NHS
The Shrewsbury and Telford Hospital
NHS Trust

Quality Account
2024/25

Partnering Ambitious Caring Trusted

Our Vision: To provide excellent care for the communities we serve

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SECTION 1: INTRODUCTION

1.0 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OFFICER

I am pleased to present the Quality Account for 2024/25 which identifies the progress made by the Shrewsbury and Telford Hospital NHS Trust over the last year to provide high-quality care for all patients accessing our services. The document showcases our achievements and acknowledges areas for further improvement. The past year has presented considerable challenges, including increased demand on our emergency services characterised by ambulance handover delays and extended waiting times. Our ongoing efforts to improve elective services and reduce patient wait times were further affected by industrial action during the initial part of 2024/25. Throughout these challenges, our staff have demonstrated exceptional dedication, working to enhance both our emergency care and elective care services to ensure that patients receive timely, high-quality care that they rightfully expect and deserve. We have achieved significant improvements in various aspects of patient care, which is a source of pride and celebration. I would like to highlight a few of these accomplishments in my summary.

- The Trust CQC Inspection report was published in May 2024. End of Life Care and Children and Young People services moved from an overall rating of 'inadequate' to 'good' and Maternity services moved from 'requires improvement' to an overall rating of 'good'. Overall, for the Trust, moved from a previous rating of 'inadequate' to 'requires improvement'. However, we acknowledge that additional efforts are required to maintain consistent quality of care across all our services.
- The Trust has sustained positive scores in our Inpatient Friends and Family Test (FFT) with an average satisfaction rate of 98.5% over the last three years. Outpatient satisfaction rates have remained consistently between 98.5 and 98.7% over the last three years. This demonstrates a consistent level of achievement and assurance.
- Improvements have been made in the handover of ambulances arriving at the Emergency Departments in Quarter 3 and 4 of 2024/25 compared to the same time the previous year.
- Improvements in the number of patients receiving an initial assessment (triaged) within 15 minutes of arrival to the Emergency Departments including for paediatric patients
- Improvements in the completion of sepsis screening for our paediatric patients following the implementation of the electronic sepsis screening tool

While acknowledging these accomplishments, we are aware that there is still significant work ahead. In the upcoming year, we will persist in our quality improvement efforts through our "Moving to Excellence" programme. We will continue collaborating with our patients and their families to deliver high-quality, safe, and patient-centred care to everyone within the Trust. We are committed to continually improving what we do to ensure that our patients receive the very best care possible, and our staff take pride in the care we provide. SaTH relies on the support of our people and partners to keep its hospitals running.

Thank you to our dedicated staff who go above and beyond each day to provide care to our patients.

Jo Williams
Chief Executive Officer

SECTION 2: PRIORITIES FOR IMPROVEMENT AND STATEMENT OF ASSURANCE

This section outlines the detail behind each of the quality priorities previously agreed for 2024/25 and provides a summary of our performance and achievements in relation to these priorities throughout the year.

It also provides a statement of assurance from the Board and a review of the Shrewsbury and Telford Hospital NHS Trust (SaTH) performance for core quality indicators. A summary of the priorities identified for 2025/26 are outlined, why we have chosen these and the actions we will take to achieve these throughout 2025/26.

2.1 REVIEW OF THE PRIORITIES FOR IMPROVEMENT 2024/2025

As part of the "Getting to Good" Programme the Trust developed a Quality Strategy. The Strategy for 2021-2024 was agreed by the Trust Board in March 2021. The Quality Strategy consisted of 3 core domains: ***Safe, Effective and Patient Experience.*** The priorities within the Quality Account for 2024/25 included nine key overarching priorities within these three core domains of the Quality Strategy:

QUALITY PRIORITIES		
SAFE	Priority 1	PSIRF Priorities
		Learning from events and developing a safety culture
		The deteriorating patient
		Inpatient falls
		Missed radiology result
		Omitted doses of time critical medication
	Priority 2	Improve cognition screening/delirium
EFFECTIVE	Priority 3	Improved patient experience in our Emergency Departments
	Priority 4	Improve our admission and discharge processes, right care, right place, right time
	Priority 5	Address and improve care for people with Diabetes (System working)
	Priority 6	Improve foot care for people with Diabetes
PATIENT EXPERIENCE	Priority 7	Learning from experience
	Priority 8	Improve Quality Standards and demonstrate NICE guidance for Mental health training
	Priority 9	Improve the care and experience for patients with Learning Disability and/or autism

The priority actions for 2024/25 and our achievements against these are shown below.

PRIORITY 1: Patient Safety Incident Response Framework (PSIRF) Priorities

What we said we would do

The PSIRF priorities were agreed to be delivered over a 2-year period. In 2024/25 work has been undertaken to progress these priorities and provide the foundation for ongoing improvement work in 2025/26 with an ongoing focus on the outcomes this improvement work has in relation to safer, high quality patient care.

1. Integrate learning from both positive and negative incidents
2. Work to identify, escalate and timely intervention of deteriorating adults and children
3. Reduce the number of inpatient falls and the level of harm
4. Understand and reduce the number of omitted doses of time critical medication
5. Improve reporting and missed radiology results

What we have achieved

1. Integrate learning from positive and negative incidents

During 2024/25 we have undertaken the following work to learn and improve from patient safety incidents:

- We have embedded the Patient Safety Incident Response Framework (PSIRF) during 2024/25. PSIRF focus is on four key aims: Compassionate Engagement with those affected by patient safety incidents, application of a systems-based approach to learning from patient safety incidents, a considered and proportionate response to patient safety incidents and a supportive oversight focused on strengthening response systems.
- Work has continued to embed a forward-thinking patient safety culture across the organisation which is focused on systems learning and genuine quality improvement.
- We have continued to embed principles from human factors and ergonomics into how we learn from incidents and have used these same techniques to understand areas of high risk to our patients and proactively redesign systems to improve safety.
- We have embraced new ways of sharing learning across teams more effectively, using this learning to improve the way we deliver care and make our care safer. Using safety intelligence, triangulation of themes is used to support improvements in care. We have continued to report and investigate incidents that could have or did cause our patients harm in a timely way, and inform patients, their carers, families and our staff when we make mistakes and share any lessons we learn to prevent future harm. We are planning our first annual safety conference in the Autumn of 2025.

- We have created a Family Liaison Team to support patients and families who have been involved in patient safety incidents to provide a single point of contact and support during reviews of care.

2. Work to identify, escalate and ensure timely intervention of deteriorating adults and children

This year, our focus has been to advance a strategic, system-wide approach to improving the recognition and management of deteriorating patients. Centred on the PIER (Prevention, Identification, Escalation, and Response) methodology, this approach integrates digital innovation and enhanced use of Early Warning Scores (EWS) to provide greater oversight, accountability, and alignment with our Trust's quality priorities.

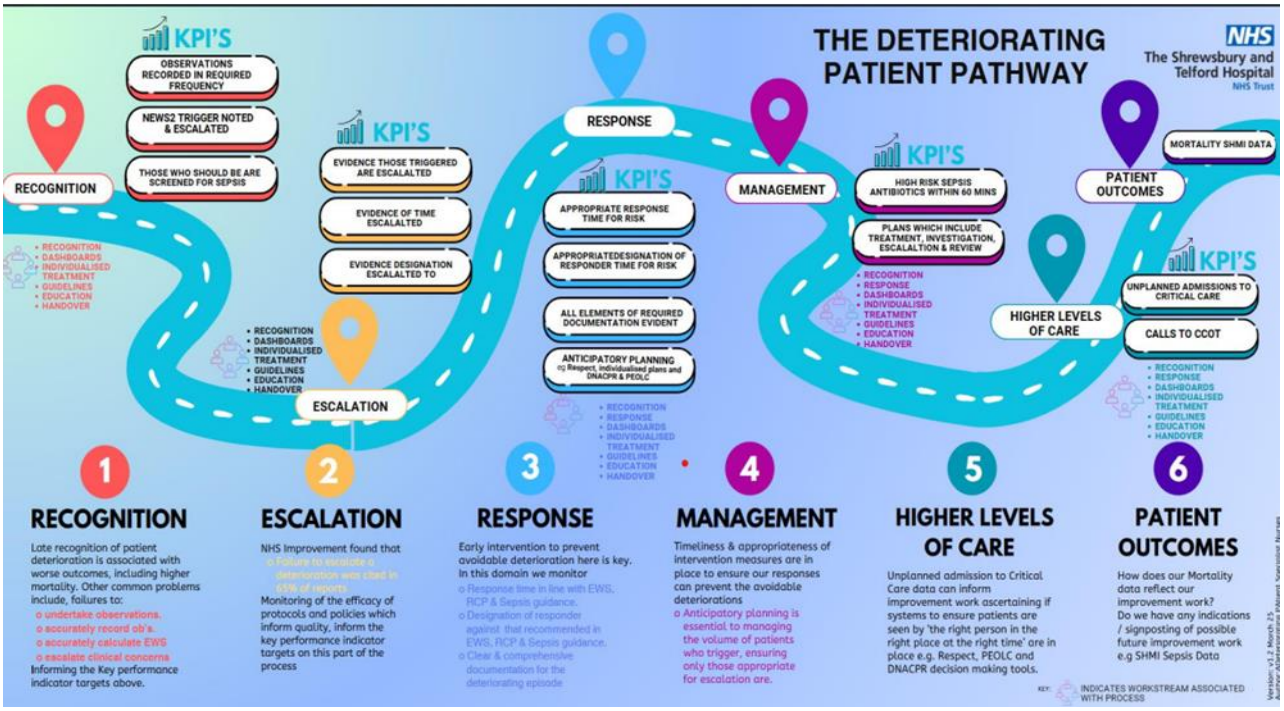
Improvement has been driven through six aligned workstreams:

- Development of real-time performance dashboards,
- Standardisation of guidelines and pathways.
- Optimisation of clinical response models,
- Implementation of individualised and anticipatory care planning,
- Strengthening of clinical handovers,
- Targeted staff education and training,

These workstreams are tailored to divisional needs and delivered in collaboration with existing transformation programs across multiple specialties

To ensure policies translate into practice, we continue to operationalise national and local guidelines through divisional action plans and clinical pathways that reflect the unique needs of each service. Divisional teams are empowered to identify priorities, implement context-specific solutions, and drive sustainable improvements aligned with the Trust's strategic goals.

As outlined below our deteriorating patient pathway has been revised, with key performance metrics including patient outcomes and the monitoring of this pathway included.



Performance dashboards, audit cycles, and learning from incidents are systematically used to monitor progress, inform local quality initiatives, and reduce unwarranted variation in care. This data-led approach has reinforced a culture of shared learning, continuous improvement, and accountability across the organisation.

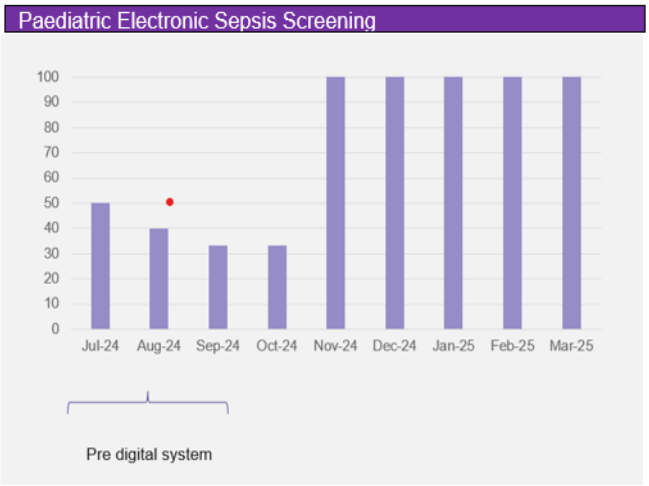
We have continued to strengthen our digital infrastructure to support real-time EWS tracking, allowing for earlier detection of deterioration and enabling more timely, effective clinical responses. These digital tools also support system-wide visibility of performance against key quality indicators, driving responsive decision-making and targeted improvements.

In July 2024, the Paediatric Vitals module for paediatric inpatient departments went live on our Paediatric ward, Children's Assessment Unit and Paediatric Emergency Department

This was an exciting development as we were one of the first Trusts in England to begin using electronic observations based on National PEWS, for our paediatric patients. The system ensures instant access to real-time information, helping staff to get the right information, in the right place at the right time and help with improved patient safety by ensuring more accurate and timely monitoring, in turn supporting early detection and intervention for deteriorating patients.

Following the implementation of Paediatric Vitals in July 2024, the new digital Sepsis Screening assessment was implemented in the paediatric areas and ED departments on the 10th of September 2024. Again, this was a positive development within the system as it has helped colleagues with early recognition of sepsis, meaning they can escalate patients who need additional care and provide earlier treatment.

Following implementation of the electronic sepsis screening tool compliance with undertaking the screening saw a significant improvement and performance has been consistently 100% since November 2024.

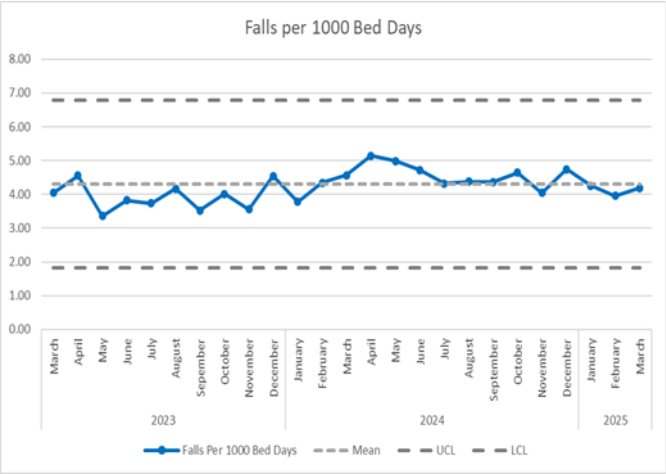


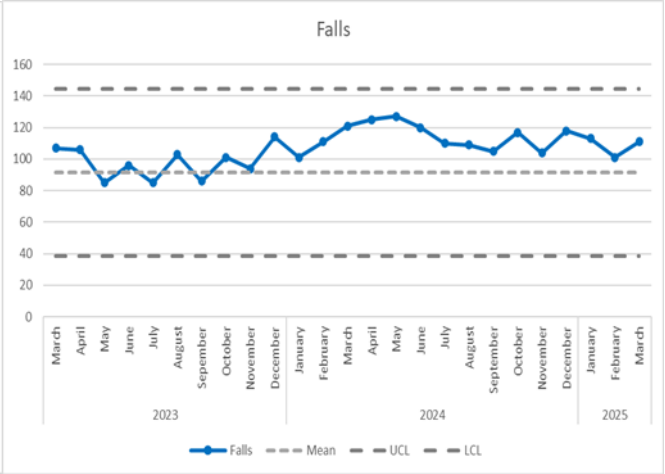
Feedback has been incredibly positive, and it is clear it will be a real benefit to teams, however with any new process there is teething issues that we are aware of and working hard to resolve. Electronic data is also available for audit and monitoring purposes.

Our integrated strategy has enhanced system responsiveness, improved oversight of deteriorating patient care, and aligned divisional activity with our commitment to delivering safe, high-quality, and patient-centred services. Work to identify, escalate and ensure timely intervention of deteriorating adults and children will remain one of our PSIRF Quality Priorities in 2025/26. Actions we will be taking in relation to this quality priority are outlined later in this Quality Account in the 'Looking forward to our Priorities for Quality Improvement 2025-2026 section under Priority 1.

3. Reduce the number of inpatient falls and the level of harm

Improvement work targeted at reducing falls continued throughout 2024/25. In 2024/25 the number of inpatient falls increased to 1365 from 1166 in 2023/24.





To note the graph showing falls per 1000 bed days is based on estimated bed days not actual and we know we have an increase in our bed base in 2024/25 with the medical escalation ward remaining open and additional patients on wards; there was an upward trend at the start of the year in April 2024 with a decrease in Q1 to a rate consistently below or just on the mean line throughout the remainder of the year.

