

authorities. Moving forward, we will build on these successes by deepening our partnerships, strengthening joint planning efforts, and ensuring that integrated care remains at the heart of our approach to service delivery.

Our performance appraisal

This section introduces the key lines of enquiry that will assess the ICB's performance across its statutory duties and themes. These key lines of enquiry examine our effectiveness in system leadership, governance, population health improvement, tackling health inequalities, enhancing productivity, and supporting broader social and economic development – with a focus on both national priorities and local system circumstances.

This section evaluates our ability to lead the NHS and the wider system effectively. It focuses on how we have developed strategies and plans, led partnerships across the system, and arranged care for our population. Additionally, it examines our assurance of performance and delivery, our role in driving transformation and learning, and our implementation of effective governance aligned with the triple aim and clinical expertise.

In 2025/26, NHS Shropshire, Telford and Wrekin developed the following strategies and plans:

- Operating Model
- Operational Plan
- Adult Mental Health Inpatient Transformation Strategy
- Joint Forward Plan
- System Integrated Improvement Plan
- System Winter Plan.

Each strategy and plan were developed in partnership with our system providers and local authorities, along with wider stakeholders.

Notable progress has been made this year in improving population health outcomes by prioritising prevention and early intervention. For example, the system expanded its community pharmacy services, delivering more than 20,700 blood pressure checks as part of hypertension detection work. This proactive approach supported early identification of cardiovascular risk – helping prevent strokes, heart attacks, and other complications linked to undiagnosed hypertension.

Addressing inequalities in healthcare outcomes and access has been a key priority this year. One example is the delivery of mobile tuberculosis screening for migrants, which increased uptake from 0% to 33%, enabling the early detection of active cases and reducing health risks in an underserved population. This targeted intervention demonstrates our commitment to reducing health inequalities and protecting vulnerable groups.

Both Health and Wellbeing Boards have a focus on our inequalities plans, including the wider determinants of health.

Reducing health inequalities

Our demographic profile

In Telford and Wrekin, life expectancy for those living in the most deprived areas is 8.8 years shorter for men and 6.4 years shorter for women compared to those in the least deprived areas. Inequalities also exist across Shropshire, where men in the most deprived communities can expect to live 4.2 years fewer than those in the least deprived areas. Circulatory disease – driven largely by preventable risk factors including smoking, obesity and high blood pressure – has been identified as the primary contributor to this gap.

Cardiovascular disease is the single largest contributor to premature mortality in deprived communities, accounting for around a quarter of all deaths in the UK. Early death rates from preventable CVD in Telford and Wrekin are significantly worse than the England average – directly contributing to the local life expectancy inequality gap.

Based on the 2021 Census, approximately 93% of Shropshire's population and around 88% of Telford and Wrekin's population identify as White. Across the combined STW area, an estimated 33,000 residents – around 6% of the population – are from ethnic minority backgrounds including Asian, Black, Caribbean, African, Mixed, or Other groups. This population has grown and diversified significantly since 2011.

Health inequalities are the unfair and avoidable differences in health across the population, and between different groups within society. These include how long people are likely to live, the health conditions they may experience, and the care that is available to them and they arise because of the environmental and social conditions in which we are born, grow, live, work and age.

These conditions influence how we think, feel and act and can impact both our physical and mental health and wellbeing. Within this wider context, healthcare inequalities are about the access people have to health services and their experiences and outcomes from those services.

Under the Health and Care Act (2022), ICBs have a duty to reduce inequalities in access to health services and the outcomes achieved from them. This duty is reinforced by the NHS Constitution for England, which commits the NHS to providing comprehensive, equitable care based on clinical need and to reducing health inequalities across the populations it serves.

As part of our statutory duty, we (the ICB) are required to reduce the inequalities experienced by our local communities in line with the National Healthcare Inequalities Improvement Programme and NHS England's Core20PLUS5 Framework.

References for the above demographic profile:

- Shropshire Council (2025). Director of Public Health Annual Report 2024/25: Health and Wellbeing in Shropshire's Communities.
- Care Quality Commission (2024). Telford and Wrekin Council: Local Authority Assessment.
- Shropshire, Telford and Wrekin ICB (2023). System Efforts to Improve Cardiovascular Disease Prevention.
- Shropshire, Telford and Wrekin ICP (2022). Interim Integrated Care Strategy V9.0.
- Office for National Statistics (2022). How Life Has Changed in Shropshire: Census 2021.
- Office for National Statistics (2022). How Life Has Changed in Telford and Wrekin: Census 2021.

Core20PLUS5

This is NHS England's approach to inform action to reduce healthcare inequalities at both national and system levels. It defines a target population – the 'Core20PLUS' – and identifies five clinical areas of focus requiring accelerated improvement.

'Core20' refers to proportion of local residents who are among the most deprived 20% of the national population, as identified by the national Index of Multiple Deprivation (IMD). There are seven different factors that the IMD considers. This includes:

- Income
- Employment
- Education
- Health
- Crime
- Barriers to housing and services
- Living environment.

Approximately 60,000 of the 510,000 people living across our geography live in areas considered to be the 20% most deprived areas across England. Of this figure, 15,000 are in Shropshire and the remaining 45,000 are in Telford and Wrekin, which is a quarter of Telford and Wrekin's whole population.

'PLUS' refers to specific groups of the population. This is an additional way of identifying other groups in society who experience health inequalities. Some PLUS groups are identified nationally, such as individuals with a learning disability or people experiencing homelessness. Others are based on local outcomes we see specific to our population, such as farming communities, service personnel and veterans, and children in care.

Data and intelligence

One of our biggest developments in 2025/26 is the strengthening of our data granularity (the level of detail this data can provide). Our Data teams have worked to develop local intelligence and create visual dashboards on healthcare inequality. This means we are now able to understand what access to services looks like for different groups of our population, and what inequality in service access and experience exists.

Using this data, we completed our first comprehensive report on service access indicators in January 2026. The aim was to understand our progress in reducing existing healthcare inequality and narrowing the gaps between different groups of people. This work also helps us to provide a robust response to NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the NHS Act 2006), which required ICBs to collect, analyse and publish information on health inequalities alongside our annual reports.

Over the last 12 months, we have:

- Enabled more children and young people from deprived areas and minoritised ethnic backgrounds to receive diabetic technology to support with managing their condition.
- Removed inequalities to ensure high cholesterol is managed fairly across all population groups, irrespective of where they live or their background.
- Reduced differences in vaccination uptake between our most and least deprived populations through targeted work in community settings closer to people's homes.
- Delivered targeted annual health checks which has resulted in higher proportions of people with learning disabilities or severe mental illness being appropriately treated for hypertension (high blood pressure).
- Helped more children and younger people from deprived areas to successfully access mental health support.
- Reduced the differences in higher pre-term births experienced by women from black and Asian ethnic backgrounds. Fewer women from deprived backgrounds are also now being recorded as smoking at time of delivery.

The full report can be viewed on our website.

Work contributing to positive progress

Leadership and accountability

We have continued to strengthen our governance arrangements to maintain clear oversight and accountability for improving healthcare inequalities across the system. Dedicated governance structures ensure that health inequality considerations remain embedded within strategic planning, commissioning decisions, performance monitoring and system transformation programmes.

Regular reporting to ICB committees and the Board enables transparent assurance on progress, risks and mitigations, and ensures that actions to reduce inequalities are aligned with national priorities, including Core20PLUS5 and the NHS operational planning guidance. This governance approach supports a whole-system commitment to addressing unwarranted variation in access, experience and outcomes.

Equality and Health Inequalities Impact Assessments (EHIA)

During 2025/26, we strengthened our approach to Equality and Health Inequalities Impact Assessments (EHIAs) to ensure that statutory duties are consistently and demonstrably met.

Under the Health and Care Act (2022), ICBs are legally required to:

- Promote continuous improvement in service quality, including safety, clinical effectiveness and patient experience across all commissioned services
- Ensure services meet the needs of the population, commissioning care that is responsive, equitable and evidence-based
- Uphold the NHS Constitution, including patient rights to safe, high-quality care and involvement in decisions
- Safeguard vulnerable populations, ensuring safeguarding principles and protocols are embedded in service design and delivery.

ICBs must ensure that assessment of quality is embedded in all decision-making processes, particularly those involving service change, commissioning, and policy development.

Historically, we operated two separate processes – an Equality and Quality Impact Assessment (EQIA) template in Microsoft Word, and an Integrated Impact Assessment (IIA) embedded within the project management platform.

In response to feedback from the Equality and Human Rights Commission (EHRC) highlighting that existing documentation did not clearly demonstrate how we discharged our responsibilities, the process has been redesigned with supporting documentation and policy. This has been co-produced and co-designed, with the National Quality Board's Shared View of Quality (NQB 2025) central to this redesign – ensuring clarity, usability, and alignment with national expectations.

Our redesigned approach brings together equality, quality, and health inequalities considerations in a single, coherent process. The EHIA makes the following aspects clear:

- Safe – minimising risk, protecting people from harm, neglect, abuse, and breaches of human rights, and ensuring learning and improvement when issues arise
- Effective – informed by high-quality training, guidelines, and evidence – improving population health and wellbeing, addressing inequalities, and enabling continuous improvement through research, audit, and benchmarking
- Positive experience, responsive and personalised – shaped by what matters to people, empowering informed decision making that is coordinated, inclusive, and equitable
- Caring – delivered with compassion, dignity, and mutual respect
- Well led – driven by collective, compassionate leadership; supported by proportionate governance, and underpinned by a just and inclusive culture that prioritises learning over blame.

During 2025/26, we have:

- Developed a new, integrated EHIA framework that brings together equality, quality and, health inequalities considerations in a single, coherent process
- Produced clear guidance notes and rationale to support consistent completion and interpretation
- Updated the policy and governance arrangements to ensure EHIAs are embedded in all relevant decision-making pathways

- Strengthened the ability to evidence compliance with statutory duties and respond to external scrutiny
- Ensured the approach reflects national expectations and supports our commitment to improving outcomes and reducing inequalities.

Peer learning and development

We have continued to invest in building capability across the health and care workforce through a strengthened programme of peer learning, development, and ambassador-led initiatives. This work supports the delivery of Core20PLUS5 and broader health inequalities priorities by equipping staff with the knowledge, skills and confidence to reduce inequalities in their roles and services.

Health Equality Ambassadors

A new local Health Equality Ambassador Programme has been launched in response to national programmes being paused. The programme aims to enhance education and awareness of health inequalities and continue to support a growing movement of staff who champion fairness, inclusion and health equality across our local NHS.

While the programme primarily targets NHS organisations, applications were opened to broader partners from across the ICS, acknowledging the positive impact of voluntary sector partners on local communities.

This growing network plays a vital role in supporting services to understand local need, champion equitable approaches and embed practical ideas and solutions that improve access, experience and outcomes for under-served groups.

This year, 21 people successfully graduated from the previous year's National Core20PLUS Ambassador Programme having delivered impactful project work to move the dial on health inequality. This work has been formally and nationally recognised, reflecting the ongoing impact and sustainability of the Ambassador model. Projects include offering targeted health checks to Core20PLUS groups, improving data accuracy and data quality for key demographic information (such as ethnicity), and delivering vaccination outreach clinics to at-risk migrant communities.

Since our local Health Equality Ambassador programme launched in November, 23 people signed up – increasing the number of local healthcare professionals participating in equality-related Ambassador programmes to more than 60.

Educational sessions

In autumn 2025, our Health Inequalities team launched a series of 'lunch and learn' sessions to create accessible, peer-led learning opportunities for staff. To date, nine sessions have been delivered to more than 65 people, covering topics including Core20PLUS5, Greener NHS, and health literacy.

The programme has improved awareness and understanding of key national and local priorities, contributed to workforce development, and facilitated shared learning across teams and sectors. Sessions planned for 2026/27 will focus on digital exclusion, inclusion health, and inequalities experienced by children and young people.

Supporting inclusion health

'Inclusion health' describes people who are socially excluded and who typically experience multiple overlapping risk factors for poor health – such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, and victims of modern slavery. Read more on the GOV.UK website.

Work has progressed to integrate the NHS England Inclusion Health Framework through:

- Raising awareness of inclusion health groups and the barriers they face through local training and peer development offers.
- Embedding inclusion health as a core consideration within commissioning documents, including service specifications and Integrated Impact Assessments (IIAs).
- Taking learning from initiatives such as MPFT's 'Keys to Employment' pilot, which supports people in prison to access and sustain employment on release. This is with the aim of aligning workforce strategies with better outcomes for inclusion health groups as we move into 2026/27.

Working with Health and Wellbeing Champions at HMP Stoke Heath

We continued to deliver the Core20PLUS5 Connectors programme with Lingen Davies Cancer Support and Qube Oswestry Community Action. More than 600 Cancer Champions represent people from all walks of life. The initiative has been successful in improving awareness of cancer signs, symptoms and local screening services amongst our under-served communities.

This year, we worked with Health and Wellbeing Champions (HAWCs) to provide training and support to staff and residents at our local prison, making a difference to the lives of their peers and finding new ways to share health information within prison restrictions.

Engaging Gypsy, Roma and Traveller communities and Afghan families

We have worked with partners across health and care to improve access to services for communities who experience some of the greatest barriers to healthcare. Recent work has involved using tailored, community-based approaches to meet people where they are and respond to their specific needs. Community health events and multiagency drop-in sessions have been held, attended by a variety of services including mental health services, blood pressure checks, help to quit smoking, children and young people's asthma services, midwifery services, children and family support, and vaccinations.

Across all events, the aim has been to reduce barriers, build trust, and provide personalised, accessible health support. Bringing services directly into communities has helped increase engagement, supported preventative health activity, and offered valuable insights to inform future inclusion health work.

Becoming a 'health literate' organisation

'Health literacy' describes someone's ability to access, understand and use health information and services to make informed decisions about their health and wellbeing. 'Organisational health literacy' is the degree to which a health organisation enables people to do this by using clearer language and communication.

This year, we have focused on making health literacy more visible. We also helped our staff to think about health literacy as part of their roles:

- In September 2025, we ran a survey to find out what staff knew. We used what we learned to create monthly 'lunch and learn' sessions, which began in December 2025. People told us they felt more confident after the sessions.
- In February 2026, we began offering a series of drop-in sessions to give staff the opportunity to ask questions or get help with resources.
- We added health literacy to our new Local Equity Ambassadors programme. As part of this, we worked with Shrewsbury and Telford Hospital NHS Trust on a health literacy session for Ambassadors.
- We also included health literacy in the guidance for our new Impact Assessment process. This helps staff to think earlier about how they involve and inform local people around any changes.

Another key focus has been strengthening our work with system colleagues:

- The ICB is an active member of the local Health Literacy Network. This group helps the whole system to work together – sometimes in new ways. All partners have begun exploring a toolkit to help staff to find useful local and national resources.
- We ran a health literacy survey for GP practices, and will use the findings to plan the support we offer to GPs next year.

Embedding the Community Language Translation and Interpretation Framework

In May 2025, NHS England published a framework to help the NHS to provide clear, consistent and high-quality translation and interpreting support for people who need it.

We responded to this by working with front-line teams who deliver services directly to patients – including local service providers and GP practices.

The aim has been to improve staff understanding of the key points in the framework, review what translation and interpreting services are currently used, and identify where improvements can be made. This work will continue in 2026/27, and will involve building the principles of the framework into the way services report on the support they provide.

Mitigating digital exclusion

This year, we have worked with our system partners to co-develop a comprehensive system plan for mitigating digital exclusion. The plan aligns to NHS England's Digital Inclusion Framework, and sets out our key aim of ensuring all residents can benefit equitably from digital health and care services.

The plan sets out a clear ambition to reduce digital exclusion across the NHS by:

- Embedding leadership and accountability for digital exclusion across NHS organisations.
- Strengthening system-wide understanding of digital support needs.
- Improving equitable access to devices, data, and connectivity.
- Building capability and confidence through a strengthened network of digital inclusion champions.
- Ensuring that all NHS digital services are designed and delivered to be inclusive, accessible and user-centred, and
- Raising awareness with both staff and members of the public of current support available to them to help them get online and feel more confident using digital.

We have made real strides in strengthening our local governance and oversight. This involves ensuring every NHS organisation has a lead for digital inclusion and that the voices of digitally-excluded communities are considered within service re-design and commissioning processes.

We have increased the number of 'data hubs' available in the local area by supporting local primary care teams to sign up to and utilise the Good Things Foundation National Databank. This enables teams to offer free mobile data and SIM cards to digitally-excluded communities on contact with the NHS. Further work is planned for the forthcoming year to continue building on this network, with a particular focus on teams working directly within Core20PLUS5 clinical areas, such as severe mental illness, children and young people's services and maternity care.

There are increasing numbers of sessions taking place within GP practices and in community settings (such as libraries across Shropshire, Telford and Wrekin) to support people to register for and feel confident and safe using the NHS App to access healthcare services.

We have also delivered a series of targeted communication campaigns for both healthcare professionals and the public to raise awareness of local support available to help people get online.

Contributing to social value through anchor

Health and employment

This year our system has increasingly focused on how we can support local residents through our contributions to social value. 'Social value' refers to the positive impact an organisation has on society beyond its primary function.

The NHS has great potential to positively impact local communities beyond just providing healthcare services. As the UK's biggest employer, the NHS spends £27 billion each year on goods and services in England alone. The NHS is responsible for 40% of the public sector's carbon footprint.

Examples of work this year have included setting up recruitment and volunteering schemes. These have focused on supporting people back into work, offering young people with learning disabilities and autism the opportunity to gain valuable work experience and paid employment in areas such as catering, pharmacy and radiology and supporting veteran-dedicated volunteer to career programmes.

Procurement and social value

This year, we strengthened our procurement processes by enhancing tender requirements to ensure prospective providers demonstrate robust plans for reducing healthcare inequalities and delivering meaningful social value.

This has taken the form of specific evaluation questions within the tender process, having a minimum section weighting for Social Value of 10%. Work is ongoing to build relevant KPIs into contracts to capture the benefits our providers are bringing to Shropshire, Telford and Wrekin – such as local employment and use of local supply chains

Better Care Fund (BCF)

The Better Care Fund (BCF) supports the integration of health, housing, and social care through pooled budgets and joint planning between the ICB and local authorities. Its purpose is to improve outcomes for residents and carers through person-centred, coordinated care. We deliver two BCF plans in partnership with Shropshire Council and Telford & Wrekin Council.

This year in Shropshire, strengthened collaborative leadership and shared governance have improved alignment across the ICB, the Integrated Place Partnership and the Health and Wellbeing Board. Integrated neighbourhood working continues to develop, including multi-disciplinary proactive care, all-age social prescribing, a coordinated care hub, and effective reablement through the Short-Term Assessment and Reablement Team. These models are supporting timely discharge and helping people remain independent at home.

In Telford and Wrekin, collaborative leadership and shared governance arrangements remain robust with clear partnership reporting and monitoring arrangements in place across urgent care and neighbourhood health programmes.

Following a review of the Care Transfer Hub, further improvements in integrated working have contributed to better discharge performance, with reductions in delayed discharges and length of hospital stay. Re-commissioning at-home care provision has further improved timely discharge of patients to their homes. Additional enablement therapy has improved access to interventions that maximise independence. Neighbourhood workstreams are progressing with strong engagement from primary care, the voluntary and community sector, and wider system partners.

From 2026/27, Better Care Fund planning will be aligned with neighbourhood planning arrangements, supporting a more consistent neighbourhood-based delivery model and sustaining the focus on partnership working, integration, and locally responsive services.

Environmental matters

The Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) has adopted a phased approach to incorporating the recommended Taskforce on Climate-related Financial Disclosures (TCFD). This is part of sustainability annual reporting requirements for NHS bodies, which stems from HM Treasury's TCFD-aligned disclosure guidance for public sector annual reports.

As interpreted and adapted for the public sector by the HM Treasury TCFD-aligned disclosure application guidance, the recommended disclosures will be gradually incorporated into sustainability reporting requirements on a phased basis up to 2025/26.

The phased approach incorporates the disclosure requirements of the following 'pillars' – Governance, Strategy, Risk management, and Metrics and targets. These disclosures are provided below with appropriate cross-referencing to relevant information elsewhere in the Annual Report and in other external publications.

In line with the reporting requirements, Shropshire, Telford and Wrekin ICB is required to categorise its disclosures as 'comply' or explain against the four pillars. This information is provided below.

It is anticipated that the disclosure will develop over successive iterations or years, as more data becomes available and understanding on this topic deepens.

Governance

The following details the compliance of Board-level oversight of climate-related issues.

From 1 April to 30 November 2025, the board-level Senior Responsible Officer (SRO) for Sustainability and Greener NHS was Nigel Lee, Chief Strategy Officer. Following organisational restructure, since 1 December 2025 the role has been held by Dr Lorna Clarson, Chief Officer: Strategy and Improving Outcomes. The Board-level Clinical Lead for Greener NHS is Vanessa Whately, Chief Nurse.

All main NHS providers have a board-level SRO and named clinical lead for Greener NHS and Sustainability as required under NHS England's statutory Green Plan Guidance (2025).

There is clear governance reporting in place from the System Climate Change Group through to the ICB Board. The details of this governance and reporting are provided in Section 5 of our Green Plan.

During 2025/26, we refreshed our Integrated Impact Assessment (IIA) process to include a specific focus on sustainability for all proposed changes. This includes decisions to commission or decommission services and any associated in-year service changes or business cases.

IIAs are required as part of the governance of decision making from intial consideration through to Board approval. Board reporting and reporting to sub-committees require the author to identify impact of the paper on sustainability and Greener NHS considerations.

Strategy

We are partially compliant with our plans, moving to full compliance in 2026/27. Our Green Plan was approved by Board in September 2025 and published on the ICB website shortly afterwards. The ICB has further work to incorporate climate change risks into its medium and long-term financial planning.

The NHS Shropshire, Telford and Wrekin Green Plan details our recognition of the risks of the impact of climate change on the sustainability of health services. There are opportunities to address these risks through the recommendations of NHS England's Green Plan Guidance (2025).

Our plan recognises the clear link between climate change and the impact on health in general and specifically on widening health inequalities and how it is necessary to pursue a strategy of working with provider trust partners and our local authorities. The ICB has a role to directly influence this through medicines, procurement, and commissioning activities, as well as in facilitating engagement and collaboration across the system.

To ensure a clear strategic direction, the Green Plan has considered the aims of our Digital Transformation Strategy and our Infrastructure Strategy, as well as the three key shifts in the 10-year NHS Plan.

Global data from the World Health Organization indicates temperature and rainfall changes enhance the spread of vector-borne diseases (transmitted through mosquitoes, ticks, and fleas). Extreme weather events such as flooding, drought, and overheating are only expected to increase and intensify. Climate change induces both immediate mental health issues (such as anxiety and post-traumatic stress) and long-term disorders due to factors like displacement and disrupted social cohesion. Air pollution increases respiratory and cardiac issues, as well as contributing to certain cancers.

These impacts are likely to lead to increased pressure on emergency departments and on the system's healthcare services, as well as having the potential to disrupt local infrastructures, transportation of goods and services, and supply chains. It is vital that our ICS enhances its resilience in the face of these risks. While our ambition to achieve net zero via reducing our carbon emissions as an NHS will assist in mitigating the risks and effects of climate change and severe weather conditions on our functions, it is also necessary to build resilience into our systems via adaptability plans.

Part of this adaptability can be seen in the models of care we are choosing to commission which are particularly important to build resilience in our rural geographies. Locally, we are delivering an increasing array of healthcare diagnostics closer to the patient's home in our community diagnostic centre alongside programmes of early intervention and prevention activities within our Family and Community Hubs. Sub-acute and rehabilitative care is delivered within the patient's home – such as our virtual ward and enablement initiatives.