The number of falls and severity of harm is shown below

Level of Harm	No	Low	Moderate	Severe
2021/22	875	404	15	15
2022/23	965	479	14	14
2023/24	719	406	25	16
2024/25	785	528	37	15

The graph shows that the Trust had 4 peaks of harm throughout the year, but subsequent months these peaks reduced towards the mean line. The trend remains below the upper control limit throughout the year.

In 2024/25 the Trust had 15 severe harm and 37 patients with moderate harm resulting from a fall. Although our numbers of harms have increased this year the number of falls resulting in severe harm to a patient has decreased to 1.1% of all harms compared to 1.4% last year. However, any fall with significant harm is unacceptable and we aim to reduce this in 2025/26. Falls reduction remains a priority in 2025/26, we will continue our work on risk assessment, care planning, cohorting and reconditioning. Some actions for improvement are included in Section 2.4, where we look at our priorities for 2025/26.

Key improvement actions which have taken place in 2024/25 in relation to trying to reduce the risk of a fall, the number of patients having a fall whilst in our care and the level of harm from a fall include:

Falls Review

A full review of falls with harm was completed to identify any themes however there were no themes identified. All pre- falls documentation and interventions were in place to mitigate against a fall occurring.

Compliance for completion of Falls Risk Assessment and Falls Prevention Actions

Throughout 2024/25 compliance with risk assessment completion has been monitored in numerous audits which has included the quality team continuing to review each fall that occurs, matrons own monthly audits and Exemplar ward accreditation programme. These have shown that compliance remains above 90% in identifying risks and completing care plans for those at risk of falls.

Reconditioning

A key improvement priority in relation to trying to reduce the risk of a fall, the number of patients having a fall whilst in our care and the level of harm from a fall in 2024/25 was the reconditioning work that has taken place throughout the year. The quality team have supported wards with reconditioning activities and have a monthly activity plan to continue this work. Monthly reconditioning meetings take place with a project plan to track progress

Our Falls Practitioner has worked with 2 pilot wards (Ward 28 and Ward 9) to commence the first project. The pilot commenced in November 2024. Meetings were held with the wards and key metrics agreed, these are tracked through the movement matters collaborative meeting that takes place every 6 weeks and updates provided to falls steering group monthly. There was a reduction in the overall number of falls during the pilot on ward 9, however, there was no change in the number of falls compared to the same time period the previous year on ward 28. It is not possible to determine if the pilot intervention had an impacted on the reduction in falls on ward 9. The reconditioning work will continue in 2025/26 as part of our falls improvement work, and we will further evaluate the impact this may have on the number of inpatient falls in the hospitals.

	5-month period (last year v this year)					
	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Total
WD28	5	6	7	2	7	27
WD9	3	9	10	11	8	41
	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Total
WD28	4	6	9	5	3	27
WD9	10	7	5	2	1	25

Hospital associated deconditioning (HAD) awareness training took place with staff on these wards to date 59% of staff on ward 28 and 60% of staff on ward 9 have received face to face training. Non-mandatory essential training was paused in the Trust in December 2024 but is due to restart in April 2025.

Energise Project

In October 2024 ‘Energise’ an active partnership in Shropshire, Telford and Wrekin came into the Trust to collaborate on a project to reduce hospital associated deconditioning on Ward 27. This project initially only funded for 6 weeks received additional support from the ICB to extend the project, doubling the length of time.

Although we did not see a reduction in the overall number of falls on ward 27 as a result of the project, successes from the project included:

- an increase in awareness for both staff and patients of the harms of deconditioning,
- 46% of staff received training on deconditioning as part of the project,
- 155 patients were spoken to and given advice around the risk of de-conditioning and preventing this whilst in hospital and 34 patients received guidance on the falls pathway for discharge.

One of the recommendations already in progress at the time and now complete is mandatory staff training. The 2 yearly falls training has been refreshed and now includes a video on prevention of deconditioning, a pledge is made at the end of the video by staff.

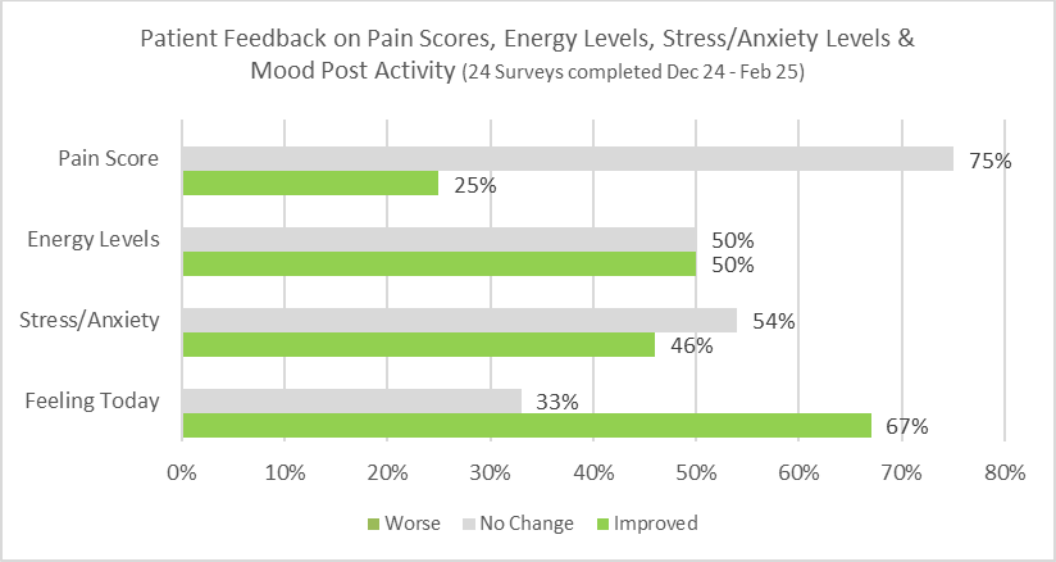
Monthly Activity Programme

Monthly activities continue across the wards with a 12-month rolling programme in place, activities to date include smoothies and fruit tasting, Valentines and Remembrance Day craft activities and chair-based yoga.

In December 2024, the chaplaincy team provided support singing Christmas carols, this was a very popular activity that has now been introduced monthly (alternate sites) and named music and move.

Encouraging patients to sing or move along to the song increasing movement and bringing joy to both patients and staff. ‘Our ‘Music and Move’ activities have been very popular on our medical and surgical wards.

A patient experience questionnaire has been introduced pre and post activity, results from this are positive demonstrating a 50% improvement in energy levels, 46% improvement in anxiety and stress levels and general mood improved for 67% of patients.



Donate 2 Motivate

A “Donate 2 Motivate” clothing store initially trailed on the project wards was successfully rolled out Trust-wide in February 2025, this is in addition to the moving wardrobe on ward 28 and store on ward 9. This project is due to be showcased at the first ‘Deconditioning live’ conference on 2nd April 2025 hosted by Professor Brian Dolan and has been reported in the local media

Our improvement work will continue through 2025/26 and will continue to develop through the leadership of our Falls Practitioner and will be aligned to the Trust’s PSIRF Inpatient falls priority. A reduction in patient falls, particularly those resulting in moderate harm or above will be one of our key Quality Priorities for 2025/26

In January 2025 a working group was launched to review the moving and handling assessment within the nursing admission documentation. In line with the National Audit of Inpatient Falls (NAIF) recommendations moving away from multi-factorial risk assessments (MAFRA) to multi-factorial assessment for optimizing safe activity (MASA) and the principles of earlier mobilisation in patients journey a bedside mobility assessment tool (BMAT) is being reviewed and prepared for trial on Ward 28 and 9. This will be one of the key falls improvement actions for next year alongside other actions outlined later in this Quality Account in the ‘Looking forward to our Priorities for Quality Improvement 2025-2026 section under Priority 1.

4. Understand and reduce the number of omitted doses of time critical medication

During 2024/25 the following improvement work took place in relation to this PSIRF quality priority:

- A task and finish group was developed in quarter one of 2024/25 to define the scope of the priority and included audits on a small number of wards to start with identifying themes that lead to omitted doses.
- This initial audit data helped to shape the development of a semi-structure observational tool used to complete observational sessions using human factors methodology by patient safety specialists, the Trust human factors specialist and the Medicine Safety Officer. Observational sessions have been completed on a number of wards over the two hospital sites and will continue into quarters one and two of 25/26.
- Semi-structured clinical staff focus groups are planned alongside review of existing evidence and literature to ensure a holistic approach is taken to identify and implement learning and sustained improvement.
- Initial audit and observational sessions have identified themes relating to omitted doses.
- Individual ward action plans have been generated and agreed with ward managers/matrons following audit to tackle immediate concerns. Wider systems related issues and themes are to be incorporated into thematic review and improvement plans.
- Trust guidance is currently in development to support clinical staff in the prevention of omitted and delayed doses of medication and required actions in the event of delayed and omitted doses

Reducing the number of omitted doses of time critical medication will continue to be a key improvement priority in 2025/26, with the observational and audit work undertaken in 2024/25 informing our improvement actions for next year alongside other actions outlined later in this Quality Account in the 'Looking forward to our Priorities for Quality Improvement 2025-2026 section under PSIRF priorities in Priority 1.

5. Improve reporting and missed radiology results

During 2024/25 the following improvement work took place in relation to this PSIRF quality priority:

- A thematic review of the key issues has been undertaken and has been fed into further discussions around short/medium and long-term potential mitigations to reduce the risk of critical radiology results being missed.
- Further focused review has suggested a potential medium-term mitigation based on the use of RadAlert combined with a dispersed model of the 'investigations team' approach suggested in the Royal Academies document.
- An outline scoping document has been produced for discussion with Divisions. key stakeholders are working to further clarify options for improvements.
- It has been noted this is likely to be a discussion that will need to focus around, the balance of risk, resource and relative priority given the timescale for longer term IT based mitigations.

- No and low harm Datix's relating to this theme continue to be monitored and are aligning with the issues highlighted in the systems review.

This will be one of the key improvement actions for next year alongside other actions outlined later in this Quality Account in the 'Looking forward to our Priorities for Quality Improvement 2025/26 section under PSIRF priorities in Priority 1.

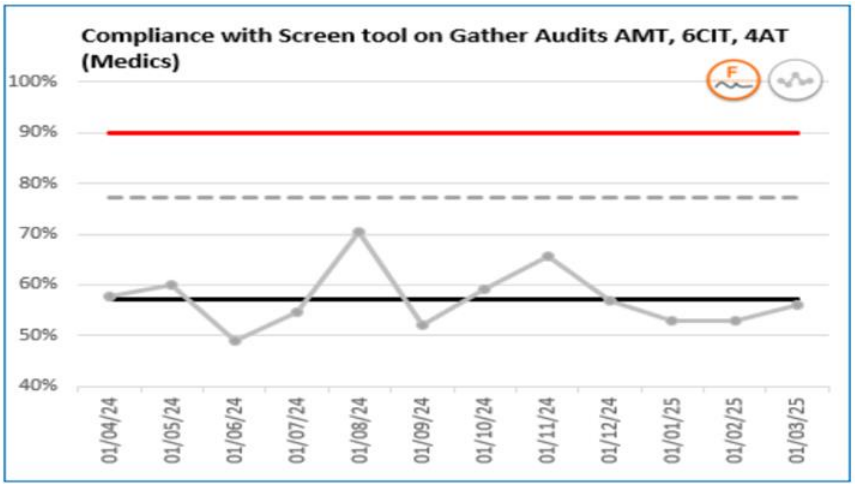
PRIORITY 2: Improve Cognitive Screening

What we said we would do

We would improve cognitive screening to ensure above 75% of patients receive a screening for Delirium/Cognition by a doctor.

What we have achieved

All people over 75 years of age who are admitted to hospital as an emergency and who stay for at least 3 days (72 hours) are required to have an assessment of their memory in line with National Standards. This will be the AMT (Abbreviated Mental Test) or 6CITS (6 item-Cognitive Impairment Test) or 4AT Delerium Screening. In 2024/25. In 2024/25 our aim was to ensure that all eligible patients were screened and that we achieved at least >75%, we did not achieve this in 2024/25.



Compliance with the cognitive screening assessment is now included in the ward quality dashboard metrics and discussed at the metrics meetings. Ward managers remind the ward teams on the daily ward/board rounds to undertake the assessment and discussions have also taken place with the Medical and Deputy Medical Director around how we can improve compliance in 2025/26.

Throughout 2024/25 our staff have undertaken Tier 1 Dementia training online and Tier 2 face to face training, to increase their awareness, knowledge and skills in relation to caring for patients with dementia and supporting their families/loved ones.

Dementia training compliance is above the Trust target of >90%:

Dementia Training	
Tier 1	Tier 2-3
95.45%	91.56%

The Trust Dementia team has worked collaboratively throughout the year with colleagues in the Midland Partnership Foundation Trust to develop and share a new referral pathway and criteria. The team have also engaged with colleagues across the Health Economy to improve referrals and hold joint multidisciplinary meetings (MDT) meetings bi-monthly to provide a more seamless service for our patients.

PRIORITY 3: Ensure improved patient experience in our Emergency Departments. Reducing waiting times, timely decision making and intervention

What we said we would do

Ensure improved patient experience in our Emergency Departments. Reducing waiting times, timely decision making and intervention.

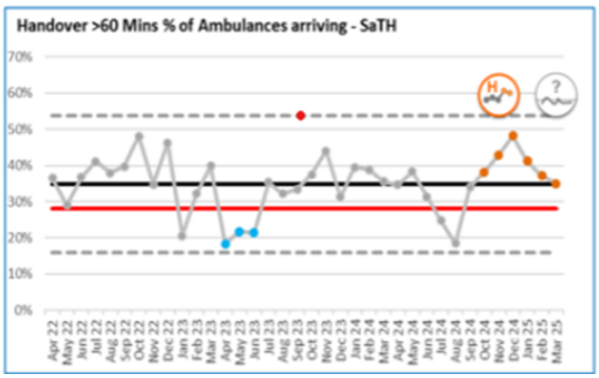
What we have achieved

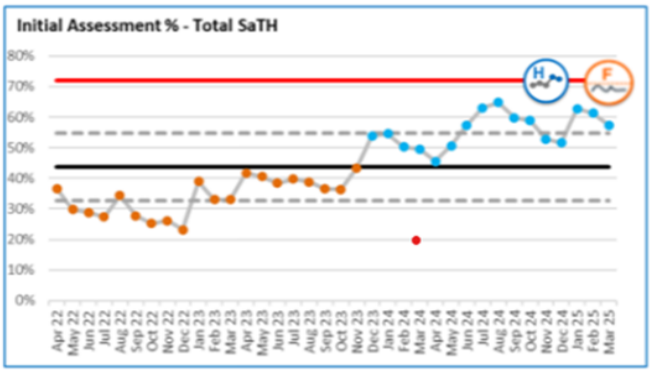
Throughout 2024/25 our Emergency Departments have remained challenged, with overcrowding in both Departments. Improving the care provided to patients in our Emergency Departments has been a key focused area for improvement. We know timely emergency care matters because:

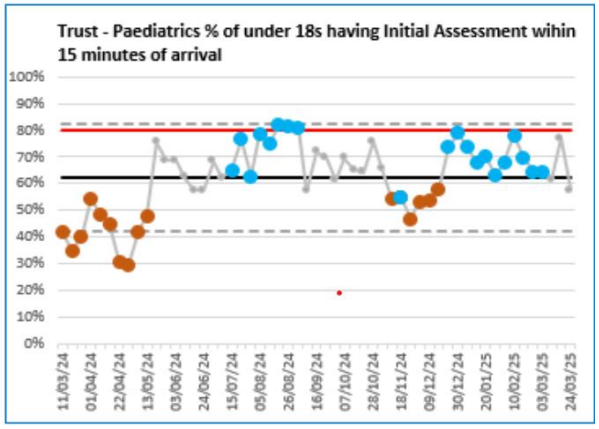
- Delayed admission from the Emergency Department is harmful, and contributes to increased morbidity and mortality
- Emergency Department crowding is associated with increased length of stay, worse quality of care and poorer patient experience.