These initiatives reduce patient and carer transport requirements – subsequently reducing carbon emissions. This mode of care delivery is enhanced through increasing digital technologies and innovations which contribute to reducing the carbon impact of healthcare within pathways of care, as well as addressing impact of adverse weather conditions.

We recently refreshed our business continuity management. The process identifies our priorities and solutions to address disruptive threats to our operational performance – including those which may be the result of climate change and extreme weather events.

The ICB is an active member of the Local Resilience Forum which monitors and responds to known local environmental hazards (detailed in our Green Plan).

Our Green Plan demonstrates our commitment to undertaking a formal adaptation assessment, guided by the NHS Climate Change Risk Assessment (CCRA) tool.

We do not yet comply with the requirement to formally assess the risks to our financial planning against a global warming pathway of a 2°C rise. This should include consideration of how these may materialise over the short, medium and long term, with an associated adaptation plan to mitigate risks.

Risk management

Our approach to risk management and ensuring board oversight of risks is described in the Corporate Governance Section of this document.

Providers hold internal risk registers related to the delivery of their sustainability aims. Collective risks are captured through templated reporting into the System Climate Change Group. The Climate Change Group can escalate risks for inclusion into the Strategic Operational Risk Register (SORR) or Strategic Board Assessment Framework (SBAF) via the Strategy and Prevention Committee. There are no current specific Green Plan risks in either register.

Metrics and targets

Healthcare in England is estimated to contribute between 4% and 5% of national emissions, and around 40% of all emissions generated by the public sector.

The strategy for Delivering a Net Zero NHS sets two targets against a 1990 baseline:

- Net zero by 2040 for the emissions the NHS controls directly (the NHS Carbon Footprint), with an 80% reduction by 2028-32
- Net zero by 2045 for the emissions the NHS can influence (the NHS Carbon Footprint Plus), with an ambition to reach an 80% reduction by 2036-39.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse emissions under TCFD requirements, as these are computed nationally by NHS England.

The ICB and its main NHS providers have all been compliant during 2025/26 with the Data Collection Standards which evidence our progress towards achieving net zero.

NHS Shropshire, Telford and Wrekin has continued to ensure that during 2025/26 all tenders contain the requirements of providers to share their carbon reduction plans and to indicate how they will add social value with regard to the greener agenda. NHS Shropshire, Telford and Wrekin's procurement policies can be found on our website.

NHS Shropshire, Telford and Wrekin does not own or have control over any estate, other resources, natural capital or landowning that require reporting in this annual report.

During 2025/26 NHS Shropshire, Telford and Wrekin has not owned, hired or leased car fleets and none of our travel costs include any flights, either international or internal within the United Kingdom. During 2024/25 the ICB did introduce a lease car scheme for its staff which includes both traditional fuel and electric/electric hybrids as options.

In 2025/26 the ICB's gross expenditure on the purchase of energy (including water services) was £128k (2024/25: £191k). The ICB's total expenditure on official business travel was £53k (2024/25: £99k), and total expenditure on waste disposal was £3k (2024/25: £4k).

As a result of meter reading arrangements at Wellington Civic Offices, we are not in a position to report detailed consumption information for these utilities.

Emergency Preparedness, Resilience and Response (EPRR) position

EPRR is a core function in the NHS. In accordance with the Civil Contingencies Act 2004, the NHS Act 2006, the Health and Social Care Act 2012 and the Health and Care Act 2022, providers of NHS-funded care must demonstrate that they have appropriate measures in place to respond to incidents and disruptive challenges, while continuing to deliver resilient services, and maintain safe patient care. Examples may include extreme weather conditions, outbreaks of infectious disease, major transport incidents, or mass casualty events.

EPRR is designed to meet the statutory requirements placed upon responding organisations by the Civil Contingencies Act, which sets out specific duties for responding organisations. All ICBs have been classed as Category 1 responders, and as such, they must comply with the full complement of statutory duties, including:

- Assessing the risk of emergencies occurring and using this to inform contingency planning
- Implementing emergency plans and business continuity management arrangements
- Providing information to the public about civil protection matters and issuing warnings, information and advice in the event of an emergency
- Sharing information with other local responders to enhance coordination
- Cooperating with other local responders to enhance coordination and efficiency

We fulfil these duties through our EPRR work programme, which is supported by various NHS-specific guidance relating to preparedness for, and response to emergencies and declared incidents.

Each year, NHS partners are obliged to complete the nationally mandated NHS Core Standards for EPRR, which set out the minimum requirements in relation to resilience. This facilitates a common approach to emergency preparedness and provides a consistent and cohesive framework for EPRR activities across the country. In 2025, we submitted an overall assessment of substantial compliance, with 91% of applicable standards being rated as fully compliant. The position was supported by NHS England Midlands Region, with no challenges made. This is an improvement on the 2024 outcome, when an overall position of partial compliance was recorded.

We will continue to prioritise our EPRR activities internally and across the healthcare system, with a focus on developing robust and resilient cluster arrangements with Staffordshire and Stoke-on-Trent ICB. We will continue to work closely with NHS and multiagency partners within the West Mercia Local Resilience Forum and Local Health Resilience Partnership to address common themes and planning priorities, ensuring that robust incident response arrangements are in place. Where necessary, the ICB will support the response to declared incidents, coordinating health system activity as appropriate.

A full summary of EPRR activities in can be found in our Annual EPRR Board Report.

Digital

Digital has continued to play a critical, supporting role in delivering high-quality, safe and sustainable services. Our focus has been on strengthening digital foundations while ensuring that technology enables, rather than complicates, care delivery for our population and workforce.

We have made significant progress in improving the reliability, security, and resilience of our digital infrastructure. Through a continued emphasis on cyber security, information governance, and data protection, we have kept systems and data safe and compliant – giving our staff and partners the confidence to work digitally and share information appropriately. These foundations are essential to enabling future innovation and supporting integrated working across the system.

Digital has also supported service transformation by improving access to information and enabling more joined up care. Shared records and digital tools continue to enhance communication across health and care settings – supporting more informed decision making and reducing duplication. This has been particularly important in supporting proactive and preventative approaches to care, as well as improving continuity of care for people with complex needs.

Throughout the year, digital inclusion has remained a key consideration. Work has continued to recognise and address digital exclusion – ensuring that digital solutions are implemented in ways that do not disadvantage those who are less able or less confident to access services digitally. This includes supporting staff awareness, understanding population needs, and working with partners to promote equitable access.

Looking ahead, digital will remain a key enabler of our strategic priorities. We will focus on further embedding digital ways of working, maximising the value of existing systems, and ensuring that future digital developments are aligned with service priorities, workforce needs, and improved outcomes for our population.

Patient experience and complaints

This year, we have continued to ensure that the experiences of patients, families, and carers directly shaped commissioning decisions, quality oversight and system-wide improvement. Partners across the system remained committed to responding to complaints transparently, compassionately, and in line with statutory requirements.

Complaints and feedback continue to offer valuable insight into how services are functioning under sustained operational pressure and help us to drive improvements both within the ICB and across commissioned services.

Our Complaints and Compliments Policy has been reviewed this year to ensure continued compliance with the regulations and alignment with best practice.

During 2025/26, NHS Shropshire Telford and Wrekin received 239 complaints compared with 171 in 2024/25. This increase reflects both heightened public expectations and the operational pressures experienced across primary, community, and acute services.

Complaints breakdown 2025/26 (up to 24/02/26)

Service	Number of complaints
GP practice	87
Continuing Healthcare	42
Hospital	41
Mental health services	20
Dental	15
Pharmacy	6
Referral Management	5
NHS 111	4
Transport services	3
Medicines Management	3
Out of hours	2
Commissioning finance	2
Prescription Ordering Department	1
Multiagency	1
Individual funding request	1
Private nursing / care home	1
Emergency response	1
Other	4
Total	**239**

Analysis of complaints

Theme	Examples	Indicative volume
Access to services / access and waiting	GP access, diagnostic delays, dental access, ophthalmology, transport	High
Safe, high-quality coordinated care	Discharge issues, clinical treatment concerns, medication problems	Medium
Better information, more choice	Communication issues, record accuracy, information clarity	Medium
Building closer relationships	Behaviour concerns	Low-medium
Other issues	Continuing Healthcare, corporate governance, commissioning queries, Special Allocation Scheme	Medium

Every complaint response is reviewed by the relevant commissioning manager and executive director and signed off by the Chief Executive Officer. This ensures senior oversight of all cases and enables rapid escalation of concerns through Quality Review Meetings, supporting learning and service improvement.

The Patient Services team shares monthly intelligence with the Chief Nursing Officer, Chief Medical Officer and the Quality team through Patient Safety Meetings. A comprehensive quarterly report is presented to the Quality and Performance Committee, providing assurance on themes, timeliness, performance against statutory targets and areas requiring further improvement.

How insights from complaints have driven improvements

Complaints data continues to drive targeted improvement across the system. During 2025/26, insights from complaints contributed to:

- Strengthened work to improve GP access
- Enhanced communication pathways between providers and patients
- Improved oversight of Continuing Healthcare processes
- Better coordination of discharge planning across acute and community services.
- These improvements demonstrate how patient experience intelligence is embedded within wider system quality governance.

Parliamentary and Health Service Ombudsman (PHSO)

Patients retain the right to request an independent review by the Parliamentary and Health Service Ombudsman (PHSO) if they are not satisfied with the ICB's response.

During 2025/26, the ICB was contacted by the PHSO regarding three cases – two relating to Continuing Healthcare process delays, and one concerning access to services for a patient with additional needs. None of these cases have progressed to formal investigation. National data on PHSO activity is publicly available on the PHSO website.

Engaging people and communities

We are committed to fulfilling our statutory duty to involve individuals, carers, and communities in the planning, development, and delivery of health and care services.

Public involvement

Guided by our Involving People and Communities Strategy, we used a blend of online and in-person methods and worked closely with partners and voluntary, community, and social enterprise (VCSE) organisations, with particular emphasis on Core20PLUS and inclusion groups.

During 2025/26, we carried out a broad range of engagement activities throughout the area, including face-to-face events and virtual methods. Highlights and success stories include:

- Working with partners to launch a follow-up diabetes survey in May 2025, building on the 2023 work to gather insights on residents' experiences.
- Continuing our Understanding Your Cancer Journey conversations, building on events in November 2024 and March 2025 attended by more than 150 people, to shape improvements to information, personalised care, and navigation.
- A short survey on SEND and Alternative Provision in April 2025 received 91 responses, informing joint priorities across education, health, and care.
- We engaged nearly 1,000 older adults, carers and professionals to inform prevention and community support around our Healthy Ageing and Frailty Strategy.
- To support the Transforming Adult Mental Health Inpatient Services Strategy (2024/27), over 180 people shared views through the engagement.
- During September and October, around 1,000 people informed recommendations for all-age ADHD and autism pathways.
- We also reviewed the Prescription Ordering Direct (POD) service, with around 1,500 participants sharing their experiences of the phasing out of the service. We undertook significant involvement activity throughout the year – engaging with more than 3,800 people on these highlighted programmes alone. Further detail and examples can be found on our Get involved webpage.

To support and promote each involvement activity, we developed bespoke communications and engagement toolkits tailored for different audiences. The toolkits were shared widely, including with our VCSE contacts. We maximised the use of all communication channels to encourage stakeholder participation, and offered a variety of engagement opportunities.

Accountability Report

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations.

It comprises three sections:

- The **Corporate Governance Report** sets out how we have governed the organisation during the period 1 April 2025 to 31 March 2026 including membership and organisation of our governance structures and how they supported the achievement of our objectives.
- The **Remuneration and Staff Report** describe our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.
- The **Parliamentary Accountability and Audit Report** brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Members Report

NHS Shropshire, Telford and Wrekin is an Integrated Care Board with a unitary Board and is part of the Shropshire, Telford and Wrekin Integrated Care System. Board composition during the period 1 April 2025 to 31 March 2026 is detailed within the table below.

NHS Shropshire, Telford and Wrekin Board composition 2025/26

Board member name	Voting status	Board role	Attendance
Andy Begley (left 31/12/25 – last meeting attended 25/06/25)	Voting Member	Local Authority Partner Member	2 of 4
Ian Bett (left 07/11/25)	Voting Member	Chief Delivery Officer	3 of 3
Neil Carr	Voting Member	NHS and Foundation Trust Partner Member	1 of 6
Dr Ian Chan	Voting Member	Primary Medical Services Partner Member	6 of 6
Dr Lorna Clarson (changed role – role ended 01/12/25)	Voting Member	Chief Medical Officer	4 of 4
Dr Lorna Clarson (changed role – role commenced 01/12/25)	Voting Member	ICB Cluster Chief Officer of Strategy and Improving Outcomes	2 of 2
Patricia Davies (role ended 30/06/25)	Voting Member	NHS and Foundation Trusts Partner Member	2 of 2
Roger Dunshea (Acting Chair until 30/06/25)	Voting Member	Non-Executive Member	6 of 6
Cheryl Etches (appointed 02/06/25)	Voting Member	Non-Executive Member	5 of 5
Dr Rachel Gallyot (appointed 01/12/25)	Voting Member	Interim Cluster Chief Medical Officer	1 of 1
Ian Green (appointed 01/07/25)	Voting Member	ICB Chair	4 of 4
Mish Irvine (appointed 01/12/25)	Non-Voting Member	ICB Cluster Chief of Staff Officer	2 of 2
Stacey Keegan	Voting Member	NHS and Foundation Trusts Partner Member	5 of 6

Prof. Trevor McMillan	Voting Member	Non-Executive Member	4 of 6
Dr Niti Pall (Left 31/01/2026)	Voting Member	Non-Executive Member	2 of 5
Dr Deborah Shepherd (left 30/11/25)	Voting Member	Primary Medical Services Partner Member	3 of 4
David Sidaway	Voting Member	Local Authority Partner Member	6 of 6
Claire Skidmore	Voting Member	Chief Finance Officer	6 of 6
Phil Smith (appointed 01/12/25)	Voting Member	Cluster Chief Officer for System Development and Integration	2 of 3
Meredith Vivian (left 30/04/25)	Voting Member	Non-Executive Member	0 of 1
Vanessa Whatley	Voting Member	Chief Nursing Officer	5 of 6
Simon Whitehouse	Voting Member	Chief Executive Officer	6 of 6
Joanne Williams	Voting Member	NHS and Foundation Trust Partner Member	6 of 6
Dr Paul Edmondson-Jones (Appointed 01/12/2026)	Voting Member	ICB Transition Director	0 of 1
Heather Johnstone (Appointed 01/12/2026)	Voting Member	Chief Nursing Officer (Interim)	1 of 1
Shokat Lal (Appointed Feb 2026)	Voting Member	Non-Executive Member	0 of 1
Mike Lawton (Appointed Feb 2026)	Voting Member	Non-Executive Member	1 of 1
Dr Simon Constable (Appointed 23/03/2026)	Voting Member	NHS Trust / FT Partner Member	1 of 1
Dr Buki Adeyemo (Appointed 23/03/2026)	Voting Member	Mental Health Partner Member	0 of 1

Member profiles

Profiles of the individuals who make up our Governing Board can be found on the ICB's Meet our Board webpage.

Member practices

The organisation has delegated commissioning responsibilities for primary care general medical services on behalf of NHS England. This includes commissioning 50 GP practices located within the geographical area coterminous with the boundaries of Shropshire Council and Telford & Wrekin Council.

A full list of Shropshire, Telford and Wrekin GP practices and addresses can be found on the ICB's GP practices webpage.

Composition of Governing Body

See Members Report above for details of governing body members.

Committees

So that the Board of NHS Shropshire, Telford and Wrekin can provide strategic direction to the organisation and to assure itself of the ICB's internal control infrastructure, it has established several committees to undertake specific roles within the governance structure. Following a comprehensive review and recommendations provided by the Good Governance Institute, the committee structure was revised, and The Governance Handbook was updated to reflect the new meeting structure. These amendments were formally approved by the Board on 29 January 2025.

Within the structure, consistent with governance best practice, each Committee has a robust set of terms of reference describing its membership and the scope of its authority. These terms of reference are reviewed at least annually and amended in respect of the evolving needs of NHS Shropshire, Telford and Wrekin. As part of the review of each committee, a record of attendance of the committee's membership is maintained.

It should be noted that with NHS Shropshire, Telford and Wrekin ICB moving to become a Cluster ICB with NHS Staffordshire, Stoke-on-Trent ICB, that some recent committee meetings have been held jointly. Where joint meetings have been held, this will be reflected within the information relating to the individual committees concerned.

Audit Committee

The committee's responsibilities included:

- Reviewing the adequacy and effectiveness of integrated governance, risk management, and internal control across NHS Shropshire, Telford and Wrekin, and report any weaknesses to the Board
- Ensuring financial systems and governance comply with the Department of Health and Social Care Group Accounting Manual
- Assessing the effectiveness of assurance processes in measuring progress toward objectives and managing key risks.

The committee met quarterly as per its terms of reference and therefore met four times during the year, including one meeting in common with Staffordshire and Stoke-on-Trent ICB.

The committee reviewed and/or approved matters relating to:

- Oversight of System Board Assurance Framework (SBAF) and Risk Management
- Received assurance reports in relation to financial management and financial controls
- Received assurance in relation to the Fit and Proper Person Test
- Approved the draft and final Annual Report for 2025/26
- Received internal and external audit reports
- Received information governance updates
- Received assurance around changes to the Governance Handbook
- Received the annual Conflicts of Interest Report and approved the role out of online training in respect of Conflicts of Interest
- Received assurance in respect of losses, special payments and waivers
- Oversight of Counter Fraud activities
- Received assurance with the Freedom to Speak Up Annual Report
- Received assurance in respect of the registers of gifts, hospitality and sponsorship and conflicts of interest
- Received assurance in respect of the use of the ICB seal
- Received assurance in respect of policy management
- Received assurance in respect of the new financial ledger system, which went live on 1 October 2025.

The attendance records for the financial year are detailed below.

NHS Shropshire Telford and Wrekin - Audit Committee attendance 2025/26

Member name and title	Meetings attended	Total meetings
Roger Dunshea, Non-Executive Director	1	1
Trevor McMillan, Non-Executive Director	2	2
Meredith Vivian, Non-Executive Director (left 30/04/25)	1	1
Niti Pall, Non-Executive Director	0	2
Cheryl Etches, Non-Executive Director (from 02/06/25)	1	2

NHS Shropshire Telford and Wrekin and NHS Staffordshire and Stoke-On-Trent Meeting in Common - Audit Committee attendance 2025/26

Member name and title	Meetings attended	Total meetings
Roger Dunshea, Non-Executive Director	1	1
Trevor McMillan, Non-Executive Director	0	1
Niti Pall, Non-Executive Director	0	1
Cheryl Etches, Non-Executive Director (from 02/06/25)	0	1

Remuneration Committee

The committee's responsibilities included:

- Determining all aspects of remuneration, contractual terms, and termination arrangements for the Chief Executive, Directors, and Very Senior Managers (VSMs) – including salary, bonuses, pensions, allowances, and benefits such as cars
- For all NHS Shropshire, Telford and Wrekin staff, the Committee set the organisations pay policy (for example, Agenda for Change), oversees contractual terms and conditions, remuneration, pensions, allowances, and gratuities, and approves termination or special payments in line with national guidance
- Confirming the pay policy and frameworks for non-executive directors.

In line with the Scheme of Reservation and Delegation, the Committee has authority to:

- Approve remuneration policies and procedures within its remit
- Make decisions on pay and allowances for ICB appointees who are not employees or non-executive directors
- Provide assurance on statutory duties related to people, including compliance with employment law and the Fit and Proper Person Regulation (FPPR)
- Review the performance of the Chief Executive and VSMs, including decisions on annual salary awards
- Approve the Fit and Proper Persons process for Board members on behalf of the Board.
- Considered redundancy papers for both voluntary redundancy and compulsory redundancy for different staffing groups as part of the ICB restructuring

The committee are required to meet two times per year, as per its terms of reference, with additional meetings held as needed. The committee met nine times during 2025/26. Including two meetings in common with Staffordshire and Stoke-on-Trent ICB.

The committee reviewed and/or approved matters relating to:

- VSM pay awards and pay framework update
- ICB Voluntary Redundancy scheme
- Transition approach for the formation of the Cluster ICB, including Executive Director and Director level posts
- Equity of pay for VSM2
- Chief Executive Officer (CEO) appointment remuneration
- Prescription Ordering Direct (POD) decommissioning
- Cluster employment arrangements, joint leadership and VSM salary ranges, confirmation of appointments and displaced staff.
- Cluster Chief Medical Officer Arrangements
- Chief Finance Officer Salary Pay
- Management of Change for Wider Workforce
- Public Health Consultant Secondment

The attendance records for the financial year are detailed below.

Remuneration Committee attendance 2025/26

Member name and title	Meetings attended	Total meetings
Prof. Trevor McMillan (Chair), Non-Executive Director	4	9
Niti Pall, Non-Executive Director	4	9
Ian Green, ICB Chair	8	9
Cheryl Etches, Non-Executive Director	8	9
Roger Dunshea, Non-Executive Director	2	9

Finance Committee

The committee's responsibilities included:

- Setting and overseeing the system financial framework – including strategic financial planning, performance monitoring and ensuring decisions consider health and social inequalities
- Managing system resource allocations – developing how revenue is distributed, overseeing transformation funding and working with Integrated Care System partners on investment and disinvestment decisions
- Overseeing national financial requirements – advising on funding regime changes, overseeing national submissions and ensuring compliance with national planning timelines
- Providing financial monitoring and assurance – ensuring clear financial information for decision-making, establishing common reporting approaches, developing modelling, long-term plans and managing system-wide financial risks
- Monitoring system financial and service performance – tracking delivery of the system financial target and reporting financial and service performance to the Board
- Leading financial governance communication – coordinating internal and external financial governance messages and supporting partners to understand links between cost, performance, quality and sustainability
- Developing the finance workforce – creating a system-wide finance staff development strategy and ensuring compliance with regulatory, legal and conduct requirements
- Overseeing capital planning – monitoring the capital programme, ensuring alignment of estates and digital plans, and overseeing prioritisation and capital bids
- Exercising delegated authority – approving financial policies and procedures within the Committee's remit, as outlined in the Scheme of Reservation and Delegation.

The Finance Committee is mandated to meet at least four times annually. The committee is scheduled to meet once a month except for August and December. Finance meetings for February

and March 2026 were scheduled to be meetings in common with Staffordshire and Stoke-on-Trent ICB to reflect cluster working arrangements.

The committee reviewed and/or approved matters relating to:

- System Board Assurance Framework (SBAF) and Strategic Operational Risk Register (SORR)
- Monthly revenue and efficiency report
- Capital Prioritisation Oversight Group update
- System Finance Improvement Programme (SIIP) update
- Mid Term Report
- Medium-Term Financial Plan and Finance Strategy
- Annual Report
- Deep Dive topics.

The attendance records for the financial year are detailed below.