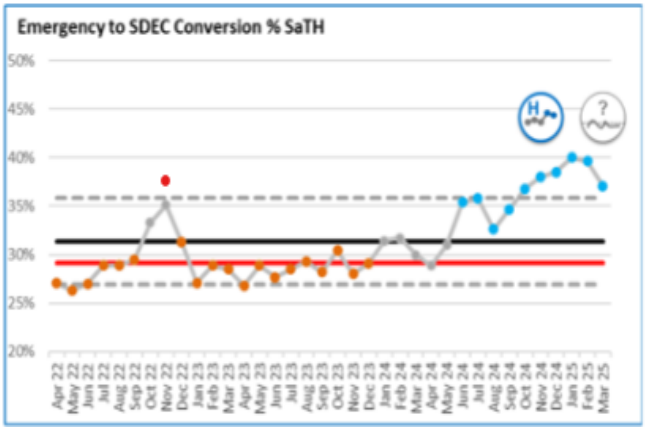
Improvement work has focused on reducing the number of delays in relation to ambulance handovers on arrival at the Emergency Departments, increasing the number of patients (adult and children) who have an initial assessment within 15 minutes of arrival, and reducing the amount of time that patients are in our

Emergency Departments either waiting for treatments and to be discharged or awaiting admission to our wards.









- There has been an improvement in the handover of ambulances arriving at the Emergency Department in Quarter 3 and 4 of 2024/25 compared to the same time the previous year, this is despite increased ambulance activity in February and March 2025.
- Initial assessment for all patients within 15 minutes of arrival to the Emergency Departments has improved
- Initial Assessment process changes for paediatrics have delivered significant improvements in initial assessment within 15 mins of arrival for paediatric patients in 2024/25.
- Initial assessment improving performance trajectories have predominantly been based on interventions relating to Same Day Emergency Care (SDEC) and Urgent Treatment Centre (UTC) streaming and reducing delays in non-decision to admit (DTA) patients. The target was for 30% of patients to be streamed to SDEC, the teams have achieved better performance than this consistently since May 2024.
- This increased productivity as a result of ED streaming to SDEC has also been a key contributor to the overall reduction in average ambulance handover times. A trajectory plan for ambulance handover improvement from the mean average of 67 minutes seen in 2024/25 to 55 minutes in 2025/26 is planned for 2025/26.

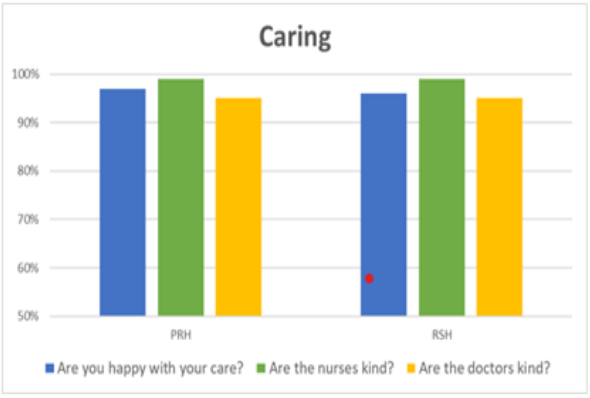
The two remaining CQC conditions relate to initial assessment for children and all patients attending ED within 15 minutes of arrival. As a result of this increased compliance with the number of adults and children who have an initial assessment (triage) within 15 minutes of arrival the Trust plans to approach the CQC about varying or removing these remaining conditions in 2025/26.

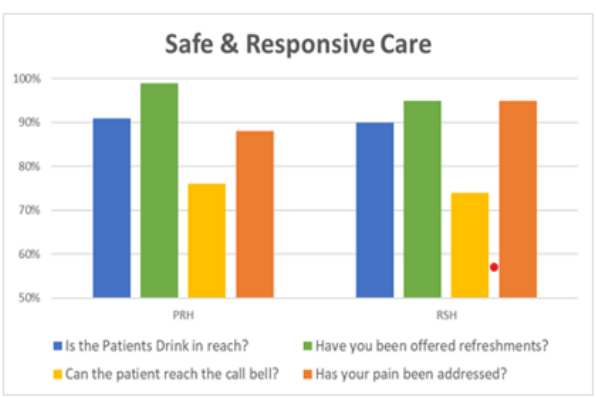
Other improvement work undertaken during 24/25 to improve the quality of services include:

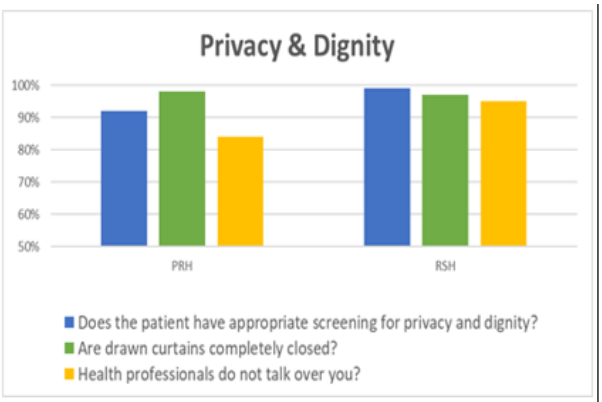
- Left without being seen process change for paediatrics which has delivered sustained improvement to support the safeguarding of our patients under 18 years old. An updated process was implemented in May 2024 in both ED's to ensure monitoring of actions taken when a paediatric patient leaves the department before being seen by a doctor are recorded and escalated appropriately. This process is led by our Paediatric Lead Nurse for the Emergency Departments. Compliance for all “actions reviewed by a senior nurse and consultant within 48 hrs" has been above 95% since the new process was implemented and when benchmarked against the 24-hour time period 92% of patients had been followed up within 24 hours.
- Offload to Assess (OTA) model implemented to ensure our patients arriving by ambulance receive assessment and diagnostics earlier in their journey
- Reconfiguration of our RSH ED with the opening of new Majors and resuscitation area as part of Hospital Transformation Programme enablement.

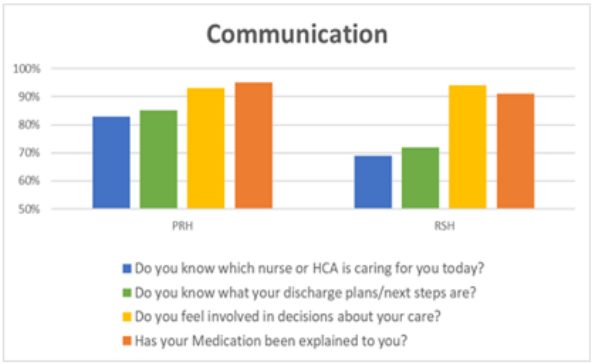
To support the Emergency Department improvements and sustain this in key areas a core set of quality and safety metrics are audited weekly by the ED matrons, these address the improvements required following the CQC inspection report published in May 2024 and the concerns identified following the Dispatches programme. These Quality audit outcomes are triangulated with safety outcomes and training data at the monthly Nursing Quality Metrics meetings. Improvements have been seen in documentation, nutrition, and privacy and dignity. This work will continue throughout 2025/26.

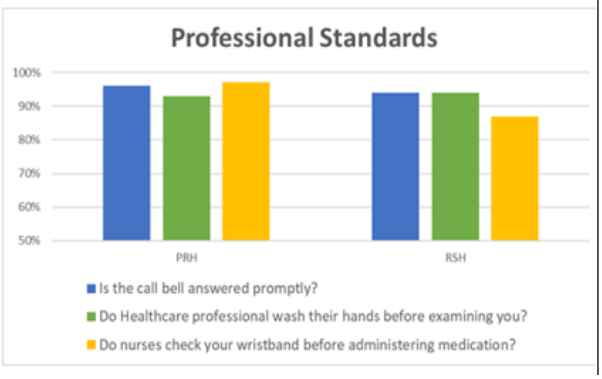
As part of these improvements a new patient experience survey commenced in March 2025 undertaken in the two Emergency Departments by our Patient Experience Team. The results shown below are taken from the enhanced Patient Experience audits, these surveys identify areas for improvement from the patient feedback as well as enabling the team to monitor the impact of any changes in service or improvement measures put in place and the benefits reported by our patients.











PRIORITY 4: Improve our admission and discharge processes through the Trust ensuring our patients are receiving the right care, in the right place, at the right time

What we said we would do

Our ambition is to ensure patients are assessed and treated in the right place at every opportunity.

1. Improve the number of discharges pre 10am and pre 12 midday
2. Improve the utilisation of the discharge lounges to support earlier patient flow from the emergency departments.
3. Reduction in the number of patients with no criteria to reside
4. Roll out criteria led discharge

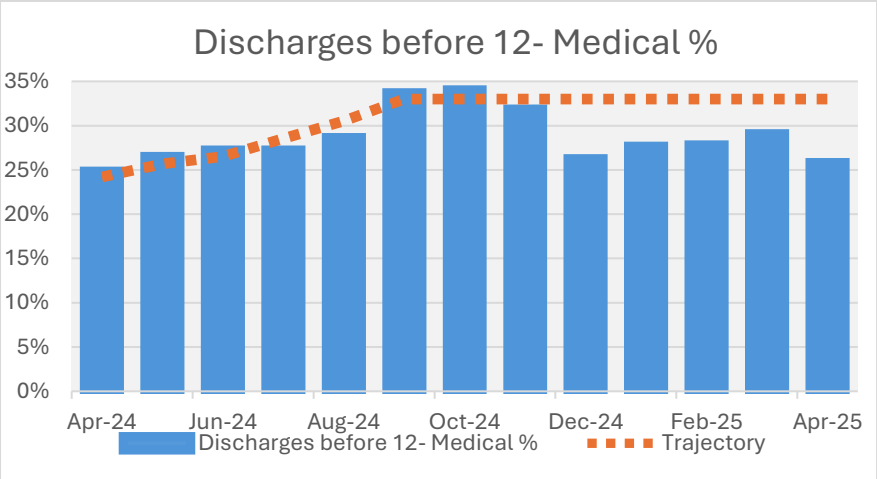
What we have achieved

1. Improve the number of discharges pre 12 midday

During 2024/25 the 'Ward Processes Improvement Workstream' primary focus has been to enhance the timeliness of discharges on the medicine wards, particularly aiming to improve pre-12 midday discharges to 33% and pre-17:00 discharges to 80%.

To achieve these goals, the decision was made to implement the S(ick)H(ome)O(thers)P(lan) model (SHOP) for both board and ward rounds. This approach was initially soft launched in June 2024, providing an opportunity to explore its potential application and identify areas for improvement. In September 2024, following valuable feedback and insights, the model was fully launched alongside a staff guide to help ensure consistency and clarity.

As the workstream introduced the model, it was observed that some wards were able to integrate the SHOP approach more seamlessly than others. While some teams adapted the model to better fit their existing routines, others encountered challenges with full implementation. Despite these variations, we saw notable progress.



Following implementation of the SHOP model both hospital sites saw a positive shift in earlier discharges with an improvement in the discharges before 10am at RSH and an improvement in discharges before 12 midday at PRH

At RSH the positive shift in pre-10:00 discharges was largely driven by improved planning for complex discharges and the ability to transfer patients to the discharge lounge (DCL) earlier in the day. However, this progress declined in November 2024 and again in December 2024 before performance plateaued as winter brought challenges, which included using the discharge lounge as additional bed capacity overnight to care for patients who were being discharged the next day so that beds could be made available in the hospital for patients to be admitted from the Emergency Departments. This practice meant that there was limited space for patients to move from the wards to the discharge lounge in the morning until those patients who had been cared for there overnight had been discharged. Discharges before midday were reduced as spaces did not become free for patients to move to the DCL until later in the day. In 2025/26 we will be taking further actions

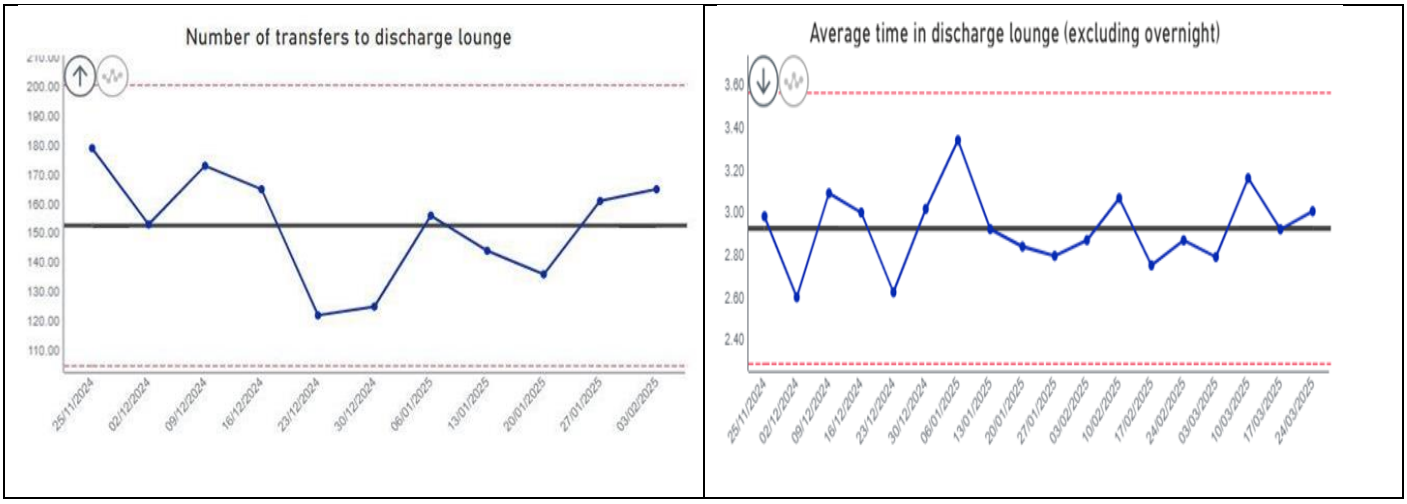
to increase our patient discharges earlier in the day which includes limiting the use of the discharge lounge overnight due to the impact this has the following day on our ability to ensure patients are transferred to the discharge lounge in a timely manner.

Although the aim was to make improvements for pre-12:00 midday discharges to 33% and pre-17:00 discharges to 80% these have not been achieved but there have been improvements despite challenges, the improvement work to ensure our patients are discharged in a timely way in the day will continue in 2025/26.

2. Improve the utilisation of the discharge lounges to support earlier patient flow from the emergency departments

To help improve flow throughout the day with earlier movement of patients from the bed base, discharge lounges have been established at both the Royal Shrewsbury and Princess Royal Hospital. This enables patients who are planned to be discharged to be moved early in the morning to the lounges where they can be monitored and supported by clinical colleagues prior to being fully discharged from the hospital.

The number of patients transferred to the discharge lounge each week is shown, this ranges from 120-180 patients per week, the graphs also show the number of hours patients spend in the discharge lounge with an average of 3 hours:



Several initiatives have been tested to improve the utilisation of the discharge lounge, alongside ensuring the best possible care for our patients; the following two improvement ideas have been tested out during this reporting period:

- **Improve communication between clinical site and the Discharge Lounges that leads to less interruptions and a reduction in waiting time for patients to be discharged**

To improve communication between clinical site, other colleagues involved in the discharge pathway and the discharge lounges, an electronic “Production Board” (excel spreadsheet) was created to replace the current stand-alone board located in each discharge lounge. By utilising a Microsoft Teams channel to gain access to the Production Board, this enabled all parties to view and update to ensure the best possible picture of the current state of the discharge pathway for all patients was known.

The process was quickly adopted, but some problems occurred in maintaining the spreadsheet when the Discharge Lounge was predominately staffed with bank and agency colleagues who could not access the spreadsheet. Overall, positive feedback has been received and, although the data does not correlate with a reduction in time spent in the discharge lounge, the number of interruptions has reduced, and clinical site colleagues have been able to progress some elements of the discharge progress more expediently. Having now tested on both sites, it has been agreed to adopt this new process and reduce the reliance on a “physical” Production board.

- **Improve patient understanding of the Discharge Lounge through provision of a leaflet**

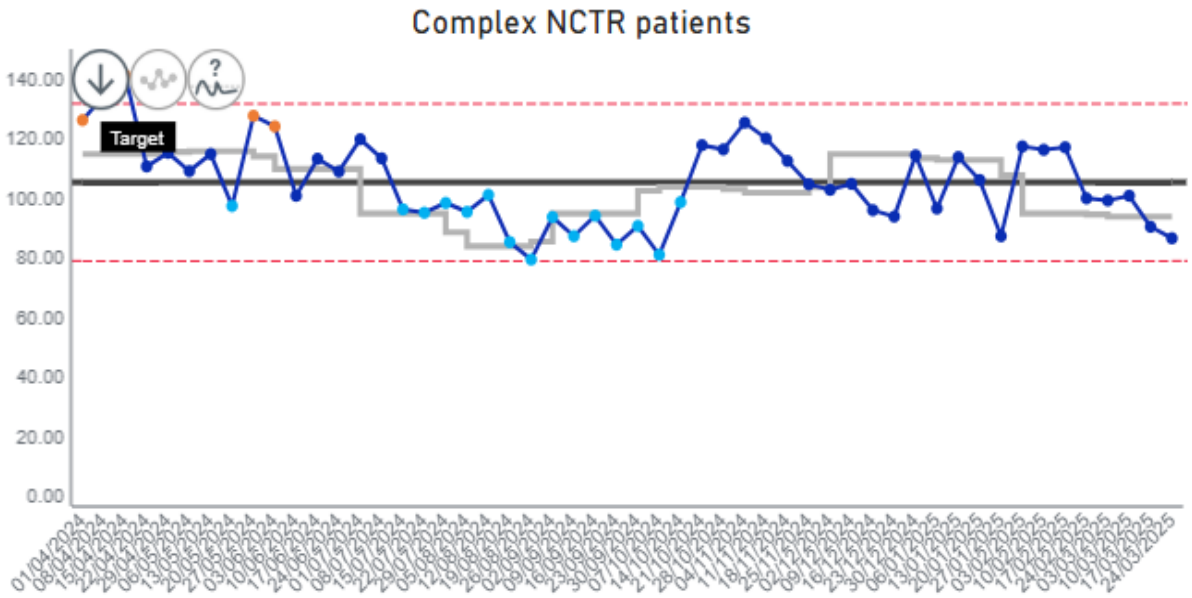
To help patients and families understand why they/their loved one is being transferred to the discharge lounge a patient leaflet was developed. This has proven helpful in providing information to patients on the discharge lounge process and what to expect. Some specific feedback from patients includes:

“It is good, the leaflet is simple and easy to understand”
“I found the discharge lounge leaflet very useful as it gave me assurance that I will be looked after”

Alongside this, the aim is to provide wards with a ‘Discharge Lounge box’ for all adult wards, Thus will contain a copy of the Discharge Lounge Standard Operating Practice Guidance for staff, Discharge Lounge leaflets for patients/families and a sign to put on the end of the bed as a visual control to inform colleagues to prepare the patient for transferring in the morning. The boxes have been purchased and soon to be tested out on the wards.

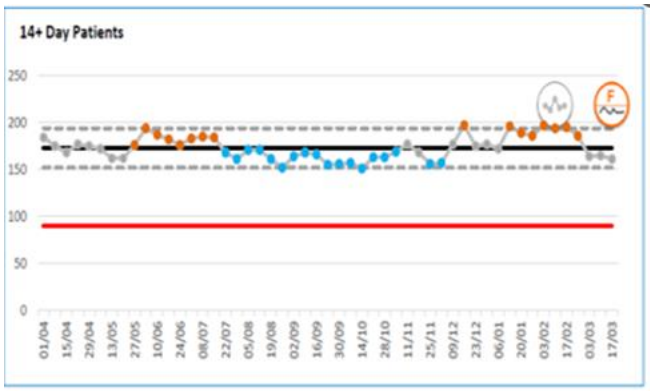
3. Reduction in the number of patients with no criteria to reside

No Criteria to Reside (NCTR) in the NHS refers to the point when a patient is assessed as no longer needing medical care in a hospital bed and can be safely discharged. This assessment means that they no longer meet the specific clinical criteria for being in a hospital setting. Throughout 2024/25 the Trust has worked with health and social care partners across the Shrewsbury, Telford and Wrekin (STW) to reduce the number of patients in hospital with NCTR. Complex NCTR has improved from an average of 120 in April 2024 to 85 in March 2025.

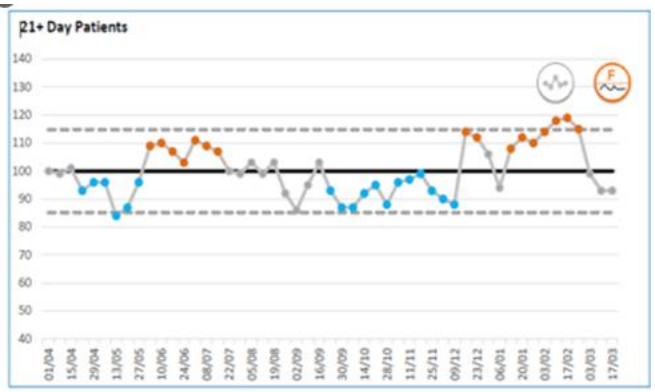


Alongside reducing the number of patients with NCTR who are in our hospital, the Trust has undertaken ongoing work throughout 2024/25 with regards to our patients with a criteria to reside (CTR); these are patients whose medical needs mean they still require care in a hospital environment. Improvement work for CTR patients with a stay of over 14 and 21 days has taken place to ensure that pre-planning for discharge is in place so that when doctors declare a patient medically fit for discharge (MFFD), the necessary provisions are already arranged to ensure a safe discharge for these patients from our hospitals.

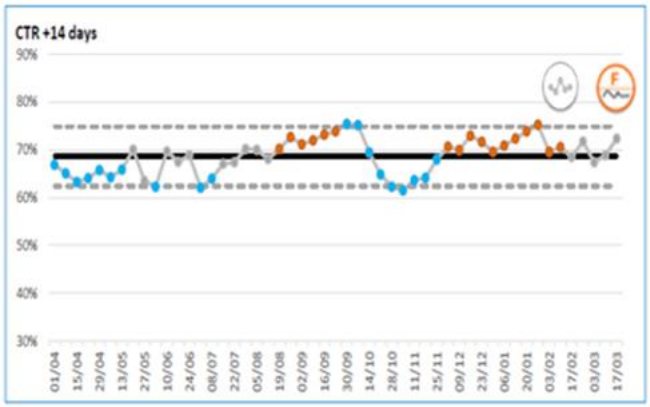
Number of Patients with a stay of 14+ days



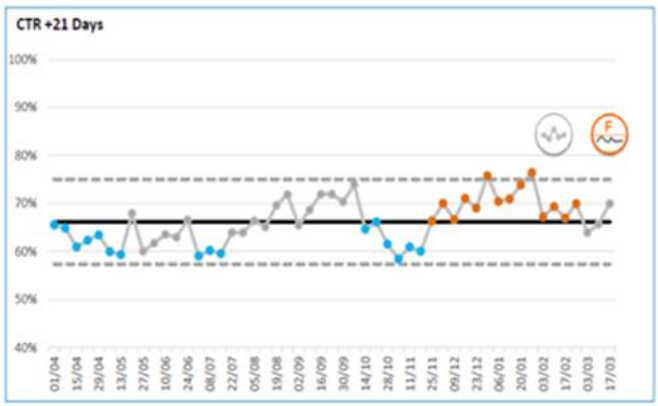
Number of Patients with a stay of 21+ days



Percentage of Patients with Criteria for Reside + 14 days



Percentage of Patients with a Criteria to Reside +21 days



A weekly Long Length of Stay (LLOS) meeting takes place every Wednesday, bringing together key stakeholders, including:

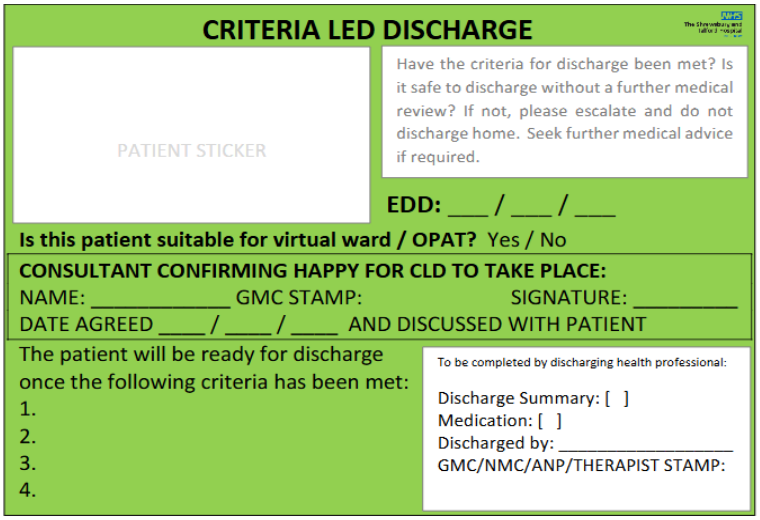
- Powys, Shropshire, and Telford & Wrekin local authorities
- Care Transfer Hub leads
- Divisional Flow Leads
- Capacity and Flow matrons

The primary focus of these meetings is on patients with criteria to reside (CTR), ensuring that discharge pre-planning is in place so that when doctors declare a patient medically fit for discharge (MFFD), the necessary provisions are already arranged.

Following the reintroduction of the LLOS meetings in September 2024, a 9-week reduction in patient length of stay was observed. Patients had clearer discharge plans, and preparation for discharge was more robust. However, due to severe site pressures and ward acuity in December 2024, the meetings were temporarily stood down for four weeks. This resulted in a noticeable increase in 14+ day patients and CTR cases, with numbers only recently showing signs of recovery.

4. Roll out Criteria led Discharge

Criteria-led discharge (CLD) is a hospital discharge process where healthcare professionals, including doctors, nurses, and other specialists use pre-agreed clinical criteria to determine when a patient is medically ready for discharge. This process aims to ensure safe and timely discharges whilst improving patient flow and reducing delays. The roll out and embedding of Criteria Lead Discharge across the Trust is a key improvement action for the Trust and is currently not an embedded process across the Trust. To support further improvements a new Criteria Led Discharge Standard Operating Procedure (SOP), has been developed for roll out across our wards.


CRITERIA LED DISCHARGE

PATIENT STICKER

Have the criteria for discharge been met? Is it safe to discharge without a further medical review? If not, please escalate and do not discharge home. Seek further medical advice if required.

EDD: ___ / ___ / ___

Is this patient suitable for virtual ward / OPAT? Yes / No

CONSULTANT CONFIRMING HAPPY FOR CLD TO TAKE PLACE:
NAME: _____ GMC STAMP: SIGNATURE: _____
DATE AGREED ____ / ____ / ____ AND DISCUSSED WITH PATIENT

The patient will be ready for discharge once the following criteria has been met:
1.
2.
3.
4.

To be completed by discharging health professional:

Discharge Summary: [ ]
Medication: [ ]
Discharged by: _____
GMC/NMC/ANP/THERAPIST STAMP:

The new SOP will provide nursing staff with written guidance, alignment with the Trust policy. It will facilitate the safe and appropriate discharge of patients identified by consultants.

A new Criteria-Led sticker has also been developed which will enable clear identification in the patient's medical notes.

PRIORITY 5: Address and improve care for people with diabetes through close working with System Partners

What we said we would do

Our ambition is to improve care for patients with diabetes through close system working with system partners.

What we have achieved

The national diabetes audit conducted by Diabetes UK in 2021-22 highlighted that significant variation exists between ICBs. with Shropshire, Telford and (STW) having lower performance than the national average in relation to preventative care and people with diabetes (PWD) receiving all care as outlined below:

Base: Asked of all respondents who have ever had an annual review.
Those who selected 'I don't know or I can't remember' have been excluded.

	All		Type 1			Type 2		
	National	ICS	National	ICS	ICS is sig lower/higher than national	National	ICS	ICS is sig lower/higher than national
Weight and BMI	81%	81%	83%	77%	Lower	81%	81%	
Blood pressure	91%	91%	89%	83%	Lower	91%	92%	
Foot check	80%	72%	71%	58%	Lower	81%	73%	Lower
Urine test	71%	65%	68%	64%		71%	65%	Lower
Blood test	92%	89%	89%	87%		92%	90%	
Smoking status review	33%	28%	43%	39%		32%	27%	Lower
None of the above	1%	1%	2%	2%		1%	1%	
Unweighted Base	39747	906	17265	404		22482	502	
Weighted Base	38325	324	17023	159		21973	184	

In Shropshire, Telford and Wrekin, PWD reported they had had a foot check of 58% for Type 1 diabetes and 73% for Type 2 diabetes, both these results were below the national average. This results in patients not accessing preventative foot care and too many starting their care pathway starting with an admission/amputation.

In 2024/25 the Trust has continued to participate, work, and contribute to delivering the system diabetic priorities. Priorities for 2024/25 included: the diabetic foot pathway, routine foot screening for people with Type 1 and Type 2 Diabetes, high Risk Management of people with Type 1 and Type 2 Diabetes and Children's Services.

System working has included the introduction of a hot clinic for patients presenting to the Emergency Department and Urgent Care Centre with diabetic foot complications. This has enabled next day access for these patients with diabetic foot issues. The Trust has also worked with System partners at the Robert Jones

and Agnes Hunt Hospital to establish a preventative service for people with diabetes and tendon related foot conditions.

For outcomes such as amputation rates and admission we know this takes longer to change and are influenced by many factors outside SaTH and across STW such as diabetes foot screening and community podiatry high risk prevention. We are engaging with other providers, commissioners and stakeholders to address these aspects through collaborative working.

PRIORITY 6: Diabetic foot care: Improve foot care for people with diabetes

What we said we would do

We aimed to improve foot care for people with diabetes by:

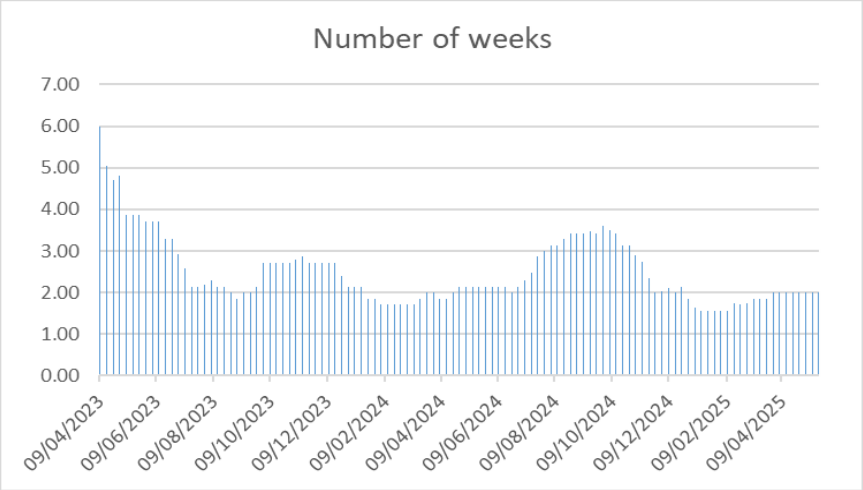
1. Ensuring quick access to a multidisciplinary foot team for people with acute foot problems.
2. Improving inpatient foot assessments and care to prevent iatrogenic harm, with new assessment documentation, preventative care and staff education.
3. To provide inpatient foot reviews with a view to using Outpatient Parenteral Antimicrobial Therapy (OPAT) for reduced hospital stay.

What we have achieved

1. Ensuring quick access to a multidisciplinary foot team for people with acute foot problems

In 2024/25 the team have undertaken ongoing work to reduce the length of time diabetic patients to wait from referral to first assessment with the Multidisciplinary team.

There has been a year-on-year reduction in the time patients are waiting as shown.



- In 2022/23 the average waiting time was 4 weeks
- In 2023/24 the average waiting time was 2.68 weeks
- At the start of 2024/25 the average wait was 2.37

These improvements in assessment to referral time have been achieved despite a significant increase in clinical need.

In 2022 clinical activity per year was 2832 contacts which has raised to 4584 contacts in 2024 and continue to rise. The aim is to reduce the time patients wait further to achieve a target of 72 hours. In 2024/25 a hot clinic for the Emergency Departments and Urgent Care Centres meaning next day access available is available to any patient presenting with a diabetes foot complaint who does not require admission. The decision to bring Podiatry inhouse to SaTH will reduce cost and offer flexibility to the needs of the service.