Section One NHS Shropshire, Telford and Wrekin Finance Committee attendance 2025/26 April 2025-January 2026

Note: Section one meeting is the ICB Finance Committee

Member name and title	Meetings attended or a representative was sent	Total meetings
Prof. Trevor McMillan (Chair), Non-Executive Director	6	8
Dave Bennett (Vice Chair), Associate Non-Executive	8	8
Claire Skidmore, Chief Finance Officer – or represented by Angela Szabo, Director of Finance	7	8
Ian Bett, Chief Delivery Officer (joined as a member September 2025) – attended the April meeting but was not formally a member	2	8
Angela Szabo, Director of Finance (joined as a member September 2025) – attended the April meeting, but was not formally a member	7	8

Section One NHS Shropshire, Telford and Wrekin and NHS Staffordshire and Stoke-on-Trent Finance Committee in common attendance 2025/26 February-March 2026

Note: Section one meeting is the ICB Finance Committee

Member name and title	Meetings attended or a representative was sent	Total meetings
Mike Lawton, Chair, Deputy Chair, SSOT	2	2
Prof. Trevor McMillan (Chair), Non-Executive Director, STW	2	2
Claire Skidmore, Chief Finance Officer – or represented by Angela Szabo, Director of Finance, STW, SSOT	2	2
Helen Dempsey, Director of Planning, SSOT	2	2
Jacqui Charlesworth, Director of Operational Finance, SSOT	1	2
Phil Smith, Cluster Chief Officer for System Development & Integration – or represented by Hayley Allison Portfolio Director for Delivery and Improvement, SSOT	2	2

Mish Irvine, Cluster Chief of Staff Officer, STW, SSOT	2	2
Rachel Gallyot, Cluster Chief Officer for Strategy and Improving Outcomes STW SSOT – or represented by Steve Fawcett, Clinical Director, Urgent & Emergency Care SSOT	2	2
Paul Edmondson-Jones, Transition Director, SSOT	1	2
Paul Winter, Associate Director of Corporate Governance, SSOT	2	2
Lynn Tolley, Director of Nursing – Maternity & Safeguarding, SSOT	2	2
Lee Squire, Associate Director – Provider Management, SSOT	1	2

Section Two NHS Shropshire, Telford and Wrekin Finance Committee attendance 2025/26 April 2025-January 2026

Note: Section two is the System Finance Committee

Member name and title	Meetings attended or a representative was sent	Total meetings
Prof. Trevor McMillan (Chair), Non-Executive Director	6	8
Dave Bennett (Vice Chair), Associate Non-Executive	8	8
Claire Skidmore, Chief Finance Officer – or represented by Angela Szabo, Director of Finance	7	8
Ian Bett, Chief Delivery Officer (joined as a member September 2025)	2	4
Angela Szabo, Director of Finance (joined as a member September 2025)	7	8
Richard Miner, Non-Executive Director - SATH	3	8
Adam Winstanley, Acting Director - SATH – or represented by Sarah Edmonds	8	8
Feroz Patel, Chief Finance Officer - MPFT – or represented by Marianne Cleeve or Glenn Head	7	8
Tina Long, Non-Executive Director - SCHT	5	8
Sarah Lloyd, Chief Finance Officer - SCHT – or represented by Jonathan Gould	8	8
Sarfraz Nawaz, Non-Executive Director - RJAH	0	0
Craig Macbeth, Chief Finance Officer RJAH (until April 2025) / Angela Mulholland-Wells (from May 2025) – or represented by Mark Salisbury	6	8
James Walton, Finance Lead - Shropshire Council – or represented by Molly Sullivan	2	8
Michelle Brockway, Finance Lead - Telford & Wrekin Council – or represented by Richard Peach	7	8

Section Two NHS Shropshire, Telford and Wrekin and NHS Staffordshire and Stoke-on-Trent Finance Committee in common attendance 2025/26 February-March 2026

Note: Section two is the System Finance Committee

Member name and title	Meetings attended or a representative was sent	Total meetings
Mike Lawton, Chair, Deputy Chair, SSOT	2	2
Prof. Trevor McMillan (Chair), Non-Executive Director, STW	1	2
Claire Skidmore, Chief Finance Officer – or represented by Angela Szabo, Director of Finance, STW, SSOT	2	2
Helen Dempsey, Director of Planning, SSOT	2	2
Phil Smith, Cluster Chief Officer for System Development & Integration – or represented by Hayley Allison Portfolio Director for Delivery and Improvement, SSOT	2	2
Mish Irvine, Cluster Chief of Staff Officer, STW, SSOT	2	2
Rachel Gallyot, Cluster Chief Officer for Strategy and Improving Outcomes STW SSOT – or represented by Steve Fawcett, Clinical Director, Urgent & Emergency Care SSOT	2	2
Paul Edmondson-Jones, Transition Director, SSOT	1	2
Paul Winter, Associate Director of Corporate Governance, SSOT	1	2
Lynn Tolley, Director of Nursing – Maternity & Safeguarding, SSOT	2	2
Cheryl Etches, Non-Executive Director, STW	1	1
Steve Perks, Assistant Director of Finance – Intervention, NHSE - Midlands	1	2
Mark Oldham, Chief Financial Officer, University Hospitals of North Midlands NHS Trust	2	2
Feroz Patel, Chief Finance Officer, Midlands Partnership University NHS Foundation Trust	2	2
Lisa Dodds, Deputy Chief Finance Officer, North Staffordshire Combined Healthcare	1	2
Richard Peach, Group Accountant, Telford and Wrekin Local Authority	2	2
Michelle Brockway, Director, Finance and Human Resources, Telford and Wrekin Local Authority	2	2
Richard Minor, Acting Director of Finance, Shropshire, Telford and Wrekin Hospitals NHS Trust	1	2
Adam Winstanley, Acting Director of Finance, Shrewsbury and Telford Hospital NHS Trust – or represented by Rodney Muskett, Acting Deputy Director of Finance – Operational, Shrewsbury and Telford Hospital NHS Trust or Sarah	2	2

Edmonds (SE)Acting Deputy Director of Finance - Strategic, Shrewsbury and Telford Hospital NHS Trust		
Jonathan Gould, Deputy Director of Finance, Shropshire Community Health NHS Trust – or represented by Anthony Simms (ASi) Shropshire Community Health NHS Trust	2	2
Tina Long, Non-Executive Director, Shropshire Community Health NHS Trust	1	2
Angela Mulholland-Wells, Chief Finance Commercial Officer, Robert Jones and Angus Hunt Orthopaedic Hospital – or represented by Mark Salisbury, Deputy Chief Finance Officer, Robert Jones and Angus Hunt Orthopaedic Hospital	2	2
Sarfraz Narwaz, Non-Executive Director, Robert Jones and Angus Hunt Orthopaedic Hospital	0	2
Lisa Healings, Chief Executive Officer, VAST	2	2
Tim Baker, City of Stoke-on-Trent Council	2	2
Ian Lichfield, University Hospitals of Derby & Burton NHS Foundation Trust	1	2
James Green, Finance Director, The Royal Wolverhampton NHS Trust	1	2
Sally Proffitt, Deputy Director of Finance, University Hospitals of North Midlands NHS Trust – or represented by Nick Sone, Deputy Director of Finance – Financial Controller, University Hospitals of North Midlands NHS Trust	1	1
Helen Conway, System Strategic Workforce Planning Lead, Staffordshire and Stoke-on-Trent ICB	2	2
Cheryl Etches, Non-Executive Director, Shropshire, Telford & Wrekin ICB	1	1
Tanya Bowen (TBo) Finance & Performance Committee Chair, University Hospitals of North Midlands NHS Trust	1	2
Jane Gaddum (JGa) Non-Executive Director, Midlands Partnership University NHS Foundation Trust	1	1

System Quality and Performance Committee

The Committee's responsibilities included:

- Assurance and regulatory compliance
- Quality structure and processes
- Quality Strategy
- Risk management
- Quality metrics approval
- Quality improvement programmes
- Performance assurance framework

- Regulatory compliance
- Outcome measures
- Triangulation of quality and performance outcomes.

The Committee meet every month with the exception of August and December as per its terms of reference. The committee met nine times during the year, with no additional meetings convened for specific purposes.

The following reports and policies were approved at Quality and Performance Committee meetings this year:

- SEND Annual Report
- Child Death Overview Panel (CDOP) Annual Report, policy and standard operating procedures
- LeDeR Annual Report (learning from lives and deaths of people with learning disabilities and/or autism)
- School Asthma Policy
- Safeguarding Adults and Children Annual Report
- Reasonable Adjustment Digital Flag Policy and Equality and Quality Impact Assessment (EQIA)
- Children in Care Annual Report
- Standard operating procedures for 104-day breach, harm review and waiting well.

Reports on the following subjects were reviewed by the Committee:

- Quality performance
- System Integrated Improvement Plan (SIIP)
- Children and young people
- Diabetes assurance
- Local Maternity and Neonatal Services
- 104-day breach and harm review
- Assurance on discharge effectiveness.
- UEC Risk Review
- Healthwatch Updates

The attendance records for the financial year are detailed below.

Quality and Performance Committee attendance 2025/26

Member name and title	Meetings attended	Total meetings
Cheryl Etches, Chair	9	9
Vanessa Whatley, Deputy Chair	6	9
Julie Garside, Director of Planning, Performance, BI and Analytics	7	9
Angie Parkes, Deputy Director of Planning, Performance, BI and Analytics	2	9
Sharon Fletcher, Patient Safety Specialist	7	9
Tracey Slater, Head of Quality	5	9
Sonia Miller, Director of Public Health - Shropshire Council	0	9
Helen Onions, Director of Public Health - Telford & Wrekin Council	6	9
Rachel Robinson, senior leadership representative - Shropshire Council	0	9
Ann-Marie Speke, senior leadership representative - Telford & Wrekin Council	2	9
Dr Ganesh Mahadeva, primary care representative	7	9
Clair Hobbs, executive representative - SCHT	6	9
Paula Gardner, executive representative - SATH	2	9
Sarah Needham, executive representative - RJAH	0	9
Liz Lockett, executive representative - MPFT	2	9
Jill Barker, non-executive representative - SCHT	6	9
Rosie Edwards, non-executive representative - SATH	6	9
Lynn Cawley, Shropshire Healthwatch	3	9
Jan Suckling, Telford and Wrekin Healthwatch	4	9

Strategic Commissioning and Productivity Committee

The committee's responsibilities included:

- Commissioning and contracting oversight – Approving commissioning policies, procurement decisions, contract awards/variations, service changes, and business cases across health and care services, including Primary General Medical Services
- Strategic decision-making – Ensuring investment decisions follow the Strategic Decision-Making Framework and national Recovery Support Programme
- System productivity – Providing oversight and assurance on productivity across the ICS
- Commissioning prioritisation – Reviewing and assuring the commissioning prioritisation framework annually
- Integrated commissioning alignment – Ensuring all reviews, policies and business cases align with the ICB's strategic framework
- People functions – Approving Human Resources, Health and Safety, Equality, Diversity and Inclusion, and staff wellbeing strategies and arrangements
- Operational support functions – Approving arrangements for Emergency Preparedness Resilience and Response, Freedom to Speak Up, Information Governance, risk management, security, policy oversight, digital/IT, and estates

- Performance management – Overseeing corporate performance arrangements, including NHS England ICB Performance Framework and CQC Well-Led requirements
- Financial management – Providing assurance on the financial plan, overseeing financial targets, budget scrutiny, standing financial instructions, risk-sharing arrangements, and financial policies
- Patient involvement – Ensuring statutory duties for public involvement and equality are met, approving patient engagement strategies and policies
- Risk oversight – Ensuring committee-related risks are captured and monitored within the Board Assurance Framework and Strategic Operational Risk Register.

The committee met monthly as per its terms of reference, with additional meetings held as needed.

The committee reviewed and/or approved matters relating to:

- Primary Care Network (PCN) allocation
- Community optometry procurement
- Community ophthalmology procurement
- Child and adolescent mental health services (CAMHS) contract extension
- NHS Reset
- Medium-Term and Long-Term Financial Plan
- Emergency Preparedness Resilience and Response (EPRR) and Business Continuity Policy
- Communications Incident Plan
- Prescription Ordering Direct service decommissioning
- EPRR Annual Audit
- Community dermatology procurement
- Termination of pregnancy procurement
- Equality and Involvement Report
- GP practice boundary increase application
- Lung cancer screening programme
- Restoring financial balance across the system
- Operational Plan
- Child Death Overview Panel Annual Report.

The attendance records for the financial year are detailed below.

Strategic Commissioning and Productivity Committee attendance 2025/26

Member name and title	Meetings attended	Total meetings
Ian Green (Chair), Non-Executive Director (from 01/07/25)	6	8
David Bennett (Deputy Chair), Associate Non-Executive Director	9	12
Prof. Trevor McMillan, Non-Executive Director	5	12
Roger Dunshea, Non-Executive Director	11	12
Niti Pall (Deputy Chair) and Non-Executive Director (left 31/12/25)	2	11
Cheryl Etches, Non-Executive Director (from 01/06/25)	7	9
Simon Whitehouse, Chief Executive Officer	6	12
Nigel Lee, ICB Chief Strategy Officer and Director of Strategy and Partnerships - SATH (left 31/12/25)	4	10
Ian Bett, Chief Delivery Officer (left 07/11/25)	4	7
Claire Skidmore, Chief Finance Officer	11	12
Vanessa Whatley, Chief Nursing Officer	8	12

Dr Lorna Clarson, Chief Medical Officer	10	12
Phil Smith, Chief Delivery Officer (from 01/12/25)	3	4

System Strategy and Prevention Committee

The committee's responsibilities include:

- Setting and recommending overall ICS strategic direction
- Leading development and approval of the Joint Forward Plan (JFP)
- Using data and benchmarking to identify improvement opportunities
- Overseeing digital and data strategy, ensuring system-wide integration
- Driving coordinated estates, procurement and commercial strategies
- Ensuring the People Plan aligns with ICS priorities
- Aligning primary care plans with the JFP and wider system programmes
- Ensuring major transformation programmes align with strategic priorities
- Embedding action on health inequalities and population health management
- Overseeing development and delivery of the ICS Green Plan
- Providing assurance on delegated activity and ensuring risks are incorporated into system risk frameworks.

The committee are required to meet four times per year, as per its terms of reference, with additional meetings held as needed. The committee met five times during the financial year, including one extraordinary meeting for specific purposes.

The committee reviewed and/or approved matters relating to:

- Terms of Reference
- Neighbourhood working approach
- Draft Finance Strategy
- Next steps – Joint Forward Plan, 10-year plan, role of strategic decision-making framework including updates and National Neighbourhood Health Implementation Programme
- Tackling inequalities in access, experience and outcomes including position and priorities for 2025/26
- Health and Wellbeing Boards alignment update
- Risk stratification
- Healthy Ageing and Frailty communications and engagement plan
- System Transformation and Digital Committee – transformation programme alignment to system strategic aims
- ICS Prevention Framework
- Infrastructure Strategy
- Green Plan (2025-28)
- Healthcare Inequalities Implementation Plan
- Digital Strategy
- Community transformation
- System Strategy development – system medium term planning
- Health Improvement and Prevention Group
- Vaccination Improvement Plan Report
- Director of Public Health Report
- Shropshire Pharmaceutical Needs Assessment Report
- Annual Public Health Report 2025 – Towards a Smoke-free Future
- Draft STW Clinical Strategy
- Draft Cardiovascular, Renal and Metabolism (CVRM) Strategy
- Local Maternity and Neonatal System equity programme.

The attendance records for the financial year are detailed below.

System Strategy and Prevention Committee attendance 2025/26:

Member name and title	Meetings attended	Total meetings
Cathy Purt (Chair), Non-Executive Director - SCHT	5	5
Niti Pall (Deputy Chair), Non-Executive Director	0	5
Nigel Lee, ICB Chief Strategy Officer and Director of Strategy and Partnerships - SATH	5	5
Claire Skidmore, Chief Finance Officer	3	5
Vanessa Whatley, Chief Nursing Officer	1	5
Dr Lorna Clarson, Chief Medical Officer	4	5
Gemma Smith, Director of Strategic Commissioning	2	5
Mark Large, Non-Executive Director - MPFT	4	5
Sarah Lloyd, Director of Finance, Digital and Estates - SCHT	0	5
Carla Bickley, Associate Director of Strategy and Partnership - SATH	3	5
Jill Barker, Non-Executive Director - SCHT	3	5
Prof. Trevor Purt, Non-Executive Director - SATH and ICB Chair of Audit and Risk Assurance Committee	4	5
James Venables, Deputy Director of Strategy and Commercial Development - MPFT	2	5
Dr Ian Chan, Clinical Director - TELDOC PCN	4	5
Helen Onions, Interim Director of Health and Wellbeing - Telford & Wrekin Council	2	5
Laura Tyler, Assistant Director Joint Commissioning - ICB and Shropshire Council	0	5
Rachel Robinson, Executive Director of Health - Shropshire Council	3	5
Nia Jones, Managing Director for Planning and Strategy – RJAH	3	5
Lynn Cawley, Chief Officer - Healthwatch Shropshire	2	5

System Transformation and Digital Group

The committee's responsibilities included:

- Overseeing and supporting the development and delivery of the Sustainability Transformation Programmes and the Financial Improvement Programme
- Ensuring programmes achieve expected financial and quality outcomes within agreed timescales and budgets
- Monitoring key risks, ensures appropriate mitigations are in place, and addresses escalated issues
- Ensuring sufficient resources are allocated, including across enabling workstreams
- Identifying and managing interdependencies with other system-wide programmes and enabling activities
- Checking that programmes remain aligned to the Joint Forward Plan, wider system strategies (including financial and clinical strategies) and support delivery of the 10 system pledges
- Providing oversight of operational groups and enabling workstreams linked to the transformation programmes
- Ensuring delivery plans support accelerated implementation and a collective approach to transformation priorities, including clarifying deliverables, impact measures and accountabilities
- Monitoring delivery of the Financial Efficiency Programme and aligns it with transformation programmes.

System Improvement Plan responsibilities include:

- Overseeing development and delivery of the System Improvement Plan to achieve financial balance
- Ensuring robust decision making for investments within available funding, working with the Finance Committee and System Transformation Group
- Developing integrated planning processes and a financial model for the system
- Developing performance oversight processes, including metrics linked to System Oversight Framework (SOF) exit criteria
- Monitoring progress against SOF exit criteria and holds committees and partners to account.

The committee also provides oversight and assurance for any additional activity delegated by the ICB or requested by system partner organisations.

The committee is required to meet four times per year, with the expectation that it meets monthly except for August and December, as per its terms of reference. The committee met eighttimes during 2025/26.

The committee reviewed and/or approved matters relating to:

- The group's terms of reference
- Programme highlight reports and programme risks
- SBAF and SORR
- Integrated working between SCHT and SATH
- Winter Plan
- Future system governance
- Hospital Transformation Programme.

The attendance records for the financial year are detailed below.

System Transformation Group attendance 2025/26

Member name and title	Meetings attended	Total meetings
Andrew Morgan (Chair), Chair in Common - SCHT and SATH	8	8
Simon Whitehouse (Vice Chair), Chief Executive Officer	8	8

Claire Skidmore, Chief Finance Officer	7	8
Dr Lorna Clarson, Chief Medical Officer	8	8
Stacey Keegan, Chief Executive - RJAH	8	8
Joanne Williams, Chief Executive - SATH (from September 2025)	8	8
Patricia Davies, Chief Executive - SCHT (left June 2025)	3	8
Andy Begley, Chief Executive - Shropshire Council (Left Dec 2025)	2	8
David Sidaway, Chief Executive - Telford & Wrekin Council	2	8
Neil Carr, Chief Executive	2	8
Ian Bett, Chief Delivery Officer (from July 2025 to October 2025)	5	6
Nigel Lee, ICB Chief Strategy Officer and Director of Strategy and Partnerships – SATH	7	8

System People, Culture and Inclusion Committee

The People Committee aims to ensure that effective plans, governance and leadership are in place to deliver workforce, organisational development (OD), culture, and equality, diversity and inclusion (EDI) priorities across Shropshire, Telford and Wrekin. Its focus is on supporting a sustainable, high quality, patient- centred- health and care system.

To achieve this, the committee:

- Aligns partners across the ICS around a shared people agenda
- Builds strategic relationships with key system, regional and national stakeholders
- Works to reduce inequalities in staff experience and promote EDI
- Provides leadership, strategic advice and assurance on people, culture and inclusion matters
- Develops a coherent approach to measuring outcomes and progress
- Encourages innovation in workforce solutions
- Provides a forum to escalate and manage strategic people related risks
- Sets direction for delivery groups and ensures outcomes are achieved.

The Committee delivers these responsibilities by:

- Overseeing workforce transformation, OD, cultural change, education and training strategies
- Ensuring delivery of the ICS Workforce Plan and NHS Long Term Workforce Plan
- Providing assurance to the ICB Board on people, culture and inclusion objectives
- Overseeing the use of Workforce Development Funding
- Receiving assurance reports from workstreams and sub-committees, including governance, delivery arrangements, risks and performance measures
- Receiving annual Freedom to Speak Up (FTSU) workforce-related themes
- Reviewing relevant elements of the Board Assurance Framework and reporting back to the ICB.

The committee is required to meet at least twice a year, but the expectation is that the committee will meet bi-monthly in line with its terms of reference. The committee met four times during 2025/26.

The committee reviewed and/or approved matters relating to:

- System People Strategy and oversight of delivery
- People Collaborative terms of reference
- Outcomes and next steps for High Potential Scheme
- System Board Assurance Framework (SBAF) and risks
- Workforce Plan delivery
- System vacancy panel
- EDI system activity including 90-day outcomes

- Recommendations of Hunter Healthcare HR Review
- Pharmacy Workforce Strategy
- Work Well programme.

The attendance records for the financial year are detailed below.

People, Inclusion and Culture Committee attendance 2025/26

Member name and title	Meetings attended	Total meetings
Harry Turner (Chair), Chair - RJAH	1	4
Martin Evans, Non-Executive Director - RJAH	4	4
Stacey-Lea Keegan, SRO for People and Workforce Chief Executive - RJAH	3	4
Teresa Boughey, Non-Executive Director - SATH	3	4
Pauline Gibson, Non-Executive Director - MPFT (replaced by Debbie Nixon)	2	4
Ellen Shaw, Interim Deputy Chief People Officer	3	4
Denise Harnin, Chief People and Culture Officer - RJAH and Exec SRO	3	4
Rhia Boyode, Chief People Officer - SATH and SCHT SRO	0	4
Alex Brett, Chief People Officer - MPFT and Exec SRO	3	4
Sarah Allen, Assistant Director of People - SCHT and SRO	2	4
Simon Balderstone, Deputy Director of People Operations - SaTH and SRO	2	4
Vanessa Whatley, Chief Nursing Officer	3	4
Hannah Preece, HR Manager - Telford & Wrekin Council	2	4
Pete Ezard, CEO - Energise STW, and Joint Chair – VCSA	1	4
Tanya Miles, Executive Director People - Shropshire Council	0	4

Transition Committee

NHS England's Model ICB – Blueprint guidance (published in May 2025) describes how the NHS must work together in 2025/26 to deliver core priorities, statutory functions and duties for the population of Shropshire, Telford and Wrekin, while laying the foundations for reform.

This included the requirement to establish a Transition Committee (TC) – including both Executive and Non-Executive Members – to ensure a safe, coherent transition, and to support the Board by taking lead responsibility for managing all local risks, tracking progress, and overseeing the development of organisational design and implementation of change processes.

The committee's responsibilities include:

- Focusing on delivering cost reduction plans, as outlined within the Model Blueprint, achieving required savings within the operating cost envelope
- Managing workforce impacts during the transition to the Model ICB core functions, incorporating staff, staff-side, and union feedback
- Designing affordable leadership and operating structures aligned with Model ICB requirements to deliver the Joint Forward Plan and annual plans
- Managing transition risks through safe and effective governance
- Ensuring timely, open, and transparent communication with staff and stakeholders throughout the transition
- Setting and managing expectations for the safe transition of transferred or reconfigured ICB functions at scale.

The Committee oversees robust Programme Management arrangements to deliver transition requirements within agreed timescales and support development of a fit-for-purpose future ICB Operating Model.

It will ensure the new Operating Model effectively delivers revised ICB functions and responsibilities, in line with the Model ICB Blueprint and emerging Strategic Commissioning frameworks, while remaining affordable.

The Committee will also oversee fair and transparent exit and workforce change processes, aligned with national guidance and local HR/Management of Change policies, working with the People, Culture and Inclusion Committee and Remuneration Committee as required.

The committee is required to meet at a regularity agreed by the Committee in line with its terms of reference. The committee met eight times from June 2025 to September 2025, before it became a Transition Committee in Common with Staffordshire and Stoke-on-Trent ICB. Since meeting jointly the committee have met seven times.

The committee reviewed and/or approved matters relating to:

- Reports from the Programme Group which was created between Shropshire, Telford and Wrekin ICB and Staffordshire and Stoke-on-Trent ICB to provide management oversight to the clustering arrangements. To date, these reports have been largely focussed on the creation and development of a programme structure to ensure that the transition to a cluster arrangement is managed efficiently and effectively in line with the ICB Model Blueprint. This includes items around future structures, governance around the merging of the two organisations, finance and accommodation.
- Discussed risks around the transition to a clustering arrangement and ensured that the Strategic Operational Risk Registers and Programme Risk Log were updated to reflect this.
- Discussed the existing national guidance in respect of the NHS Reset programme to support delivery of the NHS 10 Year Plan, acknowledging that more guidance on specific areas of ICB functions are due to be released, but no specific timings have been provided.

The attendance records for the financial year are detailed below.

Transition Committee attendance 2025/26 - March 2025 to September 2025 (Shropshire, Telford and Wrekin Only)

Member name and title	Meetings attended	Total meetings
Ian Green, Chair	7	8
Simon Whitehouse, Chief Executive Officer	6	8
Claire Skidmore, Chief Finance Officer	6	8
Dr Lorna Clarson, Chief Medical Officer	6	8
Vanessa Whatley, Chief Nursing Officer	6	8
Nigel Lee, Chief Strategy Officer	3	8
Roger Dunshea, Non-Executive Director	5	8
Cheryl Etches, Non-Executive Director	7	8
Trevor McMillan, Non-Executive Director	1	8
Dave Bennett, Associate Non-Executive Director	5	8
Niti Pall, Non-Executive Director	0	8
Alison Smith, Chief Business Officer	5	8
Lisa Kelly, HR Business Partner - Midlands and Lancashire Commissioning Support Unit	8	8
Ellen Shaw, Interim Chief People Officer	7	8

Transition Committee in Common attendance – November 2025 – March 2026 (Shropshire, Telford and Wrekin along with Staffordshire, Stoke-on-Trent)

Member name and title	Meetings attended	Total meetings
Ian Green, Chair	6	7
Simon Whitehouse, Chief Executive Officer	6	7
Claire Skidmore, Chief Finance Officer	7	7
Dr Lorna Clarson, Chief Medical Officer	4	7
Vanessa Whatley, Chief Nursing Officer	4	7
Nigel Lee, Chief Strategy Officer (Left the organisation)	1	7
Roger Dunshea, Non-Executive Director	5	7
Cheryl Etches, Non-Executive Director	3	7
Trevor McMillan, Non-Executive Director	6	7
Dave Bennett, Associate Non-Executive Director (Left the organisation)	1	7
Niti Pall, Non-Executive Director (Left the organisation)	0	7
Alison Smith, Chief Business Officer	7	7
Lisa Kelly, HR Business Partner - Midlands and Lancashire Commissioning Support Unit	1	7

Ellen Shaw, Interim Chief People Officer	7	7

Shropshire Integrated Place Partnership Committee (ShIPP)

The committee's responsibilities include:

- Overseeing delivery of key priorities from thematic partnership boards
- Working with the Board and Health and Wellbeing Board to set community health and care priorities
- Establishing working groups to implement agreed actions
- Providing assurance on the delivery, timeliness, and impact of local programmes and services
- Identifying additional activity requirements and addresses risks and mitigations.

The committee reviewed and/or approved matters relating to:

- ShIPP Terms of Reference
- Healthwatch reports and updates
- Children and Young People's Joint Strategic Needs Assessment (JSNA)
- Healthy Ageing and Frailty Strategy
- Public health nursing service
- Youth Strategy
- ShIPP priority update and 2025/26 Strategic Plan
- Dementia multi-disciplinary team
- Diabetes programme
- Musculo-skeletal Health Inequalities and Deprivation Report – Arthritis and Musculoskeletal Alliance (ARMA)
- ShIPP Prevention Funding
- ICB updates
- Draft Pharmaceutical Needs Assessment
- 2025/26 Better Care Fund Plan
- ShIPP Accelerator Group
- ShIPP Approval of Terms of Reference and Annual Report 2024/25
- Energise STW – Place universal bid
- STW GP Board introduction
- Think twice, order right medicine waste campaign
- National Neighbourhood Health Implementation Programme (NNHIP)
- Vaccination Improvement Plan
- GP out of hours service – HealthHero
- SEND JSNA
- Lung cancer screening
- Urgent and Emergency Care Winter Plan (including flu update).

The attendance records for the financial year are detailed below.

Shropshire Integrated Place Partnership Committee attendance 2025/26

Member name and title	Meetings attended	Total meetings
Tanya Miles (Chair), Chief Executive – Shropshire Council	2	5
Bev Baxter and Pete Ezard, VCSA representatives	5	5
Bridey Davies, Engagement and Stakeholder Relations Specialist	3	5
Carla Bickley, Associate Director of Strategic Planning and Partnerships - SaTH	2	5

Claire Parker, Director of Strategy and Development	4	5
Dr Catherine Beanland, Joint Clinical Director - South West PCN	2	2
Dr Charlotte Hart, Clinical Director - Shrewsbury PCN	5	5
Dr Daniela Puiu and Dr Katy Lewis, Clinical Directors - Shropshire Rural PCN	2	3
Dr Deborah Shepherd, Clinical Director - South West Shropshire PCN and ICB GP Partner Member (left 30/11/25)	3	3
Dr Edwin Green, Clinical Director - South West Shropshire PCN	2	4
Dr Jess Harvey, Clinical Director - South East Shropshire PCN and ICB GP Board representative	3	5
Emma Pyrah, Head of System Development	4	5
Gemma Smith, Director of Strategic Commissioning	0	5
Geraldine Vaughan, STW ICS MSK Transformation Programme Manager - RJAH	4	5
Julian Birch, Chair - Shropshire Patients Group – or represented by Daphne Lewis	2	5
Laura Fisher, Head of Housing, Resettlement and Independent Living - Shropshire Council – or represented by Jenny Daisley	3	5
Laura Tyler, Service Director Commissioning - Shropshire Council – or represented by Louise Forbes	1	5
Lynn Cawley, Chief Executive Officer - Healthwatch Shropshire	3	5
Paul Bowers, Head of Operations - Shropshire and Telford & Wrekin Care Group, and Care Group representative – MPFT	1	5
Peter Prokopa, Community Pharmacy Chief Officer	1	5
Rachel Robinson, Assistant Executive Director of Health and Wellbeing – or represented by Anne-Marie Speke	2	5
Sharon Fletcher, Interim Deputy Chief Nurse and Patient Safety Specialist	4	5
Simon Jones, Clinical Director - North PCN	2	5
Steve Ellis, Deputy Director of Operational Service Development - SCHT – or represented by Sam Townsend	4	5
Tomas Edge, PCN Manager and Digital Transformation Lead - North Shropshire PCN	1	5

Telford and Wrekin Integrated Place Partnership Committee (TWIPP)

The committee's responsibilities include:

- Setting and delivering place-based priorities for neighbourhood health.
- Leading collaborative system working.
- Strengthening prevention and population health
- Overseeing the Neighbourhood Health Accelerator Group and Neighbourhood Health Steering Groups
- Managing Place Prevention Grant Funding
- Providing oversight and alignment across strategic boards and programmes (Health and Wellbeing Board, Ageing Well Partnership, Better Care Fund, Children and Families, Mental Health)
- Focusing on reducing health inequalities.

The committee reviewed and/or approved matters relating to:

- TWIPP strategic priorities for 2025/26
- Telford and Wrekin Ageing Well Partnership membership review
- Developing a system-wide Healthy Ageing and Frailty Strategy
- Energise STW – Place expansion proposal
- Non-recurrent ICB prevention grant funding for neighbourhood health projects
- Areas of focus for the Healthy Conversations (Making Every Contact Count) programme
- Service and support arrangements for children and young people's mental health and wellbeing across health, education, local authority and the voluntary sector – identifying areas requiring improvement and focus.

All committee meetings were quorate with all partners represented.

Register of interests

The organisation holds registers of interest declared by our Board members and for other committees where membership includes individuals who are not Board or staff members. These can be found on our Register of Interests webpage.

Personal data-related incidents

NHS Shropshire, Telford and Wrekin reported one personal data related incident to the Information Commissioner's Office during 2025/26. However, this related to an external provider incident and was subsequently closed by the Information Commissioner, with no further action required.

Modern Slavery Act

NHS Shropshire, Telford and Wrekin fully support the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending 31 March 2026 is published on our website.

Statement of Accountable Officer's Responsibilities

Under the NHS Act 2006 (as amended), NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Shropshire, Telford and Wrekin ICB and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts
- Prepare the accounts on a going concern basis
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The NHS Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England.

NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Shropshire, Telford and Wrekin ICB. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding NHS

Shropshire, Telford and Wrekin ICB's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the NHS Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, 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 NHS Shropshire, Telford and Wrekin ICB's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Simon Whitehouse
Accountable Officer
17th June 2026

Governance statement

NHS Shropshire, Telford and Wrekin is a body corporate established by NHS England on 1 July 2022 under the NHS Act 2006 (as amended). The NHS Shropshire, Telford and Wrekin's statutory functions are set out under the NHS Act 2006

The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. It is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between 1 April 2025 and 31 March 2026, NHS Shropshire, Telford and Wrekin was not subject to any directions from NHS England issued under Section 14Z61 of the of the NHS Act 2006 (as amended).

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Shropshire, Telford & Wrekin ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the NHS Act 2006 (as amended) and in NHS Shropshire, Telford and Wrekin ICB's Accountable Officer Appointment Letter.

I am responsible for ensuring that NHS Shropshire, Telford and Wrekin ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically, and complies with such generally accepted principles of good governance as are relevant to it. Details of how this has been achieved is included within the members report above.

NHS Shropshire, Telford and Wrekin's Constitution can be found on our website. Details of membership, attendance records and highlights of work undertaken throughout the year is available in the committee section above.

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Code of Corporate Governance.

Discharge of statutory functions

NHS Shropshire, Telford and Wrekin has reviewed all of the statutory duties and powers conferred on it by the NHS Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that NHS Shropshire, Telford and Wrekin is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the organisation's statutory duties.

Risk management arrangements and effectiveness

NHS Shropshire, Telford and Wrekin has a structured approach to risk management, ensuring effective governance across corporate, clinical, financial, and information domains. This is achieved through the Risk Management Policy, the System Board Assurance Framework, and the Strategic Operational Risk Registers, enabling a coordinated approach to identifying, evaluating, and controlling risk.

Risk is managed at three key levels – prevention, deterrence, and active management. Prevention is achieved by implementing robust policies and procedures, supported by staff training in areas such as safeguarding, health and safety, and business continuity. External expertise, including legal, human resources, and information governance advisors, further strengthens this approach. Deterrence mechanisms, such as fraud prevention strategies, IT security protocols, and internal audit functions, are in place to mitigate vulnerabilities. Active risk management is embedded through systematic assessment processes, incident reporting via the Ulysses system, and intelligence gathering through provider performance monitoring, complaints, and patient feedback via the Patient Advice and Liaison Service (PALS).

The Board determines the organisation's risk appetite, balancing the need for innovation with appropriate mitigation of significant risks. The Risk Management Policy, outlines a structured methodology for identifying and assessing risks, ensuring they are managed within defined parameters rather than eliminated entirely. The Audit Committee provides independent oversight, ensuring governance mechanisms are effective, with committee-level accountability for specific risks.

Risk management is embedded across NHS Shropshire, Telford and Wrekin's activities. Impact assessments are routinely conducted when reviewing or implementing policies to ensure inclusivity and compliance. Training is mandated for Board members and staff on key areas such as health and safety, information governance, safeguarding, and fire safety. The organisation actively promotes a culture of openness in incident and serious incident reporting, fostering continuous learning and improvement. Performance monitoring and provider oversight also play a crucial role in ensuring quality standards are maintained across commissioned services.

NHS Shropshire, Telford and Wrekin actively involve patients, carers, and the wider public in identifying and managing risks that impact them. Public and patient engagement is facilitated through advisory groups,

consultations, and direct feedback mechanisms. Regular meetings with patient and community representatives provide valuable insights into emerging risks and ensure that public concerns are addressed in decision-making processes. Public consultations on service changes allow for transparency and accountability, ensuring that potential risks associated with changes to healthcare services are fully considered. NHS Shropshire, Telford, and Wrekin also collaborate with voluntary and community sector organisations to better understand and mitigate risks that may disproportionately affect vulnerable groups.

By embedding risk management across all levels of the organisation and engaging with stakeholders in a meaningful way, NHS Shropshire, Telford and Wrekin ensures that risks are identified, assessed, and managed efficiently. This structured approach strengthens governance, enhances public trust, and ultimately supports the delivery of safe, high-quality healthcare services. Our Risk Management Policy is available on the ICB website.

Capacity to handle risk

NHS Shropshire, Telford, and Wrekin has a robust and structured approach to risk management, ensuring that the organisation meets its statutory obligations while effectively identifying, assessing, and mitigating risks.

Risk management is led by the Accountable Officer, who owns the System Board Assurance Framework. The System Board Assurance Framework provides a structured documentation of principal risks that could impact the system's ability to meet its objectives. This is complemented by the Strategic Operational Risk Register, which identifies and manages lower-level risks associated with executive leads' responsibilities. These structures ensure a clear and comprehensive framework for monitoring risks across the organisation.

The Accountable Officer is supported by the Chief Business Officer, who provides guidance on risk management policies and practices. Directors are responsible for informing the Strategic Operational Risk Register, ensuring that potential risks within their areas of responsibility are identified and addressed.

Committees play a key role in overseeing risk management processes. The Board and its committees have defined responsibilities to assess and respond to risks, ensuring that risks are escalated appropriately and mitigated effectively.

Clear reporting lines exist between the Board and its committees. The Accountable Officer and executive leads ensure that risks are communicated effectively through structured reporting mechanisms. The Chief Business Officer provides additional support in maintaining transparency and alignment across all risk management efforts.

The submission of timely and accurate information is a cornerstone of effective risk management. Executive leads and their teams contribute regularly to the Strategic Operational Risk Register, ensuring that risks are identified, assessed, and updated to reflect changing circumstances.

The Board maintains rigorous oversight of risk management performance. Through regular reviews of the System Board Assurance Framework and Strategic Operational Risk Register, the Board ensures that key risks are being managed effectively.

Risk assessment

NHS Shropshire, Telford and Wrekin recognise that it is impossible to eliminate all risk and that the aim of risk management is to mitigate risks using control measures and action plans. NHS Shropshire, Telford and Wrekin's Board, and its committees, have a key role in the identification of risks in response to information presented to, and discussions held, at each meeting. A standing agenda item is included for every meeting to determine if there are any new risks that need to be considered for the Operational Risk Register.

All risks are assessed based on two elements: impact and likelihood. Each element is given a score between one and five and the multiplication of these scores generates an initial risk score. Consideration is then given to the mitigations which NHS Shropshire, Telford and Wrekin has in place, and this informs the current risk score. Risks with a score of 15 or above are overseen by the Board.

To view the end-of-year risk position as overseen by the Board, see the papers on our Previous Board Meetings webpage.

Other sources of assurance

Internal control framework

A system of internal control is the set of processes and procedures in place in the NHS Shropshire, Telford and Wrekin, to ensure it delivers its policies, aims and, objectives. It is designed to identify and prioritise the risks, 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 allows risk to be managed to a reasonable level rather than eliminating all risk – it can therefore only provide reasonable and not absolute assurance of effectiveness.

Our risk management policy defines our commitment to ensuring that the organisation has in place structures that will effectively manage risks of all kinds, in line with aims set out in our Constitution. We will take all reasonable steps to manage risks in commissioned services, staff, visitors, reputation, organisational assets, and any other issues as an integral part of our management processes.

The following control mechanisms are in place:

- Risk management
- Conflicts of interest management and training
- Constitution and Governance Handbook
- Security management
- Counter Fraud Annual Plan
- Internal Audit Annual Plan
- Performance monitoring of ICS providers and the organisation itself
- Data Security and Protection Toolkit submission
- Incident and serious incident reporting
- Quality and financial reporting
- Contract/quality performance monitoring arrangements with providers
- Policies and procedures
- Risk assessments
- Governance reporting between the Board and its committees/sub-committees
- Adult and children's safeguarding annual reports
- Emergency and business continuity planning/core standards
- External regulator reports on providers.

The organisation has a Conflicts of Interest Policy which governs the process for employees, Board members, committee members, contractors and others undertaking functions on behalf of the organisation to declare their interests where these may conflict with those of NHS Shropshire, Telford and Wrekin.

The Policy outlines a process for individuals both employed by the organisation or those not employed but acting on behalf of the organisation, to declare these interests to ensure that decisions made on behalf of NHS Shropshire, Telford and Wrekin are not compromised. The policy and registers can be found on our Conflicts of Interest webpage.

The revised statutory guidance on managing conflicts of interest (published June 2016) requires commissioners to undertake an annual internal audit of conflicts of interest management. To support ICBs to undertake this task, NHS England has published a template audit framework.

The organisation carried out its annual internal audit of conflicts of interest at the end of 2024/25 and the audit provided significant assurance, with some recommendations for further action. All recommendations have been fully accepted by the organisation, and the recommendations have been implemented. During 2025/26, it was agreed that all staff would undertake mandatory e-learning in respect of Conflicts of Interest, with three levels of learning depending on individual staff members roles.

Data quality

The Board relies on the data quality standards being adhered to which are outlined in national requirements and monitored through contracts with providers that require them to quality assure their data prior to submission.

Data quality for national data flows is measured against the Data Quality Maturity Index (DQMI), for local flows, and further data quality checks on national flows, the ICB service with NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) incorporates and reports these additional checks.

The ICB adopts and adheres to national standards and best practice as it recognises data quality underpins all reporting and analysis used to inform decision making within the commissioning cycle and beyond.

Information governance and personal data-related incidents

The NHS Information Governance (IG) Framework sets the processes and procedures by which the NHS handles information about patients and employees, particularly personal identifiable information. The NHS IG Framework is supported by an IG toolkit (Data Security and Protection Toolkit – DSPT) and the annual submission process provides assurances to the ICB, other organisations and individuals that personal information is dealt with legally, securely, efficiently, and effectively. As the DSPT submission is not due until 30 June 2026, final compliance cannot be reported in this Annual Report.

The organisation places high importance on ensuring there are robust IG systems and processes in place to help protect patient and corporate information. NHS Shropshire, Telford and Wrekin have established an IG management framework and have developed processes and procedures in line with the DSPT. We have ensured all staff undertake annual IG training and provide a staff IG handbook to ensure everyone is aware of their roles and responsibilities.

There are processes in place for incident reporting and the investigation of serious incidents. NHS Shropshire, Telford and Wrekin have reported a total of 11 incidents during the period 1 April 2025 to 31 March 2026, of which all incidents were graded as non-reportable – very low risk, with none being reportable to the Information Commissioner's Office (ICO). The organisation has developed an information asset register which enables the organisation to identify high-risk assets through data flow mapping, and this ensures that an information risk culture is embedded throughout the organisation.

NHS Shropshire, Telford and Wrekin receives an IG service from MLCSU. This enables us to receive a full, specialised service, which as a small organisation we could not reproduce in-house. A work programme has been undertaken by MLCSU to ensure that the organisation is compliant against General Data Protection Regulations. As part of this, our information has been audited, and staff training has been delivered.

Business critical models

The organisation relies on centrally provided NHS business planning models to help it plan future strategy. NHS Shropshire, Telford and Wrekin has no business-critical models that it would be required to share with the Analytical Oversight Committee.

Third party assurances

Third-party assurances are received annually from Midlands and Lancashire Commissioning Support Unit (MLCSU) for particular financial functions that are part of a service level agreement. Processes are in place to ensure that the MLCSU Internal Audit function shares its own audit findings of these functions with NHS Shropshire, Telford and Wrekin's internal auditor, who includes a precis of the findings in the Head of Internal Audit Opinion, which is part of this statement.

Freedom to Speak Up

NHS Shropshire, Telford and Wrekin have a Freedom to Speak Up policy which is based upon the template provided by the National Guardian Office. This policy supports any individual wishing to raise a concern at work, and it helps to promote the organisation's open and honest culture.

A Non-Executive Member of the NHS Shropshire, Telford and Wrekin Board acts as a Freedom to Speak Up Board-level champion. The Chief Business Officer has been responsible for Freedom to Speak Up at a Senior Leadership level.

The organisation has two Freedom to Speak Up Guardians, recruited from within NHS Shropshire, Telford and Wrekin's existing staff. Since their appointments, they have met with various teams and regularly meet with all staff networks to promote a speaking up culture.

This year has seen six contacts of which no concerns resulted in a formal response. The contacts are themed around requiring support in relation to a HR process, identifying an appropriate route to raise concerns, dissatisfaction with a management decision/perceived poor leadership, and actions that the person perceived to be contrary to the organisation's values. All colleagues were supported to identify an appropriate route to raise their concern. There has been low incidence of colleagues raising concern relating to inappropriate attitudes, behaviours, bullying and/or harassment or clinical/patient safety.

All contacts met with a Freedom to Speak Up Guardian and were appropriately provided with advice and guidance. Following raising concerns all contacts are asked if they are satisfied with the outcome, whether they would speak up again and if they felt that they had suffered detriment because of speaking up. All those that responded to the questions were satisfied with the outcome, would speak up again, and did not feel that they had suffered any detriment because of speaking up.

Control issues

The significant control issues that the organisation has been managing during the period 1 April 2025 to 31 March 2026 that would require reporting in this Annual Governance Statement are as follows:

Quality and Performance

Urgent and emergency care

During 2025/26, system pressures across the urgent and emergency care pathway continued to present significant operational challenges, most notably extended ambulance handover delays, congestion across Emergency Departments (ED), and high bed occupancy. The ICB has maintained strengthened oversight through the development of a comprehensive system-wide Urgent and Emergency Care (UEC) Improvement Plan, co-produced with partners and subject to ongoing review and approval by NHS England.

Escalation arrangements, both in and out of hours have been reinforced, with regular review of system capacity, utilisation and patient flow. A weekly harm review process remains in place, assessing delays greater than six hours and ensuring actions are taken to mitigate patient safety risks. Insight visits, mock Care Quality Commission (CQC) assessments and Getting It Right First Time (GIRFT) reviews have supported both assurance and improvement.

Regulation and patient safety

The ICB has worked closely with providers to monitor progress against CQC action plans, including via UEC transformation meetings and contract review forums. Regulatory improvements have been noted, including the lifting of the Section 31 restriction relating to admitting children and young people to paediatric wards from ED in December 2024.

Oversight of the Patient Safety Incident Response Framework (PSIRF) implementation remains a key area of focus, ensuring providers maintain effective systems for learning, thematic review, and safe incident response. Daily ambulance response data continues to be scrutinised regionally to highlight and address emerging risks.

Ambulance services

The ICB, alongside system partners, participates in monthly clinical quality review meetings with West Midlands Ambulance Service (WMAS). WMAS has continued to embed the PSIRF model, with routine monitoring of ambulance response times and quality visits to hubs. These arrangements have strengthened shared learning, governance and escalation across the system.

Mental health and dementia

System pressures have persisted across mental health pathways, including prolonged waiting times in BeeU services for children and young people and rising waiting lists for ADHD assessments in adults. Multiagency task and finish groups are in place to address demand, increase throughput and monitor system impact. Delayed transfers of care and out-of-area placements for adults remain key risks – monthly multiagency discharge events have focused on removing barriers to timely, safe discharge. Dementia performance and related quality measures are monitored quarterly.

Infection prevention and control

The ICB has continued to respond to system wide increases in Clostridium difficile (C.diff) across acute and community settings. Infection prevention and control outbreaks were monitored closely over the winter period, with partners implementing agreed actions. In addition, completion of the Monkeypox Clade 1 pathway has provided assurance regarding system readiness in the event of a suspected case.