2. **Improving in-patient foot assessments and care to prevent iatrogenic harm, with new assessment documentation, preventative care and staff education.**

All patients with diabetes should have a diabetes foot assessment on admission. As part of the work undertaken in 2024/2025 the Diabetic Foot Team (DFT) completed an audit as a baseline for their improvement work. This showed that:

- Very few people were receiving a compulsory diabetes foot assessment on admission (10%),
- Less than half of people with ulceration were correctly referred to the Multi-disciplinary Foot Team.
- People with diabetes (PWD) at high risk of developing hospital acquired foot ulceration were not being provided heel pressure relief in line with NICE guidance.

Improvement work undertaken by the DFT in 2024/25 included:

- The implementation of a new Foot Assessment
- Access to heel offloading for patients at high risk
- Mandatory Foot Training

The implementation of a new Foot Assessment which was included in the nursing admission documentation to be completed within 4 hours of admission to hospital. The Achilles Foot Assessment supports the clinicians to assess, protect report and refer patients with heel wounds to the DFT if the patient is diabetic or to the Tissue Viability Team for iatrogenic heel wounds or other heel wounds. The new assessment tool is accompanied by a Quick Reference Guide for Diabetic Foot to support clinical staff in their assessment, management and referral to specialist teams.

Following a trial, access to heel offloading boots for patients at high risk is now available on wards, previously these were not available without a referral to the Orthotic Department. This will reduce delays, as the boots are easily available now without a referral and frees up the Orthotic Department to see other patients requiring their service.

New mandatory training for foot care, assessment and prevention was implemented in 2024/25 accessed through our Learning Made Simple (LMS) online platform. The training includes.

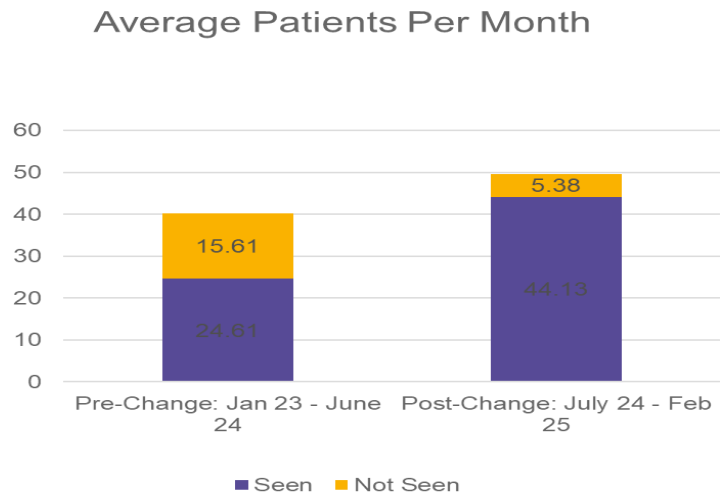
- Video training and a questionnaire for Registered nurses
- Video and questionnaire for healthcare support workers

Further improvements are required in 2025/26 to ensure all relevant staff undertake this training. Other ward-based education has been delivered by the DFT alongside junior doctor training. Diabetes Foot champions have been established in the clinical areas

The baseline audit undertaken in 2024/25 will be repeated in 2025/26 to help evaluate the impact of the improvements for patients, this will include whether patients are appropriately having their heels offloaded to prevent complications and the outcomes in relation to any reduction in the development of diabetic wounds. Alongside this, both the mandatory foot training and compliance with completion of the Achilles Foot Tool within 4 hours of admission will be added to the individual Ward Quality Dashboards so compliance with undertaking the Diabetic Foot Assessment and the training can be monitored and discussed as part of the monthly Nursing Quality Metrics Confirm and Challenge meetings to ensure we are achieving the improvements required.

3. To provide inpatient foot reviews with a view to using Outpatient Parenteral Antimicrobial Therapy (OPAT) for reduced hospital stay.

The introduction of the new Achilles Heel Tool devised to help the clinician assess, protect, report and refer heel wounds now included in the nursing admission assessment documents prompts the staff to refer diabetic patients with heel wounds to the Diabetic Foot Team.



The chart opposite shows that there has been an increase in patient with diabetes (PWD) being referred to the Diabetes foot team and inpatient podiatry

There has also been a reduction in PWD being discharged without seeing this team

Outpatient Parenteral Antimicrobial Therapy (OPAT) is a way of administering intravenous antibiotics to patients who are well enough to be treated outside of the hospital, allowing patients to receive this treatment in a less restrictive setting, like their own home whilst still receiving regular medical oversight. Ensuring

assessment of inpatients with diabetic foot issues by the Diabetic Foot Team (DFT) for consideration of continuing treatment via the OPAT service is key to ensuring these patients can be discharged from hospital but still receive the care they require. In 2024/25 we started collating how many referrals were made from the DFT to the OPAT service, the number of referrals in the year was 28. The number of referrals made will continue to be reported in 2025/26 to monitor how many patients are now accessing the OPAT service.

PRIORITY 7: Demonstrating that as a Trust we are learning and improving patient, carer and public experience through complaints, patient surveys, feedback and compliments

What we said we would do

1. Evidence of the learning from complaints within our services
2. Functioning Specialty Patient Experience Groups
3. All wards to have a *"you said, we did"* Quality Board
4. Improve our ratings in the national staff survey for the question *"If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation"*
5. Improve complaint response performance, reduction in complaints with related themes and completion of actions and evidence of learning

What we have achieved

1. Evidence of the learning from complaints within our services

During 2024/25, the Complaints Team worked with the divisions in the Trust to develop new processes in relation to the investigation of complaints. These processes have ensured greater ownership of complaints at a specialty level, with improved visibility of all open cases.

This new process has also improved the quality of the investigations to ensure that there is clear learning and actions in place to prevent recurrence of issues identified through complaints investigations. All learning is logged on Datix and shared within specialties and more widely.

We have worked with the Divisions to ensure we are more responsive. Improvements include:

- For any complaint relating to end of life care we now ensure that alongside the complaints team acknowledging the complaint within 3 days, the matron for the area where the patient was cared for is immediately notified of the concerns and will ring the family. This allows for early contact, a discussion of any immediate concerns which can be addressed and provides an additional point of

contact during the during the investigation to support the family at a difficult time and ensure that all issues raised are fully addressed. Feedback from families to date has been positive.

- We are encouraging the use of meetings with patients or families who have raised a concern to resolve these in a more timely way. These meetings are recorded, and the complainant is offered a copy of the meeting recording. Meeting guides have been developed for both staff and complainants to support the process and ensure that these meetings are beneficial in resolving issues.
- The Independent Complaints Review Group is chaired by a patient partner, with independent reviewers studying anonymised complaints, investigations, and Trust responses, identifying opportunities to improve the process for people who submit a complaint. Representatives from divisions are invited to attend to hear feedback on the cases, and recommendations from the group are taken forwards.
- The Trust introduced weekend working for the Patient Advice and Liaison Services (PALS) in April 2024, which has been well-received. In addition, work has been done to publicise PALS and to ensure that patients and their families are aware of the service and how to access it, to ensure that the Trust takes every opportunity to resolve concerns and problems early on.

During 2025/26, work will continue on improving response rates to formal complaints and raising awareness about PALS. The team will work with the specialties to provide training on investigating and responding to complaints and will look at developing a more robust system for following up learning from complaints to assess the effectiveness of the improvement work being done.

Examples of learning form complaints include:

You Said:

A number of our patients raised concerns around facilities in the ED for patients experiencing long waits and access to drinks and snacks.

We Did:

- *Review of current vending machines and new machines installed*
- *Volunteer support has been increased to allow for more hydration and snack rounds to be undertaken*
- *In-house meal provision was also reviewed for patients awaiting admission*
- *Additional checks have been introduced to ensure that patients are offered food and drink.*

You Said:

A number of concerns were received for a ward with consistent themes/issue around poor communication.

We Did:

The nursing team have been attending communication classes and are taking part in communication simulation training to improve their communication in patient interactions. We will be looking further at the delivery of communication skills training to our staff in 2025/26 .

2. Functioning Speciality Patient and Carer Experience Panels (PACE)

The Trust has eight Speciality Patient Experience Groups who meet regularly, bringing together patient partners, and staff to work collaboratively to review feedback and co-design improvement plans to enhance the experience of care delivered to people accessing services. With an objective to establish two additional groups within 2025/2026.

The Speciality Patient Experience Groups report into the Patient and Carer Experience (PaCE) Panel that is Chaired by the Chief Nurse with a patient partner as Co-Chair.

3. All wards to have a *"you said, we did"* Quality Board

The introduction of new quality boards across the Trust has provided oversight of quality, safety, and patient experience performance indicators in one place. Boards are positioned where people accessing the area can view them, for information and transparency.

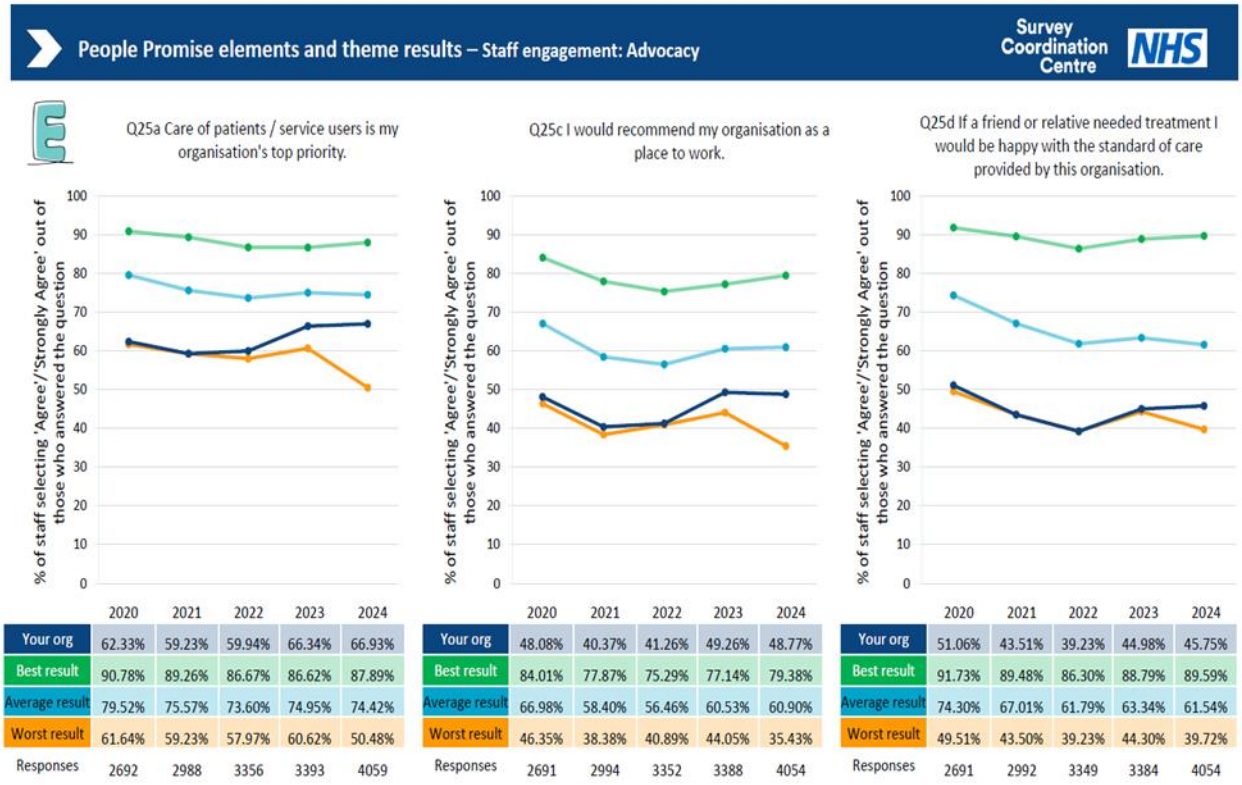
The quality boards include a "You Said, We Did" section, enabling areas to demonstrate actions taken in response to feedback. "You Said, We Did" actions are recorded on Gather, a quality measurement tool used within the Trust, providing a record of how patients, and the people important to them, have been listened to and how each area has responded to the feedback to make improvements within the area.

Feedback can be through any form such as verbal, through FFT, local inpatient survey, PALS, a compliment, or a complaint.

4. Improve our ratings in the national staff survey for the question *"If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation"*

Within the national NHS Staff Survey (2024) for the question; ***"****If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation*", staff reported a slight increase in the percentage who agreed that if a friend or relative needed treatment they would be happy with the standard of care provided by this organisation. Whilst the increase reflects a small increase, the results for the Trust remain below the average but do demonstrate a small incremental improvement year on year since 2022, against the national average which has dropped over the last 2 years, demonstrating that converse to the national average, improvements have been sustained and progressed.

The Trust score, whilst continuing to require further focus, has risen above the lower national parameter (Figure 1).



	2020	2021	2022	2023	2024
Your org	62.33%	59.23%	59.94%	66.34%	66.93%
Best result	90.78%	89.26%	86.67%	86.62%	87.89%
Average result	79.52%	75.57%	73.60%	74.95%	74.42%
Worst result	61.64%	59.23%	57.97%	60.62%	50.48%
Responses	2692	2988	3356	3393	4059

	2020	2021	2022	2023	2024
Your org	48.08%	40.37%	41.26%	49.26%	48.77%
Best result	84.01%	77.87%	75.29%	77.14%	79.38%
Average result	66.98%	58.40%	56.46%	60.53%	60.90%
Worst result	46.35%	38.38%	40.89%	44.05%	35.43%
Responses	2691	2994	3352	3388	4054

	2020	2021	2022	2023	2024
Your org	51.06%	43.51%	39.23%	44.98%	45.75%
Best result	91.73%	89.48%	86.30%	88.79%	89.59%
Average result	74.30%	67.01%	61.79%	63.34%	61.54%
Worst result	49.51%	43.50%	39.23%	44.30%	39.72%
Responses	2691	2992	3349	3384	4054

5. Improve complaint response performance

The new complaints process has helped to ensure that complaints are investigated and responded to in a timely manner with improved senior oversight. Although timeliness of response continues to be a challenge for the Trust, improvements have been made in the length of time that complaints are remaining open for, and number of overdue responses has reduced. For example:

- There has been a 30% reduction in overdue complaints
- There has been a reduction of 15% in the length of time complaints are open for
- Although Urgent and Emergency Care receive the highest number of complaints, the number of overdue complaints for the Emergency Department across both hospital sites has seen a reduction of 50% from August 2024 to end of March 2025.

PRIORITY 8: Improve Quality Standards and demonstrate NICE guidance for Mental Health Training

Our vision is clear: to provide a hospital environment where mental health care is embedded, where restrictive practices are the exception, not the norm and where every patient's dignity, safety, and legal rights are upheld at all times.

What we said we would do

1. Continue to regularly audit the quality of care provided
2. Restrictive intervention audit and monitor through Safeguarding/Governance Groups

What we have achieved

In 2024/25, our focus has remained consistent as we continue to work closely with digital, the ICB, and external partners such as Midlands Partnership Foundation Trust (MPFT) to enhance the quality of information sharing across services.

Areas of focus include risk assessments, the use of restrictive interventions, and the application of the Mental Health Act (1983).

Restrictive Intervention

As part of our ongoing commitment to enhancing the care of patients with mental health the following activities have been undertaken in 2024/25:

- We have relaunched our Mental Health and Restrictive Intervention Pathway to support staff in managing risk, delivering care that is both therapeutic and safe, and ensuring our legal and ethical responsibilities are met, particularly around the use of restrictive interventions and the application of the Mental Health Act (1983). The relaunch reflects our ambition to create a consistently high standard of mental health care within physical health settings, with clear escalation routes, improved multidisciplinary working, and more effective documentation processes.
- We have placed increased emphasis on ensuring that mental health risk assessments are conducted thoroughly, timely, and consistently documented. These assessments are vital in preventing escalation, enabling early intervention, and informing appropriate care planning.
- Quarterly audits on the use of restrictive interventions, such as enhanced observations, physical restraint, and rapid tranquilisation, continue to drive transparency and improvement. These audits highlight both strengths and areas where practice can be enhanced, particularly in the documentation of rationale, patient consent (where possible), duration, and post-incident reflection.