Critical incidents and system patient safety

System risks and critical incidents have been regularly escalated and monitored through the System Quality Group (SQG). A system-level PSIRF policy and plan have supported alignment of provider approaches, strengthened oversight of physical and psychological harm, and improved thematic learning. The ICB continues to use the Learning from Patient Safety Events (LFPSE) platform to triangulate insights and identify system level areas for improvement.

Maternity and neonatal

The ICB has sustained robust oversight of maternity and neonatal services through monthly dashboards presented at the Maternity Safety Champions forum, Local Maternity and Neonatal Systems (LMNS) Programme Board/Perinatal Quality Surveillance Group (PNQSG), Maternity Transformation Assurance Committee (MNTAC) and Quality and Safety Assurance Committee (QSAC).

Progress against the Saving Babies' Lives Care Bundle is reviewed quarterly, alongside insights from safety investigations (Patient Safety Incident Investigations – PSII and Maternity and Newborn Safety Investigations – MNSI). Six-monthly quality insight visits contribute to assurance of safety and performance.

Children's services

Paediatric transformation work at the acute trust, long waiting lists in children's community services, and Special Educational Needs and Disabilities (SEND) related risks have remained priority areas. Harm reviews for children waiting for therapy and neurodiversity services have been monitored, with insight visits supporting triangulation of quality, safety and access concerns. Looked After Children (LAC) and SEND leads continue to provide assurance and escalations through Contract Review Monitoring and monthly governance forums.

Cancer

The ICB has worked with providers, Cancer Alliances and system partners to strengthen performance against cancer waiting time standards. Mitigations include expansion of diagnostic capacity, 'Super Saturdays', mutual aid, straight-to-test pathways, and targeted workforce optimisation. Performance dashboards and analytical oversight continue to support early identification of risks.

Referral to treatment targets and 52-week waits

Significant pressures remain in meeting referral to treatment (RTT) and 52-week wait standards. System actions during 2025/26 focused on validation, productivity and utilisation improvements, independent sector engagement and pathway redesign. Workforce optimisation continued to support service recovery. Performance is monitored through routine dashboards and provider contract meetings.

Quality Team

In 2025/26, the Quality Team further strengthened system oversight through:

- Enhanced triangulation of risks across urgent and emergency care, mental health, children and young people, maternity, ambulance and community services.
- Increased frequency and depth of insight visits, providing real-time assurance on quality and safety concerns.
- Continued implementation and oversight of PSIRF, including thematic learning, quality reviews of harm, and partnership working to embed safer systems.
- Strengthened safeguarding and SEND assurance processes across Shropshire, Telford and Wrekin and Staffordshire and Stoke-on-Trent – maintaining statutory coverage during organisational transition.
- Collaboration with providers on quality improvement planning, including recovery plans, pathway redesign and performance improvement.

Future goals – 2026/27

Looking ahead to 2026/27, we will continue strengthening our system-wide approach to quality, safety, performance oversight and governance. Key areas of focus include:

1. **Strengthening system quality oversight and harm reduction:** The ICB will further enhance triangulated oversight of quality and safety across providers, including deeper thematic analysis of harm review outputs, improved cross system learning, and proactive identification of early warning signals through the Learning from Patient Safety Events (LFPSE) platform. This work will build on system level PSIRF arrangements already in place.
2. **Accelerating improvement in UEC, mental health, CYP, and RTT pathways:** The organisation will continue to drive delivery of the UEC Improvement Plan, reduce ambulance handover delays, improve patient flow, and mitigate deterioration risks in high-pressure environments. In mental health and CYP services, future goals include reducing waiting times, improving productivity, increasing access to assessment pathways, and embedding the work of multiagency task and finish groups to address system-wide bottlenecks. RTT and cancer pathway improvements remain a system priority, supported by sustained focus on validation, capacity optimisation, and redesigned pathways.
3. **Strengthening maternity and neonatal safety assurance:** The ICB will continue to develop its maternity and neonatal assurance approach, including enhanced monitoring through the LMNS, MNTAC, and QSAC forums. Future goals include maturing the Saving Babies' Lives Care Bundle oversight, improving the quality of incident investigations (PSII/MNSI), and expanding insight visits to strengthen safety culture and responsiveness.
4. **Developing an integrated approach to safeguarding, SEND and LAC oversight:** Safeguarding and SEND oversight will continue to be strengthened through clearer system pathways, improved risk escalation, aligned governance, and consistent quality oversight during the cluster transition. Children in Care oversight will be enhanced through improved reporting, strengthened provider compliance with statutory pathways, and better system connectivity with social care partners.
5. **Improving IPC and outbreak management across the system:** The ICB will work with partners to reduce C.diff rates, enhance winter surge preparedness, and embed learning from outbreaks and infectious disease pathways, including continued refinement of monkeypox Clade 1 processes. A stronger data driven approach to IPC assurance will be developed, with greater emphasis on early identification of risk signals and system-wide responses.

6. **Enhancing digital and data quality resilience:** A key priority will be supporting providers through digital transitions – particularly incident management platforms such as the move between Ulysses and Datix – ensuring data integrity, safe migration, improved analytics capability, and a more consistent approach to system intelligence reporting across the cluster.
7. **Strengthening financial governance and system recovery:** The ICB will continue to deliver its multi-year financial recovery plan in partnership with NHS England and system providers. Future goals include increased integration of quality and performance insights into financial planning, advancing joint decision making on system transformation programmes, and maintaining a robust internal control environment.

Finance, governance and control

NHS Shropshire, Telford and Wrekin has an underlying financial deficit position, but the ICB has delivered year on year reductions in the underlying deficit. The ICB has also delivered a favourable variance against its annual plan for the last two financial years after deficit support funding. The 25/26 year-end financial position is reporting a surplus outturn and a favourable variance against the full year submitted plan. Longer term we have a developed medium term financial plan supporting ongoing financial recovery and a strategy which is supported by our overall system transformation programme. We have met the previous conditions of the undertakings with NHS England, and these are now lifted. We have a system finance strategy in place working with our partner NHS Trusts and NHS Foundation Trusts (system providers) to deliver the Recovery Plan that brings together NHS Shropshire, Telford and Wrekin, provider and additional system wide recovery initiatives.

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.

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

The Quality and Performance Committee oversees the systems and processes in place with regard to provider quality performance for NHS Shropshire, Telford and Wrekin.

The Strategic Commissioning and Transformation Committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable ICB finance plan that includes financial performance of NHS Shropshire, Telford and Wrekin as a corporate body. The System Finance Committee contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board in the development and delivery of a robust, viable and sustainable system financial plan.

The Audit Committee provides assurance that NHS Shropshire, Telford and Wrekin is acting effectively, efficiently, and economically and this includes receiving and reviewing all recommendations made by the internal auditors. The Accountable Officer has responsibility for reviewing the effectiveness of the system of internal control within NHS Shropshire, Telford and Wrekin.

Commissioning of delegated services (primary care services and specialised services)

NHS Shropshire, Telford and Wrekin ICB has signed a delegation agreement (DA) with NHS England and has held full commissioning responsibilities for delegated services during the 2025/26 reporting period. To the best of the ICB leadership's knowledge, all delegated services were commissioned in accordance with 2025/26 delegation agreements and national service specifications.

The ICB leadership can provide the necessary evidence of compliance with the delegation agreements, any associated developmental requirements and national service specifications, and show how effectively the delegated function is operating (either directly or via multi-ICB working arrangements) should NHS England or a third party (such as external auditors) ask for such evidence. Where there were known compliance issues, the organisation's leadership collectively with other ICBs, has engaged with NHS England's regional leadership to notify and address such issues in a timely manner.

The ICB leadership can provide the necessary evidence of core commissioning requirements compliance (see annex A in the assurance guidance document), should NHS England or a third party (such as external auditors) ask for such evidence.

Procurement Decisions Register

In the interests of transparency, the register of procurement decisions, like the register of interests, will be published on our Register of procurement decisions webpage and will be made available on request for inspection at the ICB's headquarters. The registers will also be reported to Audit Committee three times a year, reported twice yearly to the Board and included in our Annual Report.

Delegation of ICB functions

NHS Shropshire, Telford and Wrekin have a Scheme of Reservation and Delegation that sets out delegated areas of responsibility and authority and clearly defined limits that properly reflect roles and responsibilities.

It is underpinned by a comprehensive system of internal control, including budgetary control measures, and ensures that there are sufficient safeguards and management mechanisms in place to maintain high standards in terms of effective, efficient and economic operation of the group. The scheme captures the decision-making roles of the Accountable Officer, directors, Board and committees, and is linked to the terms of reference of each committee.

The Audit Committee maintains an oversight of delegated functions and responsibilities to ensure that resources are used efficiently and economically and that there are effective processes in place to guard against fraudulent usage.

The organisation, in accordance with its Constitution, reviews its Scheme of Reservation and Delegation annually. Amendments to the overarching Scheme of Reservation and Delegation are taken to the Board for approval. The organisation remains accountable for all its functions – including those that it has delegated.

Counter fraud arrangements

NHS Shropshire, Telford and Wrekin's counter fraud service in 2025/26 was provided by 360 Assurance who offer the service of an Accredited Local Counter Fraud Specialist (LCFS), contracted to undertake counter fraud work proportionate to the organisation's identified risks.

The Government's Functional Standard (Govs13: Counter Fraud) was launched in October 2018 and is being implemented across all government departments and arms-length bodies, including the NHS who moved to adopt the new standards in 2021. The Audit Committee receives a regular report from the LCFS which details activities undertaken against each of the Standards, and the LCFS produces an annual report detailing the year's activities. There is executive support and direction for a proportionate proactive work plan to raise awareness of the zero tolerance to fraud and to address identified risks.

The Chief Finance Officer, who is a member of the organisation's Governing Body, is proactively and demonstrably responsible for tackling fraud, bribery and corruption and oversees that appropriate action is taken regarding any NHS Counter Fraud Authority quality assurance recommendations. In addition, the LCFS role is further supported by a nominated Counter Fraud Champion who provides a senior voice within the organisation to champion the counter fraud agenda, and to enable and support the counter fraud programme of work.

Head of Internal Audit Opinion

Following completion of the planned audit work for the period 1 April 2025 to 31 March 2026, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of NHS Shropshire, Telford and Wrekin's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

As required by the Global Internal Audit Standards (GIAS) in the UK Public Sector, my opinion provides an overall conclusion on the framework of governance, risk management and control. In forming my opinion, I consider:

- outcomes from internal audit work (including a review of the Board Assurance Framework)
- implementation of internal audit actions
- third party/other assurances.

The work undertaken within the 2025/26 Internal Audit Plan is limited to the scope agreed with executive officers and approved by the Audit Committee, and as detailed within our final reports.

I am providing an opinion of Significant Assurance that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.

This opinion should be taken in its entirety for the Annual Governance Statement and any other purpose for which it is repeated.

Summary findings

Limitations to the opinion

It is management's responsibility to develop and maintain a sound system of governance, risk management and control. This opinion is based on the work undertaken at the time of issue, the scope of which has been agreed with management. Where good levels of control are concluded, there are still instances where this may fail, for example, poor judgement in decision-making, human error, control processes being deliberately circumvented, management overriding controls and the occurrence of unforeseeable circumstances As our scope of work is limited, there may be weaknesses in control systems that we are not aware of.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of a risk-based plan supported by a robust and organisation-led Assurance Framework, which is one component that the Board considers in making its Annual Governance Statement.

Outcomes from internal audit work

In line with the GIAS, your Internal Audit Plan was developed using a risk-based process aligning our work with your System Board Assurance Framework and strategic objectives. The planning process is designed to ensure that I discharge my statutory responsibility to provide a balanced Head of Internal Audit Opinion at the end of the financial year.

The 2025/26 Internal Audit Plan was shared with External Audit and Counter Fraud colleagues to ensure effective use of resources. The Internal Audit Plan was approved by the Audit Committee on 16th April 2025.

During the year, we have liaised with designated lead officers within the organisation to discuss delivery of the Internal Audit Plan and to ensure that the work agreed at the start of the financial year continues to be reflective of changes in your risks and assurance needs. As a result of this, changes to the plan have been approved by the Audit Committee in relation to the following reviews:

- The ICB requested a review of collaborative system working arrangements as part of the planning and development of the System Integrated Improvement Plan (SIIP). This work was required to fulfil an action on the SIIP. It was agreed that we would use audit days originally

allocated to the Patient Safety Integrated Response Framework (PSIRF) review in light of capacity pressures within the Quality team at that time.

- Following completion of the SIIP Collaborative review at the request of the ICB we were asked to complete a second review (SIIP2) with a focus on progress with delivery of the SIIP. The time for the ICB element of the work was taken from the planned audit of the Equality Duty.
- NHSE Grip and Control checklist was added to the HFMA checklist as a wider scope.

Progress in relation to the delivery of your Internal Audit Plan has been reported regularly to the Audit Committee.

In forming my opinion, I have considered the outcomes of assignments.

At the time of writing, no high-risk issues have been identified and formally reported from our 2025/26 work.

The assurance levels provided for all reviews undertaken is summarised below:

Level of assurance	Area of audit
Substantial assurance	• None to date
Significant assurance	• Cyber Governance • Freedom to Speak Up • HFMA Financial Sustainability checklist • NHS England's Grip and Control checklists • System Integrated Improvement Plan (SIIP) 1 • Financial systems* • Board assurance • SIIP Stage 2 • Project Management Office (PMO)
Moderate assurance	• None to date
Limited assurance	• None to date
Weak assurance	• None to date
Other	• DSPT (Substantial / High confidence – NHS England opinion level)

* Our Financial Systems work due to timing focuses on the ISFE1 period.

Third party/other assurances

The following third party/other assurances for the period 1st April 2025 to 31 March 2026 have been identified and considered in the year:

- Report on Internal Controls NHS CSU (TypeII) Payroll — no exceptions to report
- Report on Internal Controls NHS CSU (TypeII) Calculating Quality Reporting Service (CQRS) National – no exceptions to report
- Report on Internal Controls (TypeII) NHS Business Service Authority – Prescription Payments Process System – no exceptions to report.
- Report on Internal Controls (TypeII) Electronic Staff Record System – no exceptions to report

The 2025 NHS Staff Survey results for NHS Shropshire, Telford and Wrekin ICB indicate a better position than most ICBs, with the organisation performing above the ICB benchmarking group average in 8 out of 9 People Promise themes.

In line with national policy. The ICB utilises the national Integrated Single Financial Environment Ledger (ISFE) which was updated to a new version (version 1 to version 2) in October 2025. The standard year end ISAE3402 (International Standards Assurance Engagement) report from NHS

SBS on the system should cover both periods and versions. We anticipated receiving assurances on the transfer from ISFE1 to ISFE2 through a ISAE3402 report this is not available at the time of writing.

ICBs are no longer subject to formal segmentation during 2025/26, with oversight focused on delivery of national priorities, financial sustainability and leadership capability. We have been advised that the ICB have been removed from the Recovery Support Program.

Implementation of internal audit actions

As part of GIAS, I am required to consider the appropriateness of the organisation's response to internal audit recommendations and action subsequently agreed. We use our online action tracking system to provide a summary of open and closed actions in progress reports to each Audit Committee.

The table below shows the status of implementation of internal audit actions:

Implementation of internal audit actions	
High risks closed on time	0/0
Historic actions (pre-1 April 2025) outstanding	0
First follow up rate – high and medium risks	76% (22/29)
Overall implementation rate – high and medium risks	90% (26/29)

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of this review by:

- The board
- The audit committee
- If relevant, the risk / clinical governance / quality committee
- Internal audit
- Other explicit review/assurance mechanisms.

The role and conclusions of each were captured in the reports of the assurance committees to the Board.

Based on the work we have undertaken to date on the ICB's system of internal control, we do not consider that within these areas there are any issues that need to be flagged as significant control issues within the Annual Governance Statement (AGS).

The ICB may wish to consider whether any other issues have arisen as well as recognising the challenging environment within which we are operating, including the results of any external reviews, when determining whether anything should be highlighted within the AGS.

Conclusion

In line with the Head of Internal Audit Opinion, I can confirm that there is significant assurance that NHS Shropshire, Telford and Wrekin governance, risk management, and internal control are effective – with no major issues identified.

Simon Whitehouse
Accountable Officer
17th June 2026

Remuneration and Staff Report

Remuneration committee

The Remuneration Committee was established by NHS Shropshire, Telford and Wrekin ICB to recommend approval of the remuneration and terms of service for the Executive Directors, other staff employed with Very Senior Manager (VSM) pay terms and conditions and Non-Executive appointments to the Board.

The composition and responsibilities of the Remuneration Committee can be found in the Governance Statement.

Policy on the remuneration of senior managers

The remuneration of the Chief Executive Officer, Executive Directors, Chair and Non-Executive Directors who serve on the Board is determined by the Remuneration Committee, with reference to recognised national Integrated Care Board Executive Pay Ranges and Guidance and benchmarking with other ICBs.

The Remuneration Committee is also responsible for determining pay for all other non-Agenda-for-Change roles with reference to national guidance and benchmarking. NHS Midlands and Lancashire Commissioning Support Unit (MLCSU) provide independent advice and support to NHS Shropshire, Telford and Wrekin and the Remuneration Committee in relation to employment and remuneration matters.

Percentage change in remuneration of highest paid director

Percentage change in remuneration of highest paid director – year ended 31 March 2026

2025/26	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	10.13%	0.00%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	10.45%	0.00%

Percentage change in remuneration of highest paid director – year ended 31 March 2025

2024/25	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	5.33%	0.00%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	8.21%	0.00%

The increase in the highest paid director salary banding reflects a change in responsibilities following the appointment to Cluster Chief Executive Officer from 1st October 2025. The increase

in all staff reflects the annual pay award received for 2025/26, and the impacts of reduced headcount of lower banded roles following the internal Management of Change processes. No annual pay award for Very Senior Managers (VSM) was paid in 2025/26 due to the ICB being under the National Recovery Support Programme status at the time of the pay award. This was directed by national guidance. As at 31st March 2026, remuneration ranged from £24k to £219k based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff). 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.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component. The banded remuneration of the highest paid director / member in NHS Shropshire, Telford & Wrekin in the reporting period 1st April 2025 to 31st March 2026 was £215k to £220k. The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Pay ratio relationship to the remuneration of the organisation's workforce 2025/26

2025/26	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	33,487	50,273	62,682
Salary component of total remuneration (£)	33,487	50,273	62,682
Pay ratio information	6.5	4.3	3.5

Pay ratio relationship to the remuneration of the organisation's workforce 2024/25

2024/25	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	26,530	44,962	56,454
Salary component of total remuneration (£)	26,530	44,962	56,454
Pay ratio information	7.4	4.4	3.5

During the reporting period 2025/26, no employees received remuneration in excess of the highest-paid director/member (2024/25: nil). The movements in ratios from 2025/26 reflect the annual pay award (Agenda for Change) and for VSM no pay award was awarded due to the national recovery programme status as such any pay increase was based on a change to responsibilities. There are also the impacts of reduced headcount at lower banded roles following the internal Management of Change processes. Remuneration ranged from £24k to £219k (2024/25 £24k-£199k). 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

Agenda for change

The majority of our other employees are employed and paid in line with the NHS Terms and Conditions of Service (TCS) for Agenda for Change. A small number of clinical colleagues are remunerated by a locally agreed clinical pay scale and terms and conditions

Policy on the remuneration of senior managers

The remuneration of the Chief Executive Officer, Executive Directors, Chair and Non-Executive Directors who serve on the board is determined by the Remuneration Committee, with reference to recognised national Integrated Care Board Executive Pay Ranges and Guidance and benchmarking with other Integrated Care Boards. The Remuneration Committee is also responsible for determining pay for all other non-agenda for change roles with reference to national guidance and benchmarking. Midlands and Lancashire Commissioning Support Unit (MLCSU) provide independent advice and support to NHS Shropshire, Telford and Wrekin and the Remuneration Committee in relation to employment and remuneration matters.

Remuneration of very senior managers

Remuneration for Very Senior Managers at NHS Shropshire, Telford and Wrekin is agreed with reference to the national Integrated Care Board Pay Framework. Where full time salaries exceed the threshold appropriate approval is sought via NHS England and the Department of Health and Social Care.

Following the Cluster agreement between NHS Shropshire, Telford and Wrekin ICB and NHS Staffordshire and Stoke on Trent ICB a number of Executive Director roles are now shared across both organisations. The relevant entity for each Director remains as the employee and bears all associated remuneration costs. No recharge is made to the other ICB for these services.

Senior manager remuneration (including salary and pension entitlements)

Salary and pension benefits – 1 April 2025 to 31 March 2026 - Audited

Name	Title	Appointment dates	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100** £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a-e) (bands of £5,000) £000
David Bennett*	Associate Non Executive Director	01/04/25 to 31/03/26	10-15	-	-	-	-	10-15
Ian Bett	Interim Chief Delivery Officer (left 7th November 2025)	01/04/25 to 07/11/25	75-80	-	-	-	67.5-70	140-145
Ian Chan	Partner Member for Primary Care/Clinical Lead	01/04/25 to 31/03/26	65-70	-	-	-	-	65-70
Lorna Clarson	Chief Medical Officer (1st April 2025 to 30th November 2025); Chief Officer: Strategy & Improving Outcomes (1st December 2025 to 31st March 2026)	01/04/25 to 31/03/26	145-150	-	-	-	-	145-150
Roger Dunshea*	Non Executive Director, Acting Chair (until 30th June 2025)	01/04/25 to 31/03/26	25-30	-	-	-	-	25-30
Cheryl Etches*	Non Executive Director (appointed 2nd June 2025)	02/06/25 to 31/03/26	10-15	-	-	-	-	10-15
Rachel Gallyot ~	Interim Chief Medical Officer (1st December to 31st March 2026)	01/12/25 to 31/03/26	-	-	-	-	-	-
Ian Green*	Chair (appointed 1st July 2025)	01/07/25 to 31/03/26	45-50	-	-	-	-	45-50
Shokat Lal ~	Non Executive Director (1st December to 31st March 2026)	01/12/25 to 31/03/26	-	-	-	-	-	-

Mike Lawton ~	Executive Director (1st December to 31st March 2026)	01/12/25 to 31/03/26	-	-	-	-	-	-
Trevor McMillan*	Non Executive Director & Deputy Chair (from 1st May 2025)	01/04/25 to 31/03/26	10-15	-	-	-	-	10-15
Navnit Pall*	Non Executive Director (left 31st January 2026)	01/04/25 to 31/01/26	10-15	-	-	-	-	10-15
Deborah Shepherd*	Partner Member for Primary Care (left 30th November 2025)	01/04/25 to 30/11/25	10-15	-	-	-	-	10-15
Claire Skidmore #	Chief Finance Officer & Deputy Chief Executive Officer	01/04/25 to 31/03/26	175-180	-	-	-	37.5-40	215-220
Phil Smith ~	Chief Officer System Development and Integration (1st December 2025 to 31st March 2026)	01/12/25 to 31/03/26	-	-	-	-	-	-
Meredith Vivian*	Deputy Chair, Lay Member for Patient & Public Involvement (left 30th April 2025)	01/04/25 to 30/04/25	5-10	-	-	-	-	5-10
Vanessa Whatley	Chief Nursing Officer (1st April 2025 to 30th November 2025); Interim Chief Nursing Officer (1st December 2025 to 31st March 2026)	01/04/25 to 31/03/26	125-130	-	-	-	17.5-20	145-150
Simon Whitehouse $	Chief Executive Officer	01/04/25 to 31/03/26	215-220	-	-	-	25-27.5	240-245

*Note: Not in the NHS Pension Scheme in this employment.