We recognise that documentation remains a key area for improvement, especially in high-pressure environments such as ED and inpatient escalation areas. Work is underway to embed revised templates and checklists into clinical systems, ensuring that staff have user-friendly, legally sound tools to guide and record their actions accurately. These improvements aim to reduce variation, enhance legal defensibility, and support high-quality care reviews.

Mental Health Act Audits

We have continued to regularly audit our compliance with the Mental Health Act. These audits help identify any recurring gaps and track improvements over time, Key themes include:

- Timeliness and accuracy in MHA documentation
- Clear escalation routes when mental health risks emerge
- Appropriate arrangements for patients awaiting assessment

To support improvement, we have introduced some new resources and updated other resources and tools including:

Grab Packs for Mental Health Act - these are tailored grab packs developed by the Clinical Site Manager (CSM) Team for use for both adult and paediatrics. These include a quick reference guidance on MHA procedures aligned with legislation and best clinical practice for the CSM to access.

Standardised Checklists - Checklists have been introduced to ensure that all steps related to the legal and clinical management of patients under the Mental Health Act are completed and recorded appropriately. This supports consistency in care and facilitates handover.

Mental Health Champions – the Mental Health Champions promote mental health awareness, staff support and signposting

Ongoing Training –The Trust has continued to invest in professional development with an increasing focus on de-escalation training, trauma-informed care, and promoting a culture of least restrictive practice. Training includes Mental Health Act training for our CSM team and doctors, de-escalation training for our Enhanced Care Team, Emergency Care staff, Paediatric staff, Mental Health Champions and Security Team.

PRIORITY 9: Improving the care of patients with a learning disability and/or autism cared for in the Trust

What we said we would do

1. Undertake Oliver McGowan training
2. Implement a Learning Disability and Autism Patient and Carer Experience Panel (PACE)
3. Ensure all patients with a Learning Disability have a Patient Passport

What we have achieved

1. Undertake Oliver McGowan training

The Oliver McGowan Mandatory Training on Learning Disability and Autism is the standardised training that was developed for this purpose and is the government's preferred and recommended training for this mandatory training that health and social care staff to are required to undertake.

There are two tiers of training:

- **Tier 1** The Oliver McGowan Mandatory Training is for people who require general awareness of the support autistic people or people with a learning disability may need.
- **Tier 2** The Oliver McGowan Mandatory Training provides more detailed learning for those who may need to provide care and support for autistic people or people with a learning disability.

Throughout 2024/25 staff at SaTH have undertaken the Oliver McGowan e-learning training.

Oliver McGowan Training e-learning 2024/25
86.3%

The Oliver McGowan e-learning is part of Tier 1 and Tier 2 training. For Tier 1 training this is followed by a one hour online interactive session and Tier 2 training is a full day face to face training, which includes training delivered by people with lived experience. The provision of this training in the System has been challenging and there has been limited training sessions available for staff to attend. The Trust has been working as part of the Oliver McGowan Mandatory training STW Stakeholder Group, this Group has been working to determine the best way of delivering this training in 2025/26 and whether this will be a system or local provider model moving forward. In 2025/26 we will aim to achieve >90% compliance with this training.

2. Learning Disability and Autism Patient and Carer Experience Panel (PACE)

A Learning Disabilities (LD) and Autism Patient Experience Group has been established in Quarter 3 of 2024/2025. The group consists of internal and external stakeholders, in addition to patient representatives with lived experience. The purpose of the group is to ensure that the voice of patients, carers, and the public is heard in Trust decision making processes and driving improvements. The group reports into the Patient and Carer Experience (PaCE) Panel, chaired by the Interim Chief Nurse. This panel will play a key role in guiding our improvements next year by providing the essential patient/carer perspectives on the improvement work and whether these are having a positive impact on the care we provide to patients.

3. Patient Passports

A patient passport is a document that helps healthcare staff understand a patient's specific needs and preferences when they are admitted to hospital. People with LD may be admitted with a passport or this may be commenced when they are in hospital by our LD Liaison Nursing team or by SaTH staff and should be used to guide care preferences. The use of these patient passports in the delivery of patient care is not consistent and as a Trust we are committed to improve the use of these and as a consequence improve the individualised care provided to patients with LD and their families.

In December 2024, to ascertain the staffs 'current knowledge base relating to LD patient passports, the Quality Team undertook an LD Patient Passport Ask5 audit on our adult inpatient wards, this involves asking questions to 5 staff in each clinical area.

What is the hospital passport	What will you find in the hospital passport?	Where can you get a blank copy of the hospital passport?	Who would you contact if you needed further information about the patient?	What would you do with the hospital passport?	Have you had the face-to-face learning disability awareness training?	Average
57.9	78.5	45.5	69.4	73.6	6.6	55.2

The results show that only 57.9% of the staff asked knew what a hospital passport was, and of these only 73.6% knew how to use the passport.

Increasing the knowledge and skills of our staff in relation to LD patient passports and working with patients and their families is a key priority for the Trust and will remain one of our 9 key quality priorities in 2025/26, to ensure patients get the individualised care and support they need to meet their care needs.

2.2 STATEMENT OF ASSURANCE FROM THE BOARD

Relevant Health Services and Income

The Shrewsbury and Telford Hospital NHS Trust (SATH) is the main provider of hospital services for Shropshire, Telford and Wrekin and mid Wales. It is an acute teaching hospital working across two main sites - The Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) in Telford. Both hospital sites provide a wide range of acute hospital services including emergency services,

critical care services, diagnostics, outpatients, trauma and orthopaedics and renal dialysis services. Inpatient vascular, general surgery and oncology services are provided at the RSH. Inpatient paediatrics, gynaecology and consultant-led obstetrics services are provided at the PRH. Acute Stroke and Stroke rehabilitation services are also provided at the PRH site. The Trust also provides community and outreach services for dialysis, audiology, therapies and maternity services. Our focus is to ensure our patients receive safe, high quality and effective care.

During 2024/25 the Shrewsbury and Telford Hospital NHS Trust provided a wide spectrum of acute services to NHS patients through our contracts with Integrated Care Board, NHS England and other commissioning organisations to the value of £675.319 million.

The Trust has reviewed the data against the three dimensions of patient experience, patient safety and clinical effectiveness. Where data was available this has been reviewed included:

- Clinical outcomes from local and national audits
- Performance against national targets and standards including those related to the quality and safety of services where this data was available.

To Note: it has not been possible to review all data due to unavailability of some key datasets due to the ongoing challenges with the Data Warehouse.

Statement regarding registration with the Care Quality Commission (CQC)

The Care Quality Commission has not taken enforcement action against the Shrewsbury and Telford Hospital NHS Trust during 2024/25.

The Care Quality Commission (CQC) are the regulators of quality standards within all NHS Trusts. They monitor our standard of care through inspections, patient feedback and other external sources of information.

The CQC publishes which Trusts are compliant with all the essential standards of care they monitor, and which organisations have ‘conditions’ against their services which require improvements to be made. The Trust is required to register with the CQC, and its current registration status is registered.

The CQCs most recent inspection of the Trust took place on 10 and 11 October 2023. The unannounced CQC inspection reviewed core services including End-of-Life Care, Medical Care (including older people’s services) and Urgent and emergency services at both the RSH and PRH. Children and young people and Maternity services at the PRH were also inspected by the CQC. The inspection report was published in May 2024.

The inspection resulted in the following ratings for the 2 hospital sites:

Princess Royal Hospital

Service	Safe	Effective	Caring	Responsive	Well Led	Overall
Medical Care (inc. Older peoples care)	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Children & Young People	Good	Good	Good	Good	Good	Good
Critical Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of Life Care	Good	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Urgent and Emergency Services	Inadequate	Good	Requires Improvement	Inadequate	Requires Improvement	Inadequate
Maternity	Good	Good	Good	Good	Good	Good
Outpatients	Good	Not Rated	Good	Good	Good	Good
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

Royal Shrewsbury Hospital

Service	Safe	Effective	Caring	Responsive	Well Led	Overall
Medical Care (inc. Older peoples care)	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement	Requires Improvement
Critical Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
End of Life Care	Good	Good	Good	Good	Good	Good
Surgery	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Urgent and Emergency Services	Requires Improvement	Good	Requires Improvement	Inadequate	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Not Rated	Good	Requires Improvement	Good	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement

End of Life Care (at both sites) and Children and Young People services moved from a previous overall rating of 'inadequate' in the 2021 inspection to good across all 5 CQC domains and a 'good' rating overall. Maternity services moved from a previous overall rating of 'requires improvement' to green in all 5 CQC domains and an overall rating of 'good'. However, we know that there is still further work to do in our medical and urgent and emergency care services.

Overall, for the Trust, we moved from an overall rating of 'inadequate' to 'requires improvement'. Our services were rated as 'requires improvement' for safe, effective, responsive and well-led and overall 'good' for caring.

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

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

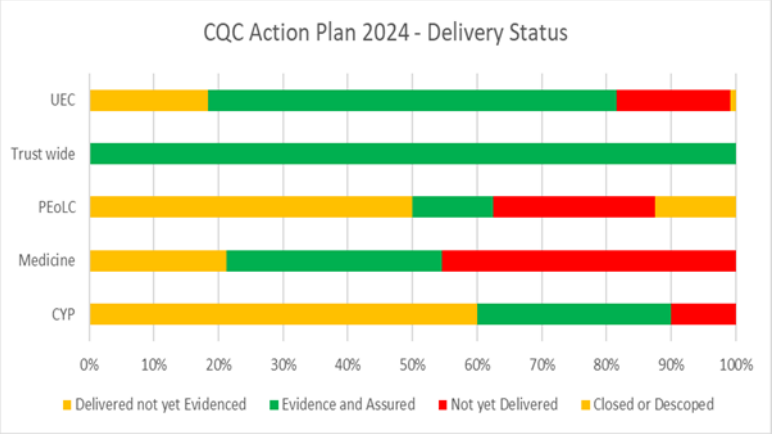
Trust Overall	Safe	Effective	Caring	Responsive	Well Led	Overall
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

The Care Quality Commission has not taken enforcement action against the Trust in 2024- 25 and the Trust has not been subject to any special reviews or investigations by the Care Quality Commission during 2024/25.

Prior to the CQC inspection the Trust had five CQC Section 31 conditions on its registration which were applied against both the Princess Royal Hospital and the Royal Shrewsbury Hospital. Following the inspection the Trust made a successful application to the CQC, and three Section 31 conditions were removed from the Trust's registration. There are 2 conditions which remain in place on the Trust's registration,

these both relate to the initial assessment of all patients and triage of children within 15 minutes in our Emergency Departments.

Throughout 2024/25 there has been ongoing improvement work as part of our new overarching CQC Improvement Plan developed following recent of the CQC Inspection report.



At the end of 2024/25:

- 54.4% of actions are ‘evidenced and assured’
- 22.2% of actions are ‘delivered not yet evidenced.
- 22.2% of actions are ‘not yet delivered’ but with actions progressing for these with
- 1.2% of actions are closed/descoped.

Some of the improvements made include:

- Improvements in the process for follow-up of children who leave the Emergency Department before being seen by a clinician to ensure that there has been no harm as a result of this.
- Improvements in the number of children attending the department who are triaged within 15 minutes
- Improvement in the completion of patient risk assessments on admission to the wards
- Improvements in Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training in Children and Young People services.

We have made improvements in relation to the 2 remaining conditions in place on our registration and will be applying to the CQC in 2025/26 for consideration of these 2 remaining conditions to be varied or removed given the progress we are making.

Participation in Clinical Audit and Confidential Enquires

The Trust aims to use clinical audit as a process to embed clinical quality, implement improvements in patient care, and as a mechanism for providing evidence of assurance about the quality of services.

During 2024/25, 72 national clinical audits and 10 national confidential enquiries were prioritised by the HQIP (Healthcare Quality Improvement Partnership) for Trust's to participate in (where applicable). During that period, SaTH participated in 90**%** (65/72) of the national clinical audits and all *(10/10)* of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that were prioritised for Trusts to participate in are listed in Tables 1 and 2 below. Some examples of actions taken to improve patient care following participation in national audits are listed in Table 3.

Table 1: National Clinical Audits 2024/2025.

Table 1 – national clinical audits 2024/25				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
British Association of Urological Surgeons (BAUS)	Penile Fracture Audit	✓	×	Not applicable, no applicable cases
	I-DUNC (impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard Care of Practices	✓	×	Relevant urologists not invited to participate
	Environmental Lessons learned and Applied to the bladder cancer care pathway audit (ELLA)	✓	×	Not invited to participate
Breast and Cosmetic Implant Registry		×	×	Not applicable
British Hernia Society Registry		✓	×	
Case Mix Programme (CMP) – Intensive Care National Audit and Research Centre (ICNARC)		✓	✓	All eligible cases
Child Health Clinical outcome Review Programme	Emergency surgery in children and young people	✓	✓	Currently in progress
	Juvenile Idiopathic Arthritis	✓	✓	7/7 cases submitted

Table 1 – national clinical audits 2024/25				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
	Testicular torsion	✓	✓	7/9 cases submitted
Cleft Registry and Audit Network (CRANE)		×	×	Referred to specialist centre
Emergency Medicine QIPs:	Adolescent Mental Health	✓	✓	Delayed until 2026
	Care of Older People	✓	✓	Currently in progress
	Time critical medications	✓	✓	Currently in progress
	Mental Health – Self harm	✓	✓	Currently in progress
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies in Children and Young People		✓	✓	Currently in progress
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	✓	✓	All eligible cases
	Inpatient Falls	✓	✓	13/18 submitted to date
	National Hip Fracture Database (NHFD)	✓	✓	All eligible cases
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)		✓	✓	
Maternal, new-born and infant clinical outcome programme (MBRACE)	Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	✓	✓	All eligible cases
	Maternal mortality confidential enquiries	✓	✓	All eligible cases
	Maternal mortality surveillance	✓	✓	All eligible cases
	Perinatal mortality and serious morbidity confidential enquiry	✓	✓	All eligible cases
	Perinatal Mortality Surveillance	✓	✓	All eligible cases
Medical and Surgical Clinical outcome Review Programme (NCEPOD)	Acute Limb Ischaemia	✓	✓	Currently in progress
	Blood Sodium Study	✓	✓	Currently in progress
	Community Acquired Pneumonia	✓	✓	4/13 questionnaires returned

Table 1 – national clinical audits 2024/25				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
	End of Life Care	✓	✓	No data submitted, NCEPOD did not select any cases for the Trust
	Endometriosis	✓	✓	6/13 questionnaires returned
	Managing acute illness people with learning disability	✓	✓	Currently in progress
	Rehabilitation following critical illness	✓	✓	12/12 questionnaires returned
Mental Health Clinical Outcome Review Programme	Real-time data collection of probable suicide deaths by mental health in-patients and patients who died within 14 days of discharge	×	×	Not applicable
	Suicide (& homicide) by people under mental health care	×	×	Not applicable
National Adult Diabetes Audit (NDA)	National Diabetes Core Audit. Includes: - Care Processes and Treatment Targets - Complications & Mortality - Type 1 Diabetes - Learning Disability and Mental Health - Structured Education - Prisons and Secure Mental Health Settings			
	Diabetes Prevention Programme (DPP) Audit			
	National Diabetes Footcare Audit (NDFA)	✓	✓	
	National Diabetes Inpatient Safety Audit (NDISA)	✓	✓	
	National Pregnancy in Diabetes Audit (NPID)	✓	✓	All eligible cases
	Transition (Adolescents and Young Adults) and Young Type 2 Audit			
	Gestational Diabetes Audit	✓	✓	All eligible cases, data is routinely collected via

Table 1 – national clinical audits 2024/25				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
				Maternity Services Data Set (MSDS)
National Audit of Cardiac Rehabilitation		×	×	Not applicable
National Audit of Cardiovascular disease in primary care (CVD Prevent)		×	×	Not applicable
National Audit of Care at the End of Life (NACEL)		✓	✓	Currently in progress
National Audit of Dementia		✓	✓	All eligible
National Bariatric Surgery Registry		✓	✓	13/3/25 & 9/4/25 emailed
National Cancer Audit Collaborating Centre (NATCAN)	National Audit of Metastatic Breast Cancer (NAoMe)	✓	✓	All eligible cases
	National Audit of Primary Breast Cancer (NAoPri)	✓	✓	All eligible cases
	National Bowel Cancer Audit (NBOCA)	✓	✓	All eligible cases
	National Kidney Cancer Audit (NKCA)	✓	✓	All eligible cases
	National Lung Cancer Audit (NLCA)	✓	✓	All eligible cases
	National Non-Hodgkins Lymphoma Audit (NNHLA)	✓	✓	All eligible cases
	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	✓	All eligible cases
	National Ovarian Cancer Audit (NOCA)	✓	✓	All eligible cases
	National Pancreatic Cancer Audit (NPaCA)	✓	✓	All eligible cases
	National Prostate Cancer Audit (NPCA)	✓	✓	All eligible cases
National Cardiac Arrest Audit (NCAA)		✓	✓	All eligible cases
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit	×	×	Not applicable
	Congenital Heart Disease (CHD)	×	×	Not applicable
	National Heart Failure Audit (NHFA)	✓	✓	All eligible cases
	National Audit of Cardiac Rhythm Management (CRM)	×	×	Not applicable

Table 1 – national clinical audits 2024/25				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
	Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	All eligible cases
	National Audit of Percutaneous Coronary Interventions (PCI)	×	×	Not applicable
	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	×	×	Not applicable
	Left Atrial Appendage Occlusion (LAAO) Registry	×	×	Not applicable
	Patent Foramen Ovale Closure (PFOC) Registry	×	×	Not applicable
	National Audit of Mitral Valve Leaflet Repairs (MVLR)	×	×	Not applicable
National child mortality database		✓	✓	All applicable
National Clinical Audit of Psychosis (NCAP)		×	×	Not applicable
National Comparative Audit of Blood Transfusion programme	National Comparative Audit of NICE Quality Standard QS138	✓	✓	All eligible cases
	National Comparative Audit of Bedside Transfusion Practice	✓	×	Time/staffing constraints
National Early Inflammatory Arthritis Audit (NEIAA)		×	×	Not applicable
National Emergency Laparotomy audit (NELA)	Laparotomy	✓	✓	65%
	No Laparotomy	✓	✓	Currently in progress
National Joint Registry (NJR)		✓	✓	All eligible cases
National Major Trauma Registry (NMRT)		✓	✓	All eligible cases
National Maternity and Perinatal Audit (NMPA)		✓	✓	All applicable
National Neonatal Audit Programme (NNAP)		✓	✓	All applicable
National Obesity Audit		✓	✓	Trust not required to submit data, it is extracted from Hospital Episode Statistics Data (HES)
National Ophthalmology Database (NOD)	Age-related Macular Degeneration Audit	✓	✓	
	Cataract Audit	✓	✓	All eligible cases
National Paediatric Diabetes Audit (NPDA)		✓	✓	All eligible cases

Table 1 – national clinical audits 2024/25				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
Perinatal Mortality Review Tool (MBRRACE)		✓	✓	All eligible cases
National audit of Pulmonary Hypertension		×	×	Not applicable
National Respiratory Audit Programme (NRAP)	Adult Asthma Secondary Care	✓	×	Due to staffing issues
	Children and young people asthma secondary care	✓	✓	
	Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	✓	×	Due to staffing issues
	Pulmonary rehabilitation	×	×	Not applicable
National Vascular Registry		✓	✓	All eligible cases
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry		×	×	Not applicable
Paediatric intensive care (PICaNet)		×	×	Not applicable
Perioperative Quality Improvement Programme		✓	×	Capacity issues. Initial plans in place to begin collecting data in collaboration with theatre teams
Prescribing Observatory for Mental Health (POMH-UK)	Rapid Tranquillisation in the context of the pharmacological management of acutely disturbed behaviour	×	×	Not applicable
	The use of melatonin	×	×	Not applicable
	The use of opioids in mental health services	×	×	Not applicable
Quality and Outcomes in Oral and Maxillofacial Surgery	Oncology & Reconstruction			
	Trauma			
	Orthognathic Surgery			
	Non-melanoma skin cancers			
	Oral and Dentoalveolar Surgery			
Sentinel Stroke National Audit Programme (SSNAP)		✓	✓	All eligible cases
Serious Hazards of Transfusion (SHOT): UK National haemo-vigilance scheme		✓	✓	All eligible cases
Society for Acute Medicine's Benchmarking Audit (SAMBA)		✓	✓	All eligible cases

Table 1 – national clinical audits 2024/25			
Title	***Eligible***	***Participating***	***Submission rate (%) / Comment***
UK Cystic Fibrosis Registry	×	×	Not applicable
UK Renal Registry Chronic Kidney Disease Registry	✓	✓	All eligible cases
UK Renal Registry National Acute Kidney Injury Audit	✓	✓	All eligible cases

Based on information available at the time of publication.

Table 2: National Confidential Enquires 2024/2025

Table 2 – National Confidential Enquiries 2024-25 (10)				
Title		***Eligible***	***Participating***	***Submission rate / Comment***
Child Health Clinical outcome Review Programme	*Emergency surgery in children and young people	✓	✓	Currently in progress
	* Juvenile Idiopathic Arthritis	✓	✓	7/7 cases submitted
	* Testicular torsion	✓	✓	7/9 cases submitted
Medical and Surgical Clinical outcome Review Programme (NCEPOD)	*Acute Limb Ischaemia	✓	✓	Currently in progress
	*Blood Sodium Study	✓	✓	Currently in progress
	*Community Acquired Pneumonia	✓	✓	4/13 questionnaires returned
	*End of Life Care	✓	✓	No cases selected for the Trust by NCEPOD
	*Endometriosis	✓	✓	6/13 questionnaires returned

Table 2 – National Confidential Enquiries 2024-25 (10)				
Title		***Eligible***	***Participating***	***Submission rate / Comment***
	*Managing acute illness people with learning disability	✓	✓	Currently in progress
	*Rehabilitation following critical illness	✓	✓	12/12 questionnaires returned

Based on information available at the time of publication.

***Audits on HQIP commissioned NCAPOP List 2024/2025.**

Table 3: Examples of actions taken following national audits

Examples of actions taken following participation in national audits are listed in Table 3 below.

Table 3 - Examples of actions taken following National audits	
Title	***Action / Outcome***
Myocardial Ischaemia National Audit (MINAP)	• A dedicated proforma /pathway for patient presenting with ACS (Acute Coronary Syndrome) has been designed and implemented to improve care and outcomes for these patients
National Asthma & COPD audit programme (NACAP); secondary care workstream - children & young people asthma	• The Respiratory Nurse Specialist Team now deliver training sessions for new nurses starting on the paediatric ward • PAWZ (Paediatric Asthma and Wheeze) document has been implemented, with an ongoing teaching programme to ensure appropriate assessment and treatment • A new triage document has been introduced to prompt administration of steroids within one hour and support with regular medication adherence

Table 3 - Examples of actions taken following National audits	
Title	***Action / Outcome***
UK Comparative audit of Acute Upper Gastrointestinal Bleeding (AUGIB) and the use of blood	• The Trust had a 3% mortality rate compared to 8.7% nationally, despite our patients being older with more comorbidity. More patients treated at the Trust were risk-assessed and had care bundles completed than the national average • The SaTH AUGIB clerking document including a care bundle has been relaunched
Testicular Torsion (NCEPOD)	• The audit showed satisfactory compliance with the audit standards
National Comparative Audit of NICE Quality Standard QS138 (2023)	• The audit showed that patients were not always receiving both verbal and written information. Further staff education has been delivered to improve this
Dementia audit - PRH 2023	• A business case is in progress to ensure that Specialist dementia staff are available 7 days per week across both sites • Dementia champions programme has been relaunched across all clinical areas
The Society of Acute Medicine Benchmarking audit (SAMBA)	• SaTH performed very well across the SAMBA benchmark indicators compared to the national averages
MAGPIES – Mapping Global Surgery	• Audit showed good compliance with the audit standards. No further action required
Care of Elderly people in ED – Royal College of Emergency Medicine (RCEM) – Quality Improvement Project (QIP) May 2023- September 2024 - RSH	• The frailty score has been incorporated as a mandatory requirement in the new ED electronic documentation • A poster has been displayed in ED to prompt clinicians of potential causes of delirium
Care of Elderly people in ED - RCEM – QIP 04th October 2023 to 03rd October 2024 - PRH	• To ensure documentation of Delirium screening, falls risk assessment and frailty assessment with interventions these elements have been made mandatory in care flow

Table 3 - Examples of actions taken following National audits	
Title	***Action / Outcome***
Fracture Liaison Service Database	• New moving and handling assessment implemented to support the bedside vision project aiming to keep patients more active in hospital • The accompanying policy has been updated to improve patient assessment

Based on information available at the time of publication.

Table 4: Trust Local Audits

The Trust also undertook 294 local audits, shown in Table 4 below:

TABLE 4 – Trust local audits 2024-25		
CLINICAL SUPPORT SERVICES – PATHOLOGY		
No.	**Audit Title**	**Key actions/improvements following audit**
6017	Evaluating the Histopathological Adequacy of Surgical Margins in Head and Neck Skin Cancer Excision	• Excision margins not always adequate potentially requiring further excision • The Trust have adopted the new National Comprehensive Cancer Network (NCCN) guidelines • Loop magnification introduced
6059	Vulval specimens	• Specimens were not always categorised into HPV-a and HPV-i • A VIN mini-proforma has now been implemented & the Vulva SCC proforma was updated to improve categorisation
6060	Testis specimens at SATH and review of the tertiary referral pathway	• Not all relevant patients were referred to tertiary centre • Cases are now reviewed by 2 consultants before being listed for discussion that the Multi Disciplinary Team (MDT) meeting, ensuring timely and appropriate referral

TABLE 4 – Trust local audits 2024-25		
5495	High Grade Dysplasia in BCSP polyps for Q2/3	• Audit showed all eligible cases compliance with recording of Bowel Cancer Screening Programme BCSP dataset items
6005	Coeliac testing cascade	• No recommendations required. Audit showed compliance with the audit standards
CLINICAL SUPPORT SERVICES – RADIOLOGY		
No.	**Audit Title**	**Key actions/improvements following audit**
5990	Optimization of MRI lumbar and sacral spine protocol in patients with possible nerve root compression or cauda equina syndrome - re-audit	• The audit showed a 5% improvement with the standards. • The MR protocol has been modified to improve results further
5992	CT colonography 2023	• The results showed good compliance with the audit standards
5900	Audit of CT colonography 2023 (CTVC)	• The audited demonstrated compliance with national Bowel Cancer Screening Programme (BCSP) requirements
6167	Thyroid u-scoring and subsequent fine needle aspiration cytology - re-audit	• Following implementation of recommendations from the previous audit, this re-audit showed all eligible cases compliance with British Thyroid Society Guidelines.
CLINICAL SUPPORT SERVICES – THERAPIES		
No.	**Audit Title**	**Key actions/improvements following audit**
5690	Retrospective review of spinal patient notes against NICE guideline NG59	• The audit demonstrated compliance with NICE recommendations for the management of low back pain.
CORPORATE – TRUST WIDE		
No.	**Audit Title**	**Key actions/improvements following audit**
5677	Swan Model of Care - re-audit	• The 2024 re-audit results show an overall improvement compared to the 2022 audit

TABLE 4 – Trust local audits 2024-25		
		• Additional funding was secured to replace damaged or missing mood lights
5520 & 5664	Policy for the use of the ReSPECT form - June 2023	• The Respect Me campaign has successfully introduced the Respect package across the wards.
SURGERY, ANAESTHETICS & CANCER – THEATRES, ANAESTHETICS & CRITICAL CARE		
No.		**Key actions/improvements following audit**
5926	Anaesthetic case note PRH 2023 & 2024	• A training programme for estimation of blood loss is being delivered throughout 2025
5742	General anaesthesia in obstetrics 2024	• New drug trollies, changes to drug rounds and work with Pharmacy regarding drugs to take home (TTO's) have been introduced.
5892	Obstetric Theatre Cases 2023	• Good compliance with the audit standards demonstrated. No further actions required
5697	Anaesthetic Management of Spina Bifida in the Obstetric Anaesthetic Clinic	• Good compliance with the audit standards demonstrated. No further actions required.
5698	Remifentanil patient controlled analgesia (PCA) During Labour	• Good compliance with the audit standards demonstrated. No further actions required.
5644	Obstetric Anaesthetic Clinical Documentation Audit 2023	• Good compliance with the audit standards demonstrated. No further actions required.
5587	Peripartum Hyponatraemia	• Hyponatraemia guidelines have been introduced
5581	Staffing Level Requirements in Obstetric Anaesthesia	• There was all eligible cases cover of out-of-hours weekday and weekend work by both resident duty anaesthetists and non-resident consultant on-call anaesthetists.
SURGERY, ANAESTHETICS & CANCER – HEAD & NECK AND OPHTHALMOLOGY		

TABLE 4 – Trust local audits 2024-25		
No.	**Audit Title**	**Key actions/improvements following audit**
6050	Retrospective audit on Pterygium recurrence following primary surgery at SATH	• No major complications in the last 9 years.
5447	Aflibercept for diabetic macular oedema TAG346	• Good compliance with the audit standards demonstrated. No further actions required
5768	Post op care of Total Thyroidectomy	• The guidelines were updated to improve compliance and will be re-audited in 2025
5779	AHP Intravitreal injection service audit	• Current rate of adverse events has improved since the previous audit in 2021 and is lower than average
5450	Post Op Complications in Powered Microdebrider Turbinoplasty IPG498	• The audit showed good compliance with NICE guidance and that Microdebrider turbinoplasty is safe and effective.
6181	Self-reflective audit on Tonsillectomy	• Patient information resources have been updated to provide advice on symptom relief and reiterate the importance of regular analgesia for 7-10 days.
SURGERY, ANAESTHETICS & CANCER – TRAUMA & ORTHOPAEDIC		
No.	**Audit Title**	**Key actions/improvements following audit**
5591	Joint replacement (primary): hip, knee and shoulder - NICE NG157	• Revised Consent forms for hip and Knee arthroplasty including all relevant information implemented
5658	Mortality from tibial fractures in the elderly	• Good compliance with the audit standards demonstrated. No further actions required
5933	Outcome of hyaluronic acid injections to the knee	• Good compliance with the audit standards demonstrated. No further actions required
5818	Casenotes & Stamp Audit - 2024 (Jun-23 patients) – PRH	• This re-audit showed improvements in documentation since implementation

TABLE 4 – Trust local audits 2024-25		
		of recommendations from the previous audit. • To continue to monitor via audit.
5640	Confusion screen and Vit D - re-audit	• Re-audit showed significant improvement in testing within 24hrs of admission
5250	Chest wall trauma: pain management	• Good compliance with the audit standards demonstrated. No further actions required
SURGERY, ANAESTHETICS & CANCER – SURGERY		
No.	**Audit Title**	**Key actions/improvements following audit**
5866	Renal and ureteric stones: assessment and management - NICE NG118 & QS195	• Good compliance with the audit standards demonstrated. No further actions required
5885	Rapid Jaundice Pathway	• Good compliance with the audit standards demonstrated. No further actions required.
5853	Urology OTD Theatre Cancellation - re-audit	• The re-audit has shown a significant overall reduction in cancellations, leading to increased theatre utilisation following implementation of recommendations from the previous audit.
5518	Faecal incontinence - CG49 & Faecal incontinence - QS54	• SaTH compares well against the national standards. • A pelvic floor proforma has been devised to clearly document all assessments and discussions of available options
4944	Varicose veins in the legs re-audit - CG168 & QS67	• Re-audit shows the Trust is compliant with all recommendations in NICE clinical guideline CG168. • A re-audit is planned.
SURGERY, ANAESTHETICS & CANCER – ONCOLOGY & HAEMATOLOGY		
No.	**Audit Title**	**Key actions/improvements following audit**