Claire Skidmore was appointed as Chief Finance Officer & Deputy Chief Executive Officer for the Clustered organisation with effect from 1st December 2025 and 19th December 2025 respectively.

$ Simon Whitehouse was appointed as Chief Executive Officer for the Clustered organisation with effect from 1st October 2025.

~ The following Directors and Non Executive Directors are employed by NHS Staffordshire and Stoke on Trent ICB and following their appointment to the Clustered organisation from 1st December 2025 all associated remuneration costs remain with that ICB, and are fully disclosed within their Annual Report. No recharge is made to NHS Shropshire, Telford and Wrekin ICB.

- Rachel Gallyot – Interim Chief Medical Officer (Salary - £115-120k; Pension Related Benefits - £nil; Total - £115-120k)
- Phil Smith – Chief Officer System Development and Integration (Salary - £145-150k; Pension Related Benefits - £45-47.5k; Total - £195-200k)
- Shokat Lal – Non Executive Director (Salary - £15-20k; No pension related benefits)
- Mike Lawton – Non Executive Director (Salary - £15-20k; No pension related benefits)

Salary and pension benefits – 1 April 2024 to 31 March 2025 - Audited

Name and title	Appointment dates	(a) Salary (bands of £5,000) £000	(b) Expense payments (taxable) to nearest £100** £	(c) Performance pay and bonuses (bands of £5,000) £000	(d) Long term performance pay and bonuses (bands of £5,000) £000	(e) All pension-related benefits (bands of £2,500) £000	(f) TOTAL (a-e) (bands of £5,000) £000
David Bennett, Associate Non-Executive Director*	01/04/24 to 31/03/25	10-15	0	0	0	0	10-15
Ian Bett, Interim Chief Delivery Officer (appointed 12/08/24)	12/08/24 to 31/03/25	65-70	0	0	0	52.5-55	120-125
Ian Chan, Partner Member for Primary Care / Clinical Lead; Interim Chief Medical Officer – Jobshare (10/06/24-31/08/24)	01/04/24 to 31/03/25	65-70	0	0	0	0	65-70
Lorna Clarson, Chief Medical Officer (appointed 01/09/24)	01/09/24 to 31/03/25	90-95	0	0	0	97.5-100	185-190
Roger Dunshea, Non-Executive Director, Acting Chair (from 01/11/24)*	01/04/24 to 31/03/25	30-35	0	0	0	0	30-35
Ganesh Mahadeva, Interim Chief Medical Officer – Jobshare (10/06/24-31/08/24)	10/06/24 to 31/08/24	20-25	0	0	0	5-7.5	25-30
Neil McKay, Chair and GP/Healthcare Professional (left 31/10/24)*	01/04/24 to 31/10/24	35-40	0	0	0	0	35-40
Trevor McMillan, Non-Executive Director*	01/04/24 to 31/03/25	10-15	0	0	0	0	10-15
Navnit Pall, Non-Executive Director*	01/04/24 to 31/03/25	10-15	0	0	0	0	10-15
Julian Povey, Partner Member for Primary Care (left 30/06/24)*	01/04/24 to 30/06/24	0-5	0	0	0	0	0-5

Gareth Robinson, Chief Delivery Officer (left 01/09/24)	01/04/24 to 01/09/24	70-75	0	0	0	2.5-5	70-75
Deborah Shepherd, Partner Member for Primary Care (appointed 01/09/24)*	01/09/24 to 31/03/25	5-10	0	0	0	0	5-10
Claire Skidmore, Chief Finance Officer and Deputy Chief Executive Officer	01/04/24 to 31/03/25	175-180	0	0	0	22.5-25	200-205
Meredith Vivian, Deputy Chair, Lay Member for Patient and Public Involvement*	01/04/24 to 31/03/25	10-15	0	0	0	0	10-15
Vanessa Whatley, Chief Nursing Officer	01/04/24 to 31/03/25	125-130	0	0	0	135-137.5	265-270
Nicholas White, Chief Medical Officer (left 09/06/24)	01/04/24 to 03/06/24	25-30	0	0	0	0	25-30
Simon Whitehouse, Chief Executive Officer	01/04/24 to 31/03/25	195-200	0	0	0	25-27.5	220-225

*Note: Not in the NHS Pension Scheme in this employment.

Pension benefits

Please note that the cash equivalent transfer value was calculated by the NHS Pensions Agency.

Pension entitlements of senior managers – 1 April 2025 to 31 March 2026 - Audited

Name and title	Appointment dates	(a) Real increase in pension at pension age (bands of £2,500) £000	(b) Real increase in pension lump sum at pension age (bands of £2,500) £000	(c) Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £000	(d) Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000	(e) Cash Equivalent Transfer Value at 31 March 2025 £000	(f) Real Increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2025 £000	(h) Employers Contribution to partnership pension £000	(a) Real increase in pension at pension age (bands of £2,500) £000
Ian Bett	Interim Chief Delivery Officer (left 7th November 2025)	01/04/25 to 07/11/25	2.5-5	5-7.5	35-40	85-90	590	60	714	-
Lorna Clarson	Chief Medical Officer (1st April 2025 to 30th November 2025); Chief Officer: Strategy & Improving Outcomes	01/04/25 to 31/03/26	-	-	40-45	95-100	922	-	845	-

	(1st December 2025 to 31st March 2026)									
Rachel Gallyot ~	Interim Chief Medical Officer (1st December 2025 to 31st March 2026)	01/12/25 to 31/03/26	-	-	-	-	-	-	-	-
Claire Skidmore*	Chief Finance Officer & Deputy Chief Executive Officer	01/04/25 to 31/03/26	2.5-5	-	70-75	170-175	1,326	38	1,409	-
Phil Smith ~	Chief Officer System Development and Integration (1st December 2025 to 31st March 2026)	01/12/25 to 31/03/26	-	-	-	-	-	-	-	-
Vanessa Whatley	Chief Nursing Officer (1st April 2025 to 30th November 2025); Interim Chief Nursing Officer (1st December 2025 to 31st March 2026)	01/04/25 to 31/03/26	0-2.5	-	45-50	120-125	1,067	23	1,124	-

Simon Whitehouse*	Chief Executive Officer	01/04/25 to 31/03/26	2.5-5	-	80-85	195-200	1,722	34	1,811	-

Accrued pension benefits included in this table for any individual affected by the Public Service Pensions Remedy have been calculated based on their inclusion in the legacy scheme for the period between 1 April 2015 and 31 March 2022, following the McCloud judgment. The Public Service Pensions Remedy applies to individuals that were members, or eligible to be members, of a public service pension scheme on 31 March 2012 and were members of a public service pension scheme between 1 April 2015 and 31 March 2022. The basis for the calculation reflects the legal position that impacted members have been rolled back into the relevant legacy scheme for the remedy period and that this will apply unless the member actively exercises their entitlement on retirement to decide instead to receive benefits calculated under the terms of the Alpha scheme for the period from 1 April 2015 to 31 March 2022.

* Mrs Claire Skidmore and Mr Simon Whitehouse are affected by the public service pensions remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995 to 2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

Mr David Bennett is a non-voting member of the Board but is included within the Remuneration table disclosures due to his associate non-executive director position.

Partner members of the Board are not employed by NHS Shropshire, Telford and Wrekin or seconded from other organisations and are not required to be included in the Remuneration tables disclosure. They are substantively employed by their own organisations but sit on the System Board for System purposes. The relevant disclosures will be incorporated within their own respective employer organisation's annual report tables.

~ Directors employed by NHS Staffordshire and Stoke on Trent ICB and following their appointment to the Clustered organisation from 1st December 2025 all associated remuneration costs remain with that ICB, and are fully disclosed within their Annual Report. No recharge is made to NHS Shropshire, Telford and Wrekin ICB.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

NHS Shropshire, Telford and Wrekin does not have any to report during the year ended 31st March 2026.

Payments to past directors

In the year ended 31st March 2026 NHS Shropshire, Telford and Wrekin made no payments to a Director requiring special approval from Treasury.

Staff Report

Number of senior managers

Body copy goes here

Staff numbers and costs - Audited

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 2020/21 & 2021/22 NHS Clinal Commissioning Groups continued to pay over contributions at the former rate with the additional amount being paid by NHS England on Clinical Commissioning Groups behalf. This has continued for the organisation since 2022/23. The full cost and related funding has been recognised in these accounts and further detail explaining the reason for this increase can be found in Note 4.4.

Employee benefits of permanent and other employees

Employee benefits	Permanent employees £'000	Other £'000	Total £'000
Salaries and wages	£'000	£'000	£'000
Social security costs	12,777	858	13,635
Employer Contributions to NHS Pension scheme	1,791	-	1,791
Other pension costs	2,933	-	2,933
Apprenticeship Levy	-	-	-
Other post-employment benefits	55	-	55
Other employment benefits	-		-
Termination benefits	-		-
Gross employee benefits expenditure	8,077	-	8,077
	25,633	**858**	**26,491**

Staff composition

Staff Analysis by Gender (based on staffing at 31.03.2026)

	Headcount by Gender		
Staff Grouping	**Female**	**Male**	**Totals**
Board Member	7	7	14
Other Senior Management (Band 8C+)	24	16	40
All Other Employees	167	38	205
Grand Total	**198**	**61**	**259**

% by Gender	
Female	**Male**
50.0%	50.0%
60.0%	40.0%
81.5%	18.5%
76.45%	**23.55%**

Senior Staff Analysis by Band (based on staffing at 31.03.2026)

Pay Band	Headcount
Ad Hoc / Local	0
Apprentice	0
Band 1	0
Band 2	2
Band 3	24
Band 4	14
Band 5	13
Band 6	43
Band 7	42
Band 8 – Range A	43
Band 8 – Range B	24
Band 8 – Range C	14
Band 8 – Range D	4
Band 9	1
Medical	12
VSM	17

Board (off payroll)	6
Grand Total	**259**

Sickness absence data

Staff sickness absence 2025	2025-26 Number
Total Days Lost	3099.15
Total Staff Years	278.05
Average Working Days Lost	11.15

The sickness absence data for the ICB in 2025 was whole time equivalent (WTE) days available of 62560.8 and WTE days lost to sickness absence of 3099.15 and average working days lost per employee was 11.15 which was managed through the absence management policy.

Staff turnover percentages

ICB Staff Turnover 2025-26	2025-26 Number
Average FTE Employed 2025-26	262.15
Total FTE Leavers 2025-26	81.72
Turnover Rate	31.17%

The ICB Staff Turnover Rate for 2025-26 has been calculated by dividing the total FTE Leavers in-year by the average FTE Staff in Post during the year. The ICB's Total FTE Leavers in year was 81.72. The ICB's Average FTE Staff in Post during the year was 262.15. The ICB Staff Turnover Rate for the year was 31.17%

Staff engagement percentages

We participated in the NHS Staff Survey for first time in 2023 which a completion rate of 62%. In 2024, we had an increase of 12% in the response rate with a final completion score of 74%, this was further improved this year with a response rate of 76% in 2025.

Staff policies

All staff policies include statements regarding supporting and promoting the equality and diversity of our workforce. Our Recruitment and Selection policy and processes support the recruitment of disabled colleagues via using the 'two ticks' symbol and offering reasonable adjustments for all who may need it to enable them to participate in a selection process.

For colleagues that become disabled during their working life with the organisation, we have policies which support reasonable adjustments and redeployment to ensure they can remain at work and continue with their career progression.

Our trade union facility time reporting requirements

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
1	0.8

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	1
51%-99%	0
100%	0

Percentage of pay bill spent on facility time

Description	Figure
Total cost of facility time	£2,178.55.
Total pay bill	£25,060,289
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.009%

Paid trade union activities

Description	Figure
Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	10%

Health and safety

We contract a health and safety service from NHS Midlands and Lancashire Commissioning Support Unit, which includes health and safety audits of the ICB offices. Two audits were undertaken during 2025/26 – no high-level issues were identified, and any actions identified as part of the audits have been addressed throughout the year.

In addition to these audits, staff are required to undertake health and safety related mandatory training. This includes fire safety; health, safety and welfare; infection prevention and control; moving and handling; and display screen equipment. Compliance with mandatory training is monitored via the electronic staff record. There are also several policies in place to support health and safety within the workplace.

There was one minor health and safety-related incidents during 2025/26, however no injuries were reported and appropriate action was taken following the incident to prevent future reoccurrence.

Other employee matters

Like other ICBs across the country, we have responded to the national NHS Reset programme. Work has developed at pace to develop the ICB Cluster Operating Model and the leadership structure to ensure we are well positioned to discharge our statutory functions.

To support the required running cost reductions, a voluntary redundancy scheme has been opened for all ICB staff. In parallel, formal management change of programmes have been implemented to bring together teams from across the Cluster to form the new Clustered organisation.

This has been an unsettling period for staff, and all colleagues are working hard to ensure that our approach is compassionate, and we are offering support to colleagues to navigate this period. The change programme will continue into 2026/27. It is pleasing to note the continuation of largely improving Staff Survey results despite the challenging context within which they have been operating. Further details on the Staff Survey results are outlined below.

Across the system, agency usage had reduced from 4% to 1.8% of total workforce spend, with a focus on reducing our reliance on the bank workforce. Enhanced controls over bank spend have been introduced, supported by the launch of regional bank rates. In addition, the use of the NHS Professionals bank has been mobilised and delivered numerous successful recruitment campaigns to fill key substantive posts.

At the same time, the overall workforce headcount is now just 0.2% above plan compared with 5.2% above plan at the end of 2024/25. We have delivered on our commitment to reduce the non-clinical workforce to the national target, which will continue into 2026/27.

Key challenges for 2026/27 include maintaining the current trajectory on reducing bank reliance at the same time as expanding our Urgent Community Response service, eliminating all Band 2 and 3 agency workers, and working towards the national ambition for a sickness rate of 4.1%.

Our health and wellbeing

We aim to create a culture where we all feel heard and valued, and in which diversity is respected. We understand our health and wellbeing can be affected by all kinds of factors at work – workload, capacity, relationships with colleagues and the physical working environment can all have an impact. Likewise, factors outside work, including lack of sleep, financial worries, health conditions, caring responsibilities and other personal circumstances can have an impact – especially if they have changed recently.

A dedicated area of our staff intranet site is dedicated to health and wellbeing – including information around fitness and health, looking after wellbeing, menopause, men's health, mental health support at work, mental health first aid, finances, pensions and retirement, domestic abuse and weight management.

Our health and wellbeing offer is promoted regularly within staff newsletters and during staff huddles.

Whistleblowing

Our dedicated Freedom to Speak Up Policy includes whistleblowing. More information can be located within the Freedom to Speak Up section of this Annual Report.

Colleague engagement and involvement

We keep our colleagues engaged and informed through a range of activities, including:

- Team Brief – held fortnightly via MS Teams. If an urgent communication is needed, we will arrange a special Team Brief, or a staff message will be sent out.
- Bi-weekly Staff Bulletin – for sharing key messages about process, policy and system updates.
- CEO Message – a message directly from the Chief Executive Officer, Simon Whitehouse.
- People Forum – monthly meetings with staff representatives for the sharing of feedback and organisation updates.
- Staff Chat – an open chat forum on MS Teams for staff to post queries, news, updates events and training opportunities.
- Shro and Tel – our staff intranet site, where we host key updates and information, policies and procedures and opportunities.

Staff Engagement Group

The People Forum has played a central role in strengthening staff experience and organisational culture throughout the year, driving improvements across communication, health and wellbeing, organisational development, and policy engagement.

Members have actively gathered and escalated staff feedback, supported the rollout and refinement of HR policies, coordinated wellbeing initiatives such as health and wellbeing days and Active Advent, and contributed to shaping organisational change through discussions on values, behaviours, and leadership support. The Forum has also enhanced cross-ICB collaboration, including work on shared policies, lessons learnt processes, and access to development opportunities.

This collective effort reflects the Forum's commitment to ensuring staff voices inform decision making and that a supportive, inclusive working environment continues to evolve.

Employee voice

Staff Survey

The NHS Staff Survey ensures staff have a voice and feel they are being listened to. As a result of feedback from the surveys, we have implemented further initiatives in terms of staff support, engagement opportunities and development.

Despite the current challenges and changes, the 2025 NHS Staff Survey results show a steady increase in participation and continued improving results in six of the nine domains. There have been notable improvements in staff feeling safe to speak up about concerns, including feeling secure raising concerns about clinical practice.

Improvements in manager support and care, employees level of autonomy and control, being clear on their responsibilities, and feeling trusted, show strong commitment to compassionate and clear leadership, during this period. Results within the team working subset show improvement across the board, with a12% improvement in the area of having a set of shared objectives, and almost 10% in talking about team effectiveness, when compared to last year.

The insight and feedback gathered through the Staff Survey will be used to inform our organisational development plan for the year ahead, as well as enabling us to develop targeted employee support and engagement offers to expand support through the continuing transitional period. Staff will also have the opportunity through a range of engagement activities to shape the future vision and values

of the new Clustered organisation. Meanwhile, we are working to embed and bring to life the activities contained in the ICB Model Blueprint – focusing on developing understanding and expertise to effectively deliver our primary role as a strategic commissioner.

People Pulse

We continue to use a quarterly People Pulse Survey to provide a snapshot of how staff are feeling throughout the year, alongside our employee engagement group who meet regularly and provide real time feedback on topical issues. Any additional feedback from the quarterly surveys is built into the overall organisational development programme with the aim to provide continuous improvement.

Public Sector Equality Duty (PSED)

As part of our commitment to upholding the principles of the Equality Act 2010, we have embedded the Integrated Impact Assessment process within our service and policy development framework. This ensures that all decisions are made with due regard to eliminating discrimination, advancing equality of opportunity, and fostering good relations among diverse communities.

The Integrated Impact Assessment process systematically assesses the impact of policies, service changes, and functions on individuals with protected characteristics – age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, and sexual orientation. By identifying both positive and negative impacts, the assessment enables us to implement mitigating actions that address potential inequalities and ensure compliance with statutory obligations.

A key aspect of the assessment process is the focus on health inequalities, ensuring that services are designed to meet the needs of underrepresented and vulnerable groups. Engagement with affected populations, including socially-excluded communities and carers, is central to this approach – allowing for inclusive decision-making and the development of equitable healthcare services.

We also remain committed to making reasonable adjustments for individuals with disabilities and ensuring that access to services is not compromised. The Integrated Impact Assessment also plays a vital role in fostering good relations by promoting engagement, mutual understanding, and inclusion. The process considers the impact of policies on seldom-heard groups, rural communities, and those with mental health conditions – ensuring that services are accessible and responsive to diverse needs. Beyond equality considerations, the assessment evaluates broader factors such as environmental sustainability, workforce implications, and access to services. Travel and accessibility impacts are reviewed to ensure that any service reconfiguration does not disproportionately affect individuals with protected characteristics or those experiencing socio-economic deprivation.

Through the implementation of the Integrated Impact Assessment, we continue to demonstrate our legal and moral commitment to equality, diversity, and inclusion. By embedding these considerations within strategic planning, it ensures that services are fair, inclusive, and aligned with the principles set out in the NHS Constitution and the Health and Care Act 2022.

Our Integrated Impact Assessment template and policy can be found on our Equality, Diversity and Inclusion webpage. We also complete and publish the annual NHS England Equality Delivery System, equality objectives, and the ICB's gender pay gap. Evidence can be found on our Equality, Diversity and Inclusion webpage.

Integrated Impact Assessments (IIA's)

Integrated Impact Assessments (IIA's) are routinely used to assess the potential impact of new or revised services, pathways and commissioning approaches, and increasingly used at the start of a review and redesign piece of work to inform bespoke development needs that will mitigate known inequalities. These assessments help identify risks of exclusion, disadvantage or variation in access and experience, and ensure that mitigating actions, reasonable adjustments, and inclusive service models are built in at the earliest stage.

Workforce diversity profile and recruitment reporting

Shropshire, Telford and Wrekin ICB has a predominantly female, older, white workforce, with increasing but still limited representation of younger staff and disabled staff.

Diversity patterns vary across pay bands, with senior roles showing higher non-disclosure rates for several characteristics and stronger male representation.

Some protected characteristic groups are broadly in line with, or above, local population averages (e.g, ethnicity), while others (notably disability and younger age groups) show lower representation. Diversity patterns vary across pay bands, with senior roles showing higher non-disclosure rates for several characteristics and stronger male representation.

Gender Pay Gap

Gender	2025 average hourly rate	2025 median hourly rate
Male	£35.36	£27.49
Female	£25.83	£22.99
Difference	£9.52	£4.50
Pay gap %	26.93%	16.36%

Substantial changes are expected as the ICB Reform measures (including new cluster structures and Management of Change processes) are completed.

Therefore, any targeted actions based on this year's figures may also become quickly outdated as the new staffing structure is finalised. Once the new organisation design is fully embedded and workforce numbers stabilise, the ICB will be in a stronger position to undertake a more accurate analysis of the gender pay gap and implement actions that reflect the future workforce.

The ICB remains committed to transparency and to addressing gender-based inequalities and will continue to monitor developments closely throughout this period of transition.

ICB Equality, Diversity and Inclusion (EDI) objectives

Both Staffordshire and Stoke-on-Trent ICB and Shropshire, Telford and Wrekin ICB have proposed an EDI framework which will be supported by both workforce and patient/population focused equality. Objectives will focus on aligning policies, data practices, leadership responsibilities, and cultural expectations across the cluster ICBs to create a coherent and collaborative Equality, Diversity and Inclusion (EDI) and Public Sector Equality Duty (PSED) agenda. The intention is to build a shared framework that supports inclusive employment practices, improves workforce experience, and ensures that both ICBs continue to meet their statutory duties while adapting to the evolving reform landscape. This work will require sustained engagement, careful change management and a continued emphasis on staff wellbeing and communication throughout the transition.

Executive EDI objectives

Individual EDI objectives for our Executive team will be produced and aligned to their specific directorates, roles and responsibilities.

Member of the executive team	Objective
Chief Delivery Officer	Deliver a programme of improvement in relation to equality and diversity that benefits both staff and patients within the ICB and the system.
Chief Finance Officer	Demonstrate a clear commitment to advancing EDI by actively encouraging, promoting and supporting EDI activities and networks and ensuring an inclusive recruitment approach.
Chief Executive Officer	Demonstrate a clear commitment to advancing EDI.
Chief Strategy Officer	Ensure EDI is included within all appropriate ICB Strategy and plan documentation.
Chief Nursing Officer	Continue to deliver Board agreed strategic objectives for EDI with current priority on racism.
Chief Medical Officer	Demonstrate a clear commitment to advancing EDI.

Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

While ICBs are not mandated to produce standalone Workforce Race Equality Standard (WRES) or Workforce Disability Equality Standard (WDES) reports, they are encouraged to adopt and apply the principles of these standards within their workforce equality work. Shropshire, Telford and Wrekin ICB has reflected these principles within its Public Sector Equality Duty (PSE assessmentD) reporting for this cycle.

Shropshire, Telford and Wrekin ICB adopt WRES and WDES fully as a way of embedding equality considerations through its own longstanding workforce reporting practices. As governance, data processes and operating models across the cluster become more closely aligned, both ICBs aim to move toward a single, harmonised approach towards WRES and WDES. This unified model will strengthen diversity, transparency, comparability and shared learning, supporting improved equality outcomes across the cluster.

Equality and Health Inequalities Impact Assessments (EHIA)

See the Reducing health inequalities section of this report for details of our approach to Equality and Health Inequalities Impact Assessments.

ICB staff networks

During 2025/26, staff networks and support groups were active and provided a platform for staff to support, express, and voice a range of experiences. Information and feedback from these network groups progress through the governance process with the aim of influencing ICB policies, procedures, and day-to-day functions.

Our learning and development

We are committed to the ongoing training and development of our staff. This year, we have continued to monitor our compliance rates for statutory and mandatory training, sharing these with staff and encouraging them to complete their training. As a result, the rates have been maintained over the last 12 months.

A variety of training opportunities were introduced to staff to improve their skills, including specialised courses tailored for health and care professionals. These are delivered in diverse formats, including webinars, forums, Continuing Professional Development (CPD) sessions, and face-to-face events. At

a local level, there is regular access to specialised training such as Human Resources (HR) workshops, 'lunch and learn' sessions on a variety of topics, and – new for this year – pension workshops.

This offer has been extended with a programme of employee support – sessions focused on wellbeing, career transition and skills development to prepare employees for the ICB transition. All training and development opportunities are regularly communicated, and staff encouraged to participate. In 2026/27, we will build on our achievements and work across the new Cluster, as well as with the system to offer further opportunities for staff.

Our strong partnerships with further education providers locally support our commitment to delivering our duties beyond only our employed staff. A new cohort of 45 students enrolled for health T-levels in September 2025, across midwifery, Allied Health Professions and adult nursing pathways. Our Integrated Care System partners provide diverse and meaningful placements across health and care to support the T-level programme.

The Level 2 Adult Social Care Certificate is now available to social care providers with delivery integrated within the Health Care Support Workers programme. This is run through the Training Academy hosted by Telford College. A Level 1 award in Interpersonal Skills has also been embedded within the Health Care Support Worker Academy programme to further strengthen the induction and training programme for new to care staff.

We have continued to partner with our local authority colleagues to use existing capacity to enhance expertise in the delivery of Oliver McGowan learning disability training – broadening access for all system partners. The trajectory for the whole system to complete this training exceeds the 30% nationally indicated threshold. As a result, a small allocation of additional funding was secured which has enabled some free training places to supplement those purchased by providers.

Looking ahead, NHS Shropshire, Telford and Wrekin will be leading the system on the new national WorkWell health and skills programme. This targets people at risk of unemployment due to health-related conditions, and works with individuals and employers to remove health-related barriers to employment.

People, culture and inclusion

The ICB navigated a series of significant challenges during 2025/26 which have tested the resilience of our workforce and the system as a whole. These challenges are driven by demand for services remaining high – particularly across urgent and emergency care – with system flow and timely access continuing to require sustained focus and close collaboration with partners.

The ICS People, Culture and Inclusion Annual Report 2025/26 serves as a testament to the hard work and dedication of our exceptional people, and as a roadmap for the future of health and social care in Shropshire, Telford and Wrekin.

Looking ahead to 2026/27, we will focus on working together to achieve financial balance for the system, continue to prioritise our equality, diversity, and inclusion work, and support the health and wellbeing of our staff.

Working together, we look forward to driving this journey of transformation and collaboration, with a shared commitment to improving health outcomes, reducing inequalities, and building a workforce that is supported, empowered, and equipped to meet the challenges ahead.

Expenditure on consultancy

There was no consultancy expenditure incurred by NHS Shropshire, Telford and Wrekin in the year ended 31st March 2026. The small credit value reported relates to the release of prior year accrual where invoiced expenditure in 2024/25 was less than the accrued value.

Off payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, ICBs must publish information on their highly paid and/or senior off-payroll engagements. The tables below show the existing arrangements as of 31 March 2026. For all off-payroll engagements agreed in the year ended 31st March 2026, for more than £245* per day.

Length of all highly paid off-payroll engagements

Number of existing engagements as of 31 March 2026 Of which, the number that have existed:	Number
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

*The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant. NHS Shropshire, Telford and Wrekin can confirm that all existing off-payroll engagements have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax.

For all off-payroll engagements between 1st April 2025 to 31st March 2026, for more than £245(1) per day.

Table: Off-payroll workers engaged at any point during the financial year

For all off-payroll engagements between 1 April 2025 to 31 March 2026, for more than £245(1) per day:

Number of temporary off-payroll workers engaged between 1 April 2025 to 31 March 2026 Of which:	Number
Number not subject to off-payroll legislation (2)	0
Number subject to off-payroll legislation and determined as in-scope of IR35 (2)	0
Number subject to off-payroll legislation and determined as out of scope of IR35 (2)	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: Number of engagements that saw a change to IR35 status following review	0

Notes

1. The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
2. A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table: Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2025 to 31 March 2026:

Description	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during reporting period (1)	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 reporting period. This figure should include both on payroll and off-payroll engagements (2)	14

Notes

1. There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months.
2. As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero.

Exit packages

Exit packages agreed in the year ended 31 March 2026 - Audited

Exit package cost band (inc. any special payment element)	Number of compulsory redundancies Whole numbers	Cost of compulsory redundancies £s	Number of other departures agreed Whole numbers	Cost of other departures agreed £s	Total number of exit packages Whole numbers	Total cost of exit packages £s	Number of departures where special payments have been made Whole numbers	Cost of special payment element included in exit packages £s
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	18	102,604	8	52,297	**26**	**154,901**	-	-
£10,000 - £25,000	13	209,668	22	389,505	**35**	**599,173**	-	-
£25,001 - £50,000	9	326,516	11	355,957	**20**	**682,473**	-	-
£50,001 - £100,000	12	973,395	20	1,525,092	**32**	**2,498,487**	-	-
£100,001 - £150,000	5	716,055	13	1,679,074	**18**	**2,395,129**	-	-
£150,001 – £200,000	1	179,500	9	1,567,666	**10**	**1,747,166**	-	-
>£200,000	-	-	-	-	**-**	**-**	-	-
Totals	**58**	**2,507,738**	**83**	**5,569,591**	**141**	**8,077,329**	**-**	**-**

There are 141 agreed Exit packages in the financial year ended 31st March 2026. These arise following the Government Reset programme which was launched on 13th March 2025. There are a combination of voluntary and compulsory redundancies which have occurred or are scheduled to occur over the coming months. All Management of Change consultations have been launched – some have been completed whilst others remain in progress. There were two agreed Exit packages in the financial year ended 31st March 2025.

These tables report the number and value of exit packages agreed in the financial period. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Redundancy and other departure costs have been paid in accordance with the provisions of NHS England guidance. Exit costs in this note are accounted for in full in the year of departure. Where the NHS Shropshire, Telford & Wrekin has agreed early retirements, the additional costs are met by the NHS Shropshire, Telford & Wrekin and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Analysis of other departures

2025/26	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	83	5,569,591
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice*	-	-
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval**	-	-
Total	**83**	**5,569,591**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4 which will be the number of individuals. There were none to report in the year ended 31st March 2025.

*Any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation and relating to non-contractual payments in lieu of notice.

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

The Remuneration Report includes disclosure of exit packages payable to individuals named in that Report.

Parliamentary Accountability and Audit Report

Shropshire, Telford and Wrekin ICB is not required to produce a Parliamentary Accountability and Audit Report.

Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report.

Simon Whitehouse
Accountable Officer
17th June 2026

Annual Accounts

Please find a full copy of our annual accounts appended following this page.

Simon Whitehouse
Accountable Officer
17th June 2026

Acronyms

A&E – Accident and Emergency
ADHD – attention deficit hyperactivity disorder
AHC – annual health check
APMS – Alternative Provider Medical Services
ARFID – Avoidant/Restrictive Food Intake Disorder
ARMA – Arthritis and Musculoskeletal Alliance
BCF – Better Care Fund
BI – Business Intelligence
BMI – Body Mass Index
CAMHS – child and adolescent mental health services
C.diff – Clostridium difficile
CCRA – Climate Change Risk Assessment
CDC – Community Diagnostic Centre
CDOP – Child Deaths Overview Panel
CEO – Chief Executive Officer
CETV – cash equivalent transfer value
CFS – chronic fatigue syndrome
CPD – Continuous Professional Development
CP-IS – Child Protection Information Sharing
CQC – Care Quality Commission
CSE – Child Sexual Exploitation
CSPR – Child Safeguarding Practice Review
CUES – Community Urgent Eyecare Service
CVD – cardiovascular disease
CVRM – cardiovascular, renal and metabolism
CYP – children and young people
DA – delegation agreement
DES – Directed Enhanced Service
DFE – Department for Education
DHSC – Department of Health and Social Care
DSPT – Data Security and Protection Toolkit

ED – Emergency Department

EDI – Equality, Diversity and Inclusion

EeRS – Electronic Eyecare Referral System

EHIA – Equality and Health Inequalities Impact Assessment

EHRC – Equality and Human Rights Commission

ELSEC – Early Language Support for Every Child

EPRR – Emergency Preparedness, Resilience and Response

EQIA – Equality and Quality Impact Assessment

FFP – Families First Partnership

FGM – female genital mutilation

FPRR – Fit and Proper Person Regulation

FTSU – Freedom to Speak Up

GAM – Group Accounting Manual

GIAS – Global Internal Audit Standards

GIRFT – Getting It Right First Time

GP – General Practitioner

GPMS – General Practice Management Software

HAP – health action plan

HAWC – Health and Wellbeing Champion

HFMA – Healthcare Financial Management Association

HMP – His Majesty's Prison

HMT – His Majesty's Treasury

HR – Human Resources

HRT – hormone replacement therapy

HTP – Hospital Transformation Programme

ICB – Integrated Care Board

ICO – Information Commissioner's Office

ICP – Integrated Care Partnership

ICS – Integrated Care System

IG – Information Governance

IIA – Integrated Impact Assessment

IITCSE – Independent Inquiry into Telford Child Sexual Exploitation

IMD – Index of Multiple Deprivation

IQTP – Inpatient Quality Transformation Programme

JFP – Joint Forward Plan

JSNA – Joint Strategic Needs Assessment

LAC – Looked After Children

LCFS – Local Counter Fraud Specialist

LD – learning disabilities

LeDeR – Learning from Lives and Deaths of people with learning disabilities and autism

LFPSE – Learning from Patient Safety Events

LMNS – Local Maternity and Neonatal System

LRF – Local Resilience Forum

LTC – long-term condition

MARS – mutually-agreed resignation scheme

ME – myalgic encephalomyelitis

MH – mental health

MHLDA – Mental Health, Learning Disability and Autism

MHST – Mental Health Support Team

MLCSU – NHS Midlands and Lancashire Commissioning Support Unit

MNSI – Maternity and Newborn Safety Investigations

MNSIA – Maternity and Neonatal Senior Independent Advocate

MNTAC – Maternity and Neonatal Transformation Assurance Committee

MNVP – Maternity and Neonatal Voices Partnership

MPFT – Midlands Partnership University NHS Foundation Trust

ND – neurodiversity

NDPP – National Diabetes Prevention Programme

NHSE – NHS England

NICE – National Institute for Health and Care Excellence

NNHIP – National Neighbourhood Health Implementation Programme

NQB – National Quality Board

OD – Organisational Development

PALS – Patient Advice and Liaison Service

PCN – Primary Care Network

PCTMS – Primary Care Trust Medical Services

PHSO – Parliamentary and Health Service Ombudsman

PINS – Partnership for Inclusion of Neurodiversity in Schools

PNQSG – Perinatal Quality Surveillance Group

POD – Prescription Ordering Direct

PRH – Princess Royal Hospital

PSED – Public Sector Equality Duty

PSII – Patient Safety Incident Investigations

PSIRF – Patient Safety Incident Response Framework

QSAC – Quality and Safety Assurance Committee

RJAH – Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust

RTT – referral to treatment

SAAF – Safeguarding Accountability and Assurance Framework

SATH – Shrewsbury and Telford Hospital NHS Trust

SBAF – System Board Assurance Framework

SCAT – Safeguarding Commissioning Assurance Toolkit

SCHT – Shropshire Community Health NHS Trust

SEND – special educational needs and disabilities

ShIPP – Shropshire Integrated Place Partnership Committee

SIIP – System Finance Improvement Programme

SLT – Speech and Language Therapy

SOF – System Oversight Framework

SORR – Strategic Operational Risk Register

SQG – System Quality Group

SRO – Senior Responsible Officer

SSOT – Staffordshire and Stoke-on-Trent

STW – Shropshire, Telford and Wrekin

TC – Transformation Committee

TCFD – Taskforce on Climate-related Financial Disclosures

TTOR – Think Twice, Order Once

TWIPP – Telford and Wrekin Integrated Place Partnership Committee

UASC – unaccompanied asylum-seeking children

UEC – urgent and emergency care

VCSA - Voluntary and Community Sector Assembly

VCSE - Voluntary, Community, and Social Enterprise

VSM – Very Senior Manager

WM – West Midlands

WMAS – West Midlands Ambulance Service

WDES – Workforce Disability Equality Standard

WRES – Workforce Race Equality Standard

Contents

	Page Number
The Primary Statements:	
Statement of Comprehensive Net Expenditure for the year ended 31st March 2026	**2**
Statement of Financial Position as at 31st March 2026	**3**
Statement of Changes in Taxpayers' Equity for the year ended 31st March 2026	**4**
Statement of Cash Flows for the year ended 31st March 2026	**5**
Notes to the accounts:	
Accounting policies	**6-12**
Other operating revenue	**13**
Contract Revenue	**13**
Employee benefits and staff numbers	**14-16**
Operating expenses	**16**
Payment Compliance Reporting	**17**
Finance costs	**17**
Property, plant and equipment	**17**
Leases and Right of Use Assets	**18-19**
Trade and other receivables	**19-20**
Cash and cash equivalents	**20**
Trade and other payables	**21**
Provisions	**21**
Contingencies	**22**
Financial instruments	**22-23**
Operating segments	**24**
Joint arrangements - interests in joint operations	**25**
Related party transactions	**26**
Events after the end of the reporting period	**26**
Third party assets	**26**
Financial performance targets	**27**
Analysis of charitable reserves	**27**
Losses and special payments	**27**
Mental Health Expenditure	**27**

Statement of Comprehensive Net Expenditure for the year ended 31st March 2026

	Note	**Year ended 31st March 2026 £'000**	Year ended 31st March 2025 £'000
Income from sale of goods and services	2	(14,909)	(14,969)
Other operating income	2	(1,911)	(1,441)
Total operating income		**(16,820)**	(16,410)
Staff costs	4	26,491	18,730
Purchase of goods and services	5	1,550,539	1,443,813
Depreciation and impairment charges	5	115	115
Provision expense	5	(1,346)	(9)
Other operating expenditure	5	402	1,055
Total operating expenditure		**1,576,201**	1,463,704
Net Operating Expenditure		**1,559,381**	1,447,294
Finance expense	7	46	49
Total Net expenditure for the Year		**1,559,427**	1,447,343
Comprehensive Expenditure for the year		**1,559,427**	1,447,343

Statement of Financial Position as at 31st March 2026

	Note	**31st March 2026** £'000	31st March 2025 £'000
Non-current assets:			
Property, plant and equipment	8	-	-
Right-of-use assets	9	823	938
Total non-current assets		**823**	938
Current assets:			
Trade and other receivables	10	9,410	13,214
Cash and cash equivalents	11	480	660
Total current assets		**9,890**	13,874
Total assets		**10,713**	14,812
Current liabilities			
Trade and other payables	12	(84,574)	(81,129)
Lease liabilities	9.2	(111)	(107)
Provisions	13	(1,941)	(3,353)
Total current liabilities		**(86,626)**	(84,589)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(75,913)**	(69,777)
Non-current liabilities			
Lease liabilities	9.2	(814)	(926)
Total non-current liabilities		**(814)**	(926)
Assets less Liabilities		**(76,727)**	(70,703)
Financed by Taxpayers' Equity			
General fund		**(76,727)**	(70,703)
Total taxpayers' equity:		**(76,727)**	(70,703)

The notes on pages 6 to 27 form part of this statement

The financial statements on pages 2 to 27 were approved by the Board on 17th June 2026 and signed on its behalf by:

Chief Accountable Officer

Simon Whitehouse

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

	General fund £'000	**Total reserves £'000**
Changes in taxpayers' equity for Year ended 31st March 2026		
Balance at 1st April 2025	(70,703)	(70,703)
Changes in ICB taxpayers' equity for Year ended 31st March 2026		
Net expenditure for the financial year	(1,559,427)	**(1,559,425)**
Net Recognised ICB Expenditure for the Financial year	**(1,559,427)**	**(1,559,425)**
Net funding	1,553,403	**1,553,403**
Balance at 31st March 2026	**(76,727)**	**(76,727)**

	General fund £'000	Total reserves £'000
Changes in taxpayers' equity for Year ended 31st March 2025		
Balance at 1st April 2024	(75,476)	(75,476)
Changes in ICB taxpayers' equity for Year ended 31st March 2025		
Net expenditure for the financial year	(1,447,343)	(1,447,343)
Net Recognised ICB Expenditure for the Financial year	(1,447,343)	(1,447,343)
Net funding	1,452,116	1,452,116
Balance at 31st March 2025	(70,703)	(70,703)

The notes on pages 6 to 27 form part of this statement.

Statement of Cash Flows for the year ended 31st March 2026

	Note	**Year ended 31st March 2026 £'000**	Year ended 31st March 2025 £'000
Cash Flows from Operating Activities			
Net expenditure for the financial year		(1,559,427)	(1,447,343)
Depreciation and amortisation	5	115	115
Interest paid / received	7	46	49
Other Gains & Losses		-	-
Decrease/(Increase) in trade & other receivables	10	3,804	(172)
Increase/(Decrease) in trade & other payables	12	3,445	(4,591)
Provisions utilised	13	(66)	-
(Decrease)/Increase in provisions	13	(1,346)	57
Net Cash Outflow from Operating Activities		**(1,553,429)**	(1,451,885)
Cash Flows from Investing Activities			
Net Cash Inflow (Outflow) from Investing Activities		-	-
Net Cash Outflow before Financing		**(1,553,429)**	(1,451,885)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,553,403	1,452,116
Repayment of lease liabilities		(154)	(89)
Non-cash movements arising on application of new accounting standards		-	-
Net Cash Inflow from Financing Activities		**1,553,249**	1,452,027
Net (Decrease)/ Increase in Cash & Cash Equivalents	11	**(180)**	142
Cash & Cash Equivalents at the Beginning of the Financial Year		**660**	518
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**480**	660

The notes on pages 6 to 27 form part of this statement

1 Notes to the financial statements

1.0 Accounting Policies

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2025-26 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to ICBs, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the ICB for the purpose of giving a true and fair view has been selected. The particular policies adopted by the ICB are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis and expenditure is managed within total allocation of funds.

Public sector bodies are assumed to be a going concern where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future. The legal status of ICBs remains unchanged following the government reform announcement of 13th March 2025.

1.2 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.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of modified absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer under modified absorption accounting, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

The ICB has entered into a pooled budget arrangement with Telford and Wrekin Local Authority [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for Better Care Fund (BCF), and is jointly hosted by the Local Authority and the ICB.

The ICB has also entered into a pooled budget arrangement with Shropshire Council under a Section 75 partnership agreement. This was for the purpose of commissioning health and social care services under the Better Care Fund (BCF). The host Partner for the agreement is Shropshire Council.

The pooled budget arrangements, including the Better Care Fund, have all been assessed by the ICB against IFRS 11 to establish the classification and accounting treatment of the joint arrangements. The pooled budget arrangements require unanimous consent between partners over relevant decision making and therefore management consider this Joint Control. The parties have the power, exposure and rights to variable returns from their involvement and the ability to use their powers to effect the returns but not through the use of a separate vehicle. Management therefore consider the pooled budgets to be Joint Operations. Where the ICB is a Joint Operator it accounts for its share of assets, liabilities, income and expenditure in its own accounts in accordance with the pooled budget agreements. Note 17 to the accounts provides details of the income and expenditure for these arrangements.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the ICB.

1 Notes to the financial statements continued

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard, the ICB will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
- The ICB is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the ICB to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the ICBs is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the ICB accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave 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.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/nhs-pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the ICB commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 Other Expenses

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.

1 Notes to the financial statements continued

1.9 Leases

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The ICB assesses whether a contract is or contains a lease, at inception of the contract.

1.9.1 The ICB as Lessee

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 4.72% is applied for leases commencing, transitioning or being remeasured in the 2024 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1 Notes to the financial statements continued

1.10 Cash & 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 ICB's cash management.

1.11 Provisions

Provisions are recognised when the ICB has a present legal or constructive obligation as a result of a past event, it is probable that the ICB will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows: All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 3.64% (2024-25: 4.03%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
- A nominal medium-term rate of 4.22% (2024-25: 4.07%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
- A nominal long-term rate of 5.32% (2024-25: 4.81%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
- A nominal very long-term rate of 5.07% (2024-25: 4.55%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the ICB has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.12 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the ICB pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with ICB.

1.13 Non-clinical Risk Pooling

The ICB participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the ICB pays an annual contribution to the 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 as and when they become due.

1 Notes to the financial statements continued

1.14 Contingent liabilities and contingent assets

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the ICB. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

IFRS17 Insurance contracts has replaced IFRS4 Insurance contracts and is effective for accounting periods beginning on or after 1st April 2025. This does not apply to the ICB.

1.15 Financial Assets

Financial assets are recognised when the ICB becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.15.1 Financial Assets at Amortised cost

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.15.2 Financial assets at fair value through other comprehensive income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the ICB elected to measure an equity instrument in this category on initial recognition.

1.15.3 Financial assets at fair value through profit and loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive Net Expenditure.

1 Notes to the financial statements continued

1.15.4 Impairment

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the ICB recognises a loss allowance representing the expected credit losses on the financial asset.

The ICB adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The ICB therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the ICB does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

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 the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.16 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the ICB becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.16.1 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the ICB's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.16.2 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.17 Value Added Tax

Most of the activities of the ICB 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.

1.18 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the ICB has no beneficial interest in them.

1 Notes to the financial statements continued

1.19 Losses & 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, including losses which would have been made good through insurance cover had the ICB not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.20 Critical accounting judgements in applying accounting policies and key sources of estimation uncertainty

In the application of the ICB's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed and the only items worthy of note are disclosed below.

1.20.1 Sources of estimation uncertainty

There are considered to be no sources of estimation uncertainty that are likely to have a material effect on the amounts recognised in the ICB's accounts. Estimations have been made in respect of a number of accruals. Accruals for Prescribing have been calculated based on the best available information and on historic experience. Smaller accruals have been taken for the expected liability of goods or services that were received on or before 31st March 2026.

1.21 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.

1.22 New and revised IFRS Standards in issue but not yet effective

- IFRS 18 Presentation and Disclosure in Financial Statements - 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 impact of IFRS 18 on the Public Sector is still being 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 impact of IFRS 19 on the Public Sector is still being assessed.

2. Other Operating Revenue

	Year ended 31st March 2026 Total £'000	Year ended 31st March 2025 Total £'000
Income from sale of goods and services (contracts)		
Prescription fees and charges	5,540	5,461
Dental fees and charges	9,091	8,017
Other Contract income	278	1,491
Recoveries in respect of employee benefits	-	-
Total Income from sale of goods and services	**14,909**	14,969
Other operating income		
Other non contract revenue	1,911	1,441
Total Other operating income	**1,911**	1,441
Total Operating Income	**16,820**	16,410

3. Contract Revenue

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Year ended 31st March 2026			Year ended 31st March 2025		
	Prescription fees and charges £'000	**Dental fees and charges £'000**	**Other Contract income £'000**	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Source of Revenue						
NHS	-	-	159	-	-	215
Non NHS	5,540	9,091	119	5,461	8,017	1,276
Total	**5,540**	**9,091**	**278**	5,461	8,017	1,491

	Year ended 31st March 2026			Year ended 31st March 2025		
	Prescription fees and charges £'000	**Dental fees and charges £'000**	**Other Contract income £'000**	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000
Timing of Revenue						
Point in time	5,540	9,091	278	5,461	8,017	1,491
Total	**5,540**	**9,091**	**278**	5,461	8,017	1,491

3.2 Transaction price to remaining contract performance obligations

The ICB did not have any contract revenue in the years ended 31st March 2026 or 31st March 2025 expected to be recognised in future periods, related to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1. Employee benefits

Year ended 31st March 2026

	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	12,777	858	**13,635**
Social security costs	1,791	-	**1,791**
Employer Contributions to NHS Pension scheme	2,933	-	**2,933**
Apprenticeship Levy	55	-	**55**
Termination benefits	8,077	-	**8,077**
Gross employee benefits expenditure	**25,633**	**858**	**26,491**
Less recoveries in respect of employee benefits (note 4.1.1)	**-**	**-**	**-**
Total - Net admin employee benefits excluding capitalised costs	**25,633**	**858**	**26,491**

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. For 2019/20, 2020/21 & 2021/22 NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. This has continued for the ICB since 2022/23. The full cost and related funding has been recognised in these accounts and further detail explaining the reason for this increase can be found in Note 4.4

There are 141 Exit packages in the financial year ended 31st March 2026. These arise following the Government Reset programme which was launched on 13th March 2025. There are a combination of voluntary and compulsory redundancies which have occurred or are scheduled to occur over the coming months. All Management of Change consultations have been launched – some have been completed whilst others remain in progress.

Year ended 31st March 2025

	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	13,916	298	14,214
Social security costs	1,471	-	1,471
Employer Contributions to NHS Pension scheme	2,894	-	2,894
Apprenticeship Levy	54	-	54
Termination benefits	97	-	97
Gross employee benefits expenditure	18,432	298	18,730
Less recoveries in respect of employee benefits (note 4.1.1)	-	-	-
Total - Net admin employee benefits excluding capitalised costs	18,432	298	18,730

4.1.1 Recoveries in respect of employee benefits

There are no recoveries in respect of employee benefits in the year ended 31st March 2026 or for the year ended 31st March 2025.

4.2 Average number of people employed

	Year ended 31st March 2026			Year ended 31st March 2025		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**264.35**	**6.18**	**270.53**	**273.38**	**4.79**	**278.17**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4. Employee benefits and staff numbers continued

4.3 Exit packages agreed in the financial year

	Year ended 31st March 2026					
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	18	102,604	8	52,297	26	154,901
£10,001 to £25,000	13	209,668	22	389,505	35	599,173
£25,001 to £50,000	9	326,516	11	355,957	20	682,473
£50,001 to £100,000	12	973,395	20	1,525,092	32	2,498,487
£100,001 to £150,000	5	716,055	13	1,679,074	18	2,395,129
£150,001 to £200,000	1	179,500	9	1,567,666	10	1,747,166
Over £200,000	-	-	-	-	-	-
Total	**58**	**2,507,738**	**83**	**5,569,591**	**141**	**8,077,329**

	Year ended 31st March 2025					
	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
£50,001 to £100,000	1	66,666	-	-	1	66,666
£100,001 to £150,000	1	146,666	-	-	1	146,666
Total	2	213,332	-	-	1	213,332

All other agreed departures relate to voluntary redundancies.

45 non-contractual payments were made to individuals where the payment value was more than 12 months of their annual salary.

There have been no departures where special payments have been made in the financial year ended 31st March 2026 (Year ended 31st March 2025 - £nil).

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms & Conditions of Service Handbook. Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.4 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:

4.4.1 Accounting valuation

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

4. Employee benefits and staff numbers continued

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.

4.4.2 Full actuarial (funding) valuation

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

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

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

5. Operating expenses

	Year ended 31st March 2026	Year ended 31st March 2025
Purchase of goods and services	**£'000**	£'000
Services from other ICBs, CSUs and NHS England	3,894	4,518
Services from foundation trusts	266,348	229,100
Services from other NHS trusts	778,447	730,408
Purchase of healthcare from non-NHS bodies	204,104	188,504
General Dental services and personal dental services	35,451	33,596
Prescribing costs	103,582	100,320
Pharmaceutical services	18,746	16,163
General Ophthalmic services	12,214	13,809
GPMS/APMS and PCTMS	118,900	112,309
Supplies and services – clinical	2,116	2,456
Supplies and services – general	1,539	4,848
Consultancy services	(6)	1,603
Establishment	2,043	2,999
Transport	914	887
Premises	118	505
Audit fees	192	150
Other non statutory audit expenditure		
· Other services	-	40
Other professional fees	816	916
Legal fees	412	424
Education, training and conferences	709	258
Total Purchase of goods and services	**1,550,539**	1,443,813
Depreciation and impairment charges		
Depreciation	115	115
Total Depreciation and impairment charges	**115**	115
Provision expense		
Provisions	(1,346)	(9)
Total Provision expense	**(1,346)**	(9)
Other Operating Expenditure		
Chair and Non Executive Members	140	134
Grants to Other bodies	-	34
Expected credit loss on receivables	256	890
Other expenditure	6	(3)
Total Other Operating Expenditure	**402**	1,055
Total operating expenditure	**1,549,710**	1,444,974

5. Operating expenses continued

The above includes expenditure dealt with under pooled budget arrangements as set out in Note 17.

Specialised Commissioning services from NHSE was transferred to the ICB with effect from 1st April 2024 and all expenditure is included in the above note.

External Audit Fees are inclusive of VAT and include the following:

- Statutory audit fees for the year ended 31st March 2026 is £192k, including review of MHIS compliance.

The auditor's liability for external audit work carried out for the year ended 31st March 2026 is limited to £1million.

In the year ended 31st March 2025 the full year fee paid to external auditors disclosed within Other Services (review of MHIS compliance statement) was £38.2k incl VAT. The full year expense reported in the table above includes £2.1k relating to the prior year fee.

Internal audit and counter fraud services are provided by 360 Assurance who are part of an NHS Trust. The cost of these services was £99k (incl VAT) in the year ended 31st March 2026, and is included within other professional fees.

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	**Year ended 31st March 2026**	**Year ended 31st March 2026**	Year ended 31st March 2025	Year ended 31st March 2025
	Number	**£'000**	Number	£'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	37,986	378,367	41,421	349,522
Total Non-NHS Trade Invoices paid within target	37,588	371,095	41,258	339,989
Percentage of Non-NHS Trade invoices paid within target	**98.95%**	**98.08%**	99.61%	97.27%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,332	1,266,408	1,449	975,981
Total NHS Trade Invoices Paid within target	1,306	1,265,452	1,427	975,726
Percentage of NHS Trade Invoices paid within target	**98.05%**	**99.92%**	98.48%	99.97%

The Better Payment Practice Code requires the ICB to pay valid invoices by their due date or within 30 days of receipt of the invoices, whichever is the later.

7. Finance costs

	Year ended 31st March 2026 £'000	Year ended 31st March 2025 £'000
Interest		
Interest on lease liabilities	46	49
Total finance costs	**46**	49

8. Property, plant and equipment

The ICB holds no Property, plant and equipment assets.

9. Leases

9.1 Right-of-use assets

	Buildings excluding dwellings	Information technology	Total	Of which: leased from DHSC group bodies
	£'000	£'000	£'000	£000
Cost or valuation at 1st April 2025 and 31st March 2026	**965**	**106**	**1,071**	**-**
Depreciation 1st April 2025	110	23	133	-
Charged during the year	94	21	115	-
Depreciation at 31st March 2026	**204**	**44**	**248**	**-**
Net Book Value at 31st March 2026	**761**	**62**	**823**	**-**
NBV by counterparty				
Leased from Non-Departmental Public Bodies				**823**
Net Book Value at 31st March 2026				**823**

	Buildings excluding dwellings	Information technology	Total	Of which: leased from DHSC group bodies
	£'000	£'000	£'000	£000
Cost or valuation at 1st April 2024 and 31st March 2025	965	106	1,071	-
Depreciation 1st April 2024	16	2	18	-
Charged during the year	94	21	115	-
Depreciation at 31st March 2025	110	23	133	-
Net Book Value at 31st March 2025	855	83	938	-
NBV by counterparty				
Leased from Non-Departmental Public Bodies				938
Net Book Value at 31st March 2025				938

9.2 Lease liabilities

	31st March 2026	31st March 2025
	£'000	£'000
Lease liabilities at 1st April	(1,033)	(1,073)
Additions purchased	-	-
Interest expense relating to lease liabilities	(46)	(49)
Repayment of lease liabilities (including interest)	154	89
Derecognition for early terminations	-	-
Lease liabilities at 31st March	**(925)**	(1,033)
Current liabilities	**(111)**	(107)
Non-current liabilities	**(814)**	(926)
Lease liabilities at 31st March	**(925)**	(1,033)

9. Leases continued

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	31st March 2026	**Of which: leased from DHSC group bodies**	31st March 2025	Of which: leased from DHSC group bodies
	£'000	**£000**	£'000	£000
Within one year	(154)	-	(154)	-
Between one and five years	(562)	-	(585)	-
After five years	(393)	-	(520)	-
Balance at 31st March	**(1,109)**	**-**	(1,259)	-
Balance by counterparty				
Leased from Non-Departmental Public Bodies		(1,109)		(1,259)
Balance as at 31 March		**(1,109)**		(1,259)

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	Year ended 31st March 2026	Year ended 31st March 2025
	£'000	£'000
Depreciation expense on right-of-use assets	115	115
Interest expense on lease liabilities	46	49

9.5 Amounts recognised in Statement of Cash Flows

	Year ended 31st March 2026	Year ended 31st March 2025
	£'000	£'000
Total cash outflow on leases under IFRS 16	154	89

10. Trade and other receivables

	Current 31st March 2026	**Non-current 31st March 2026**	Current 31st March 2025	Non-current 31st March 2025
	£'000	**£'000**	£'000	£'000
NHS receivables: Revenue	732	-	429	-
NHS prepayments	14	-	36	-
NHS accrued income	1,171	-	3,402	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	2,166	-
Non-NHS and Other WGA receivables: Revenue	3,123	-	1,931	-
Non-NHS and Other WGA prepayments	3,776	-	1,303	-
Non-NHS and Other WGA accrued income	91	-	621	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	1,570	-	3,890	-
Expected credit loss allowance-receivables	(1,164)	-	(908)	-
VAT	97	-	343	-
Other receivables and accruals	-	-	1	-
Total Trade & other receivables	**9,410**	**-**	13,214	**-**
Total current and non current	**9,410**		13,214	
Included above:				
Prepaid pensions contributions	-		-	

10 Trade and other receivables continued

10.1 Receivables past their due date but not impaired

	31st March 2026 DHSC Group Bodies	**31st March 2026 Non DHSC Group Bodies**	31st March 2025 DHSC Group Bodies	31st March 2025 Non DHSC Group Bodies
	£'000	**£'000**	£'000	£'000
By up to three months	171	374	17	7
By three to six months	-	(16)	(49)	1
By more than six months	-	(7)	-	1
Total	**171**	**351**	32	9

10.2 Loss allowance on asset classes

	31st March 2026		
	Trade and other receivables - Non DHSC Group Bodies	**Other financial assets**	**Total**
	£'000	**£'000**	**£'000**
Balance at 1st April 2025	**(908)**	**-**	**(908)**
Lifetime expected credit loss on credit impaired financial assets	**-**	**-**	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	**(187)**	**-**	**(187)**
Lifetime expected credit losses on trade and other receivables-Stage 3	**(69)**	**-**	**(69)**
Amounts written off	**-**	**-**	**-**
Other changes	**-**	**-**	**-**
Total	**(1,164)**	**-**	**(1,164)**

	31st March 2025		
	Trade and other receivables - Non DHSC Group Bodies	Other financial assets	Total
	£'000	£'000	£'000
Balance at 1st April 2024	(18)	-	(18)
Lifetime expected credit loss on credit impaired financial assets	-	-	-
Lifetime expected credit losses on trade and other receivables-Stage 2	(748)	-	(748)
Lifetime expected credit losses on trade and other receivables-Stage 3	(142)	-	(142)
Amounts written off	-	-	-
Other changes	-	-	-
Total	(908)	-	(908)

11. Cash and cash equivalents

	31st March 2026	31st March 2025
	£'000	£'000
Balance at 1st April	660	518
Net change in year	(180)	142
Balance at 31st March	**480**	660
Made up of:		
Cash with the Government Banking Service	480	660
Cash and cash equivalents as in statement of financial position	**480**	660
Balance at 31st March	**480**	660
Patients' money held by the integrated care board, not included above	**-**	-

The ICB does not hold any significant cash and cash equivalent balances that are not available for use by the organisation.

12. Trade and other payables

	Current 31st March 2026 £'000	**Non-current 31st March 2026 £'000**	Current 31st March 2025 £'000	Non-current 31st March 2025 £'000
NHS payables: Revenue	1,263	-	3,560	-
NHS accruals	18,601	-	314	-
Non-NHS and Other WGA payables: Revenue	9,901	-	23,295	-
Non-NHS and Other WGA accruals	32,669	-	39,210	-
Non-NHS and Other WGA deferred income	3	-	-	-
Social security costs	199	-	197	-
Tax	193	-	250	-
Other payables and accruals	21,745	-	14,303	-
Total Trade & Other Payables	**84,574**	**-**	81,129	**-**
Total current and non-current	**84,574**		81,129	

Other payables include £1,049k outstanding pension contributions at 31st March 2026 (£988k at 31st March 2025).

13. Provisions

	Current 31st March 2026 £'000	**Non-current 31st March 2026 £'000**	Current 31st March 2025 £'000	Non-current 31st March 2025 £'000
Redundancy	**-**	**-**	66	**-**
Legal claims	**280**	**-**	274	**-**
Continuing care	**1,661**	**-**	3,013	**-**
Total	**1,941**	**-**	3,353	**-**
Total current and non-current	**1,941**		3,353	

	Redundancy £'000	**Legal Claims £'000**	**Continuing Care £'000**	**Total £'000**
Balance at 1st April 2025	66	274	3,013	**3,353**
Arising during the year	-	223	1,406	**1,629**
Utilised during the year	(66)	-	-	**(66)**
Reversed unused	-	(217)	(2,758)	**(2,975)**
Balance at 31st March 2026	**-**	**280**	**1,661**	**1,941**
Expected timing of cash flows:				
Within one year	-	280	1,661	**1,941**
Balance at 31st March 2026	**-**	**280**	**1,661**	**1,941**

The redundancy provision relates to one member of staff which was settled in May 2025 following the Management of Change process completed during the year ended 31st March 2025.

The legal claims provision relates to ongoing legal cases outstanding at 31st March 2026, with the estimated costs to conclusion provided by the ICB's legal advisors. The ICB has no claims currently lodged with NHS Resolution.

A continuing care provision has been created which reflects the estimated cost of continuing care appeals currently awaiting processing. The provision is based on the number of appeals outstanding at the 31st March 2026 and these are expected to be processed within the new financial year.

14. Contingencies

The ICB has no confirmed contingent assets and one contingent liability to disclose.

The contingent liability is in relation to a clinical negligence claim and the ICB liability would be £5k.

15. Financial instruments

15.1 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 the NHS integrated care board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS integrated care board 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 NHS integrated care board in undertaking its activities.
Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS integrated care board standing financial instructions and policies agreed by the Board. Treasury activity is subject to review by the NHS integrated care board and internal auditors.

15.1.1 Currency risk

The NHS integrated care board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS integrated care board has no overseas operations and therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk

The NHS integrated care board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 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 NHS integrated care board therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the NHS integrated care board revenue comes parliamentary funding, the organisation has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

15.1.4 Liquidity risk

The NHS integrated care board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS integrated care board draws down cash to cover expenditure, as the need arises. The NHS integrated care board is not, therefore, exposed to significant liquidity risks.

15.1.5 Financial Instruments

As the cash requirements of NHS integrated care board's are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS integrated care board's expected purchase and usage requirements and NHS integrated care board's are therefore exposed to little credit, liquidity or market risk.

15. Financial instruments continued

15.2 Financial assets

	31st March 2026			31st March 2025		
	Financial Assets measured at amortised cost	**Equity Instruments designated at FVOCI**	**Total**	Financial Assets measured at amortised cost	Equity Instruments designated at FVOCI	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Trade and other receivables with NHSE bodies	1,213	-	1,213	918	-	918
Trade and other receivables with other DHSC group bodies	690	-	690	5,080	-	5,080
Trade and other receivables with external bodies	4,784	-	4,784	6,443	-	6,443
Cash and cash equivalents	480	-	480	660	-	660
Total	**7,167**	**-**	**7,167**	13,101	-	13,101

15.3 Financial liabilities

	31st March 2026			31st March 2025		
	Financial Liabilities measured at amortised cost	**Other**	**Total**	Financial Liabilities measured at amortised cost	Other	Total
	£'000	**£'000**	**£'000**	£'000	£'000	£'000
Trade and other payables with NHSE bodies	1,688	**-**	**1,688**	1,056	-	1,056
Trade and other payables with other DHSC group bodies	18,176	**-**	**18,176**	2,879	-	2,879
Trade and other payables with external bodies	64,315	**-**	**64,315**	76,747	-	76,747
Lease liabilities	925	-	**925**	1,033	-	1,033
Total	**85,104**	**-**	**85,104**	81,715	-	81,715

16. Operating Segments

As stated in IFRS8, the "Chief Operating Decision Maker" is responsible for allocating resources to and assessing the performance of the operating segments of an entity. At Shropshire, Telford and Wrekin ICB this function is performed by the Board. The ICB considers it has a single operating segment; commissioning of healthcare services. Hence finance and performance information is reported to the Board as one segment. These Statements are produced in accordance with this position.

The values relating to this operating segment can be found in the SoCNE (page 2), and SoFP (page 3), and are summarised in the table below:

Year ended 31st March 2026	**Gross expenditure**	**Income**	**Net expenditure**	**Total assets**	**Total liabilities**	**Net assets**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Shropshire, Telford & Wrekin ICB	1,576,086	(16,820)	1,559,266	10,713	(87,440)	(76,727)
Total	**1,576,086**	**(16,820)**	**1,559,266**	**10,713**	**(87,440)**	**(76,727)**

Year ended 31st March 2025	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
Shropshire, Telford & Wrekin ICB	1,463,589	(16,410)	1,447,179	14,812	(85,515)	(70,703)
Total	1,463,589	(16,410)	1,447,179	14,812	(85,515)	(70,703)

16.1 Reconciliation between Operating Segments and SoCNE

	Year ended 31st March 2026	Year ended 31st March 2025
	£'000	£'000
Total net expenditure reported for operating segments	**1,559,266**	1,447,179
Reconciling items:		
Depreciation & Amortisation	115	115
Finance cost - IFRS16	46	49
Loss on Disposal of RoU Assets	-	-
Total net expenditure per the Statement of Comprehensive Net Expenditure	**1,559,427**	1,447,343

17. Joint arrangements - interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY Year ended 31st March 2026 Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin ICB and Shropshire LA	Commissioning of health and social care services under better care fund	-	-	-	**30,581**
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin ICB and Telford & Wrekin LA	Better care fund promoting integrated working	-	-	-	**19,938**
Integrated Community Equipment Loan Service	Shropshire, Telford & Wrekin ICB, Shropshire LA and Telford & Wrekin LA	Commission, support and fund the provision of an Integrated Community Equipment Loan Service whilst Improving the quality, cost effectiveness and efficiency of the service	-	-	-	**4,668**

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY Year ended 31st March 2025 Assets £'000	Liabilities £'000	Income £'000	Expenditure £'000
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin ICB and Shropshire LA	Commissioning of health and social care services under better care fund	-	-	-	27,465
Better care fund S75 pooled budget	Shropshire, Telford & Wrekin ICB and Telford & Wrekin LA	Better care fund promoting integrated working	-	-	-	18,698
Integrated Community Equipment Loan Service	Shropshire, Telford & Wrekin ICB, Shropshire LA and Telford & Wrekin LA	Commission, support and fund the provision of an Integrated Community Equipment Loan Service whilst Improving the quality, cost effectiveness and efficiency of the service	-	-	-	4,276

17.1 Pooled budgets under the Better Care Fund

The ICB's contribution of the total value of these pooled budgets in the period ended 31st March 2026 was £51m. The partners determine the nature of the programmes of work making up the Fund and in particular whether joint control is in operation for each programme for the purposes of IFRS 11.

A summary of the schemes with each local authority is given below:

Shropshire Local Authority	**Year ended 31st March 2026 £'000**	Year ended 31st March 2025 £'000
Assistive Technologies	4,350	2,243
Care navigation/Co-ordination	2,460	2,212
Enablers for Integration	5,151	5,138
Integrated Care Planning	1,744	4,313
Intermediate Care Services	3,785	3,965
Personalised Healthcare at Home	-	322
L A Schemes	13,091	9,272
Total	**30,581**	27,465

Telford & Wrekin Local Authority	**Year ended 31st March 2026 £'000**	Year ended 31st March 2025 £'000
Intermediate Care	11,356	10,810
Community Resilience	1,929	385
Other Care	4,847	1,840
Neighbourhood Care	1,806	5,663
Total	**19,938**	18,698

18. Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
Ian Chan GP - Partner: Teldoc	7,646	-	56	-
Ian Chan - Clinical Director: Teldoc PCN	2,548	-	-	-
Simon Whitehouse Spouse - Senior Staff Nurse: University Hospital of North Midlands	31,977	-	-	-

The Department of Health and Social Care is regarded as a related party. During the period the ICB has had material transactions with entities for which the Department is regarded as the parent Department. These include:

NHS Business Services Authority
NHS England
NHS Midlands & Lancashire CSU
NHS Property Services Limited
Midlands Partnership University NHS Foundation Trust
Shrewsbury & Telford Hospitals NHS Trust
Shropshire Community Health NHS Trust
The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
University Hospital of North Midlands NHS Trust
West Midlands Ambulance Service NHS Trust

In addition, the ICB has had a number of transactions with other government departments and other central and local government bodies. The majority of these transactions have been with Shropshire Council, Telford & Wrekin Council and Welsh Government Bodies.

Payments were also made to GP practices in the period to 31st March 2026 in respect of GMS/PMS/APMS and enhanced services. One general practitioner within these practices is also a member of the ICB's Board at 31st March 2026.

19. Events after the end of the reporting period

There are no events after the end of the reporting period to report which would impact the financial statements.

20. Third party assets

The ICB does not hold any third party assets.

21. Financial performance targets

The ICB has a number of financial duties under the NHS Act 2006 (as amended).

The ICB performance against those duties was as follows:

	Year ended 31st March 2026		Year ended 31st March 2025	
	Target	**Performance**	Target	Performance
	£'000	**£'000**	£'000	£'000
Expenditure not to exceed income	1,576,310	1,576,247	1,463,753	1,463,753
Revenue resource use does not exceed the amount specified in Directions	1,559,490	1,559,427	1,447,343	1,447,343
Revenue administration resource use does not exceed the amount specified in Directions	14,865	14,865	9,452	9,429

22. Analysis of charitable reserves

The ICB does not hold any charitable reserves.

23. Losses and special payments

The ICB did not incur any losses or special payments in the year ended 31st March 2026, or the prior year ended 31st March 2025.

24. Mental Health Expenditure

Core Mental Health Expenditure	**Year ended 31st March 2026**	Year ended 31st March 2025
	£'000	£'000
Minimum expenditure in mental health services to meet the Mental Health Investment Standard as notified by NHS England	**104,445**	92,053
Eligible mental health expenditure	**106,037**	92,065
Mental health expenditure above/(below) minimum investment required	**1,592**	12
Mental health expenditure as a proportion of total expenditure	**9%**	9%

Mental health expenditure for 2025/26 was £106,037k, representing 9% of the ICB's total expenditure. This expenditure comprises commissioning spend that meets the Mental Health Investment Standard (MHIS) criteria and includes investment in a range of mental health services for adults, older adults, children and young people, and other eligible mental health services commissioned by the ICB.

The proportion of expenditure reflects the ICB's commissioning responsibilities and investment in mental health services to support the delivery of local population health needs and national mental health priorities.

In previous years compliance with the Mental Health Investment Standard has been the subject of a separate audit and issue of a compliance certificate. From 2025/26 this requirement will be completed as part of the year end audit process and values disclosed within the annual financial statements.