TABLE 4 – Trust local audits 2024-25		
6122	Palliative mortality – 428	• Good compliance with the audit standards demonstrated. No further actions required
6127	Anal consistency audit- 433	• Good compliance with the audit standards demonstrated. No further actions required
6132	Lung consistency audit – 438	• The standard of image matching was very high and there was very little interobserver error.
5444	Abemaciclib with fulvestrant for treating hormone receptor-positive, HER2-negative advanced breast cancer after endocrine therapy - TAG725	• Abemaciclib is being used in accordance with the NICE guidelines.
5777	Sickle cell acute painful episode - NICE CG143	• Audit identified a need for improvement in documentation of pain control, education and psychological support. A Sickle Cell nurse being recruited • A patient passport has been developed
5914	Use of antiemetics in RT for spinal treatments- 412	• Guidance on medication levels for this group of patients has been reviewed and the policy changed accordingly
MEDICINE & EMERGENCY CARE – EMERGENCY CARE		
No.	**Audit Title**	**Key actions/improvements following audit**
6037	Emergency Department Documentation audit 2024	• Re-audit showed that documentation has significantly improved since the trust moved over to CareFlow.
5490	Transfusion-associated circulatory overload pre-transfusion clinical assessment (TACO)	• To help reduce the risk of errors, a copy of the TACO checklist has been added to the blood transfusion request.
MEDICINE & EMERGENCY CARE – MEDICINE		
No.	**Audit Title**	**Key actions/improvements following audit**
6104	Bone protection in patients with falls/fractures	• The audit showed good compliance within the Care of the Elderly specialty,

TABLE 4 – Trust local audits 2024-25		
		with room for improvement in other areas. • Checklist stickers have been introduced to prompt staff
5810	Medical handover re-audit	• Re-audit showed improvements in several key areas of the handover process in line with RCP guidance following previous audit interventions
6057	Re-audit of antibiotic prescription & review	• The re-audit showed significant improvements following additional education.
5874	In-patients with diabetes and foot complications	• New document has been introduced on the wards to increase number of patients having foot assessment and referral to the Team. • Education programme rolled out for HCA's and Nurses
WOMEN & CHILDREN'S – GYNAECOLOGY		
No.	**Audit Title**	**Key actions/improvements following audit**
5819	Penthrox audit (QIP)	• Data forms have been updated to improve documentation of timing of Penthrox administration
WOMEN & CHILDREN'S – NEONATOLOGY		
No.	**Audit Title**	**Key actions/improvements following audit**
5630	Completion of periperm passports	• Re-audit shows an in the awareness of passports and distribution and completion of these
WOMEN & CHILDREN'S – OBSTETRICS		
No.	**Audit Title**	**Key actions/improvements following audit**
5770	Tongue Tie (Ankyloglossia) Management in the Newborn for breastfeeding (Including referral for frenulotomy)	• Good compliance with the audit standards demonstrated. No further actions required
5864	Maternity care of Pregnant Young People (under the age of 20 years) – 197	• Good compliance with the audit standards demonstrated. No further actions required

TABLE 4 – Trust local audits 2024-25		
5725	Cord Prolapse - 029 (2)	• Good compliance with the audit standards demonstrated. No further actions required
5643	Dating Scan/Nuchal Translucency Measurement Guideline – 181	• Good compliance with the audit standards demonstrated. No further actions required
5862	Influenza vaccine in pregnancy - 023 (2)	• All women included in the audit were offered the vaccine • Education delivered on documentation
5623	Determination of signs of life following spontaneous birth before 24+0weeks of gestational age where, following discussion with the parents, active survival-focused care is not appropriate – 108	• Midwifery mandatory day 5 bereavement training package has been updated
5260	Caesarean Section - NICE NG192 & QS32	• Good compliance with the audit standards demonstrated. No further actions required
5726	Discharge from Maternity to Local Authority Care (Foster Care) - 049 (re-audit)	• The findings of the re-audit have shown a considerable improvement.
5797	SBL Continuous Electronic Fetal Monitoring in Labour – Quarter 4 2023-24	• An annual fetal monitoring day for all midwives and Obstetricians has been set up • CTG reviews sessions to aide continuous learning are ongoing
5449	Refusal of Blood Products 2023	• Areas of improvement in existing guideline identified - updated with Checklist for patients refusing transfusion
5309	Obstetric Triage Re-audit (Previous audit M3004)	• Re-audit shows an increase in compliance in comparison with the 2021 audit across several standards. • The Badgernet system has been embedded
5550	SBL Continuous Electronic Fetal Monitoring in Labour – Quarter 2 2023-24	• To improve assessment 30 minutes after the CTG has been commenced, stickers have been produced and

TABLE 4 – Trust local audits 2024-25		
		attached to cards on CTG machines of delivery suite to remind staff.
5509	Screening – antenatal (maternal) including processing of test results	• Low risk results letters are now scanned onto the woman's Badgernet records at time of sending to the woman to evidence completion.
5654	Booking for Maternity Care (inc. Referral for Care) – 012	• An "early bird booking clinic" run by MSWs to allow access to the service by 10 weeks has been implemented
6183	Pregnant Women with a Learning Disability	• Good compliance with the audit standards demonstrated. No further actions required
WOMEN & CHILDREN'S – PAEDIATRICS		
No.	**Audit Title**	**Key actions/improvements following audit**
5679	Paediatric endoscopy service evaluation	• Good compliance with the audit standards demonstrated. No further actions required
5930	Gastro-oesophageal reflux disease: recognition, diagnosis and management in children and young people - NICE NG1 & Gastro-oesophageal reflux in children and young people - QS112	• Good compliance with the audit standards demonstrated. No further actions required

Clinical Audit Outcomes

The reports of 294 clinical audits were reviewed by the provider and a compliance rating against the standards audited agreed. However, 25 (8%) of these local audits demonstrated significant non-compliance with the standards audited (compared to 14% for 2022/2023). On completion of the audit, the lead auditor fills in a sign-off form with the audit conclusions, recommendations, and action plan. This includes an overall rating of compliance with the standards audited. Significant non-compliance is rated as red and denotes less than 50% overall compliance with the standards audit. These are reported to the specialty governance meetings and divisional governance meetings and then through to the Quality Operational Committee chaired by the Medical Director. SaTH intends to take actions to improve the quality of healthcare provided and will consider re-audit against these standards once actions have been appropriately embedded. These audits are listed in table 5.

Table 5 – audits demonstrating significant non-compliance with standards audited (N=20)

Table 5 – audits demonstrating significant non-compliance with standards audited		
CLINICAL SUPPORT – PATHOLOGY		
No.	**Audit Title**	**Recommendations - actions**
6059	Vulval specimens	• Specimens were not always categorised into HPV-a and HPV-i • A VIN mini-proforma has now been implemented & the Vulva SCC proforma was updated to improve categorisation
CLINICAL SUPPORT – RADIOLOGY		
No.	**Audit Title**	**Recommendations - actions**
5988	Radiology Department Preparedness and knowledge on the management of mild to severe contrast medium reactions	• To ensure staff knowledge of RCR guidelines for managing contrast reactions, printed copies of the guidance were circulated • An ongoing awareness programme educate staff on guidelines is being delivered
6044	Reporting of incidental cardiac calcification on thoracic CT	• To improve awareness, further education has been provided
CLINICAL SUPPORT – THERAPIES		
No.	**Audit Title**	**Recommendations - actions**
5778	Physiotherapy Compliance with Hip Sprint at The Princess Royal Hospital	• Data collection errors were identified and further audit is underway
SURGERY - HEAD, NECK AND OPHTHALMOLOGY		
No.	**Audit Title**	**Recommendations - actions**
5987	Monitoring glucose level in patients with odontogenic sepsis	• An education programme based on BMJ Best Practice: Sepsis in adult guidelines is being delivered
SURGERY – MSK		
No.	**Audit Title**	**Recommendations - actions**

Table 5 – audits demonstrating significant non-compliance with standards audited		
5610	Photographs for Open fracture	• Feedback has been provided to doctors and guidance on appropriate documentation has been provided • A re-audit will be carried out in 2025
5953	Mobilisation and weight bearing after orthopaedic surgery/musculoskeletal injury	• New guidelines are being introduced at a national and local level. A re-audit will be carried out following implementation
6079	Neck of Femur (NOF) Fractures Audit	• Measures implemented to ensure surgery is carried out within required timeframe including "Golden patient" for trauma theatre the next day (NOF patients given priority). • Re-audit planned for 2025 to check compliance rates and close the audit loop.
SURGERY – SURGERY		
No.	**Audit Title**	**Recommendations - actions**
5628	Compliance with Trust VTE policy on acute surgical take	• Education and training and display of a poster implemented to emphasise importance of best practice VTE prescribing
5971	One year outcome of patients with Diverticular Disease	• The audit highlighted that some colonoscopies were carried out unnecessarily. Colonoscopies are no longer carried out for uncomplicated diverticulitis
6035	Photo documentation of Rectal Retroflexion in Flexible sigmoidoscopy/colonoscopy: Are we doing it properly?	• To ensure that two images are taken at least 90 degrees apart, posters have been displayed in all endoscopy rooms, and guidance has been issued in the Endoscopy Datix Matters newsletter.

Table 5 – audits demonstrating significant non-compliance with standards audited		
SURGERY – UROLOGY		
No.	**Audit Title**	**Recommendations - actions**
5878	Status of Proper documentation post urethral catheter insertion	• Education delivered to improve documentation after urethral catheter placement
MEDICINE – EMERGENCY MEDICINE		
No.	**Audit Title**	**Recommendations - actions**
5490	Transfusion-associated circulatory overload pre-transfusion clinical assessment (TACO)	• To help reduce the risk of errors, a copy of the TACO checklist has been added to the blood transfusion request
5998	Polytrauma CT scan timing in ED at SaTH	• Education delivered to ensure all patients falling under the polytrauma category should have a CT trauma scan requested after appropriate clinical assessment with no delay in assessment and scanning aiming for 1 hour • Reminders regularly be added to message of the week.
6046	RCEM: Mental Health 2024	• Further information being obtained to support targeted improvements in non-compliant areas
MEDICINE		
No.	**Audit Title**	**Recommendations - actions**
4688	Myocardial Ischaemia National Audit (MINAP) - Oct 23 - Dec 23	• A dedicated proforma /pathway for patient presenting with ACS (Acute Coronary Syndrome) has been designed and implemented to improve care and outcomes for this group of patients
5874	In-patients with diabetes and foot complications	• New document has been introduced on the wards to increase number of patients having foot

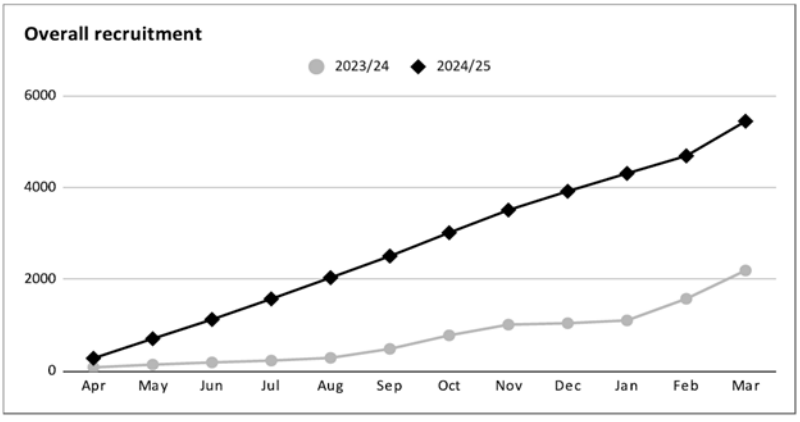
Table 5 – audits demonstrating significant non-compliance with standards audited		
		assessment and referral to the Team. • Education programme rolled out for HCA's and Nurses
5897	Accurate antibiotics prescription & review	• To improve standards of anti-microbial prescribing, morning messages have been sent using the Junior doctors WhatsApp group • Posters have been distributing throughout medical wards
5961	Safer Opioid Prescribing - re-audit	• To ensure we follow WHO stepladder pattern for analgesic prescription, teaching sessions have taken place
5995	QIP on patients being discharged on Lansoprazole indefinitely following stroke	• Education sessions are planned to improve compliance.
6036	VTE risk assessment completion	• Non-compliance within 24 hours of admission remains poor. The post-take leadership team have been asked to reinforce the importance of the assessment.
6104	Bone protection in patients with falls/fractures	• The audit showed good compliance within the Care of the Elderly specialty, with room for improvement in other areas. • Checklist stickers have been introduced to prompt staff
WOMEN & CHILDREN'S		
No.	**Audit Title**	**Recommendations - actions**
5434	Pregnancy and Complex Social Factors - NICE CG110	• Bespoke training for Early Health Assessments is being delivered by the Local Authority • To ensure that all pregnant women have a named Community Midwife

Table 5 – audits demonstrating significant non-compliance with standards audited		
		this is now a mandatory field on Badgernet
6024	VTE assessment and management of antenatal and postnatal patients at admission	• To ensure VTE risks, results and actions appropriately completed on Badgernet, staff information has been developed and circulated
6020	Deteriorating Pregnant Adult and Maternal Collapse Guideline – 4023	• A significant escalation risk has been identified and recorded in the maternity risk register • Use of the new national MEOWS audit format has been implemented • A whiteboard system has been implemented in each clinical area to allow oversight of MEOWS in rooms from outside. • Escalation posters have been designed to show pathways for escalation in clinical areas

Research and Innovation

The Research and Innovation (R&I) Department have introduced a co-produced Strategy and Vision focus on the following 5 objectives to ensure that R&I are contributing to the quality initiatives at SaTH:

Objective 1: To provide access to good quality research & innovation and embed an R&I Culture across SATH



The R&I Team have recruited over 5000 participants across 17 Speciality areas this year, reflecting a significant increase in portfolio research.

This also does not include the 669 patients recruited through the TRIOMIC colorectal cancer study as well. We continue to put patients at the heart of what we do, having developed a PPIE strategy this year and continued to develop the engagement with local communities with Blossom Lake's projects.

Objective 2: To develop Trust's staff in order to design, deliver and implement R&I in practice.

- The SaTH Education Research Innovation & Improvement week is currently being developed from 16th May, with the R&I externally sponsored conference launching the week.
- The Research across SaTH group has continued to meet this year with the objective of ensuring a research culture is embedded across all professions and specialities. The focus has especially been on incorporating research into trainee courses at the start of professional journeys alongside induction and also the consultant welcome. The group has also launched the Advanced Care Practitioner (ACP) research toolkit across the Trust.
- R&I have actively supported a number of high-profile grant application including National Institute for Health and Care Research (NIHR) programmes.
- The TRIOMIC Origin Sciences project lead by Jon Lacy Colson started recruiting in November 2024. The study aims to significantly cut waiting times and reduce anxiety associated with a colorectal cancer diagnosis. As part of the study a new test is being developed to minimize the need for invasive colonoscopies. We are awaiting the capital investment changes to be made to the building at Hollingswood House to allow a dedicated space to deliver this colorectal 2 week wait pathway service outside of the hospital setting. The study is already reflecting a positive outcome on patient experience and time to being offered an appointment.

Objective 3: Quality improvement at the heart of what we do, ensuring patient feedback is acted upon

- The amount of service evaluations being conducted within the Trust has increased again this year and this reflects the culture shift towards research, education and improvement across the Trust.
- R&I are working collaboratively with the SaTH Improvement Team and have the celebration week coming up in May 2025.
- The R&I team continue to share practice and support projects across the Trust
- Internally, R&I continue to act upon participants in research survey feedback and plan to run another patient focused thank you event in May 2025 off the back of this feedback.

Objective 4: To actively support the Trust strategic aims and build on internal relationships

- Supported the 'Getting to Good' workstream through ensuring patients have access to new innovative treatments and that outcomes of studies are translated back into practice at SATH. The R&I team were interview and given positive feedback as part of the CQC well-led inspection.
- R&I continue to work closely across the Trust with pharmacy, radiology, radiotherapy and pathology to review and set-up studies safely and efficiently. Some gaps have been highlighted in radiology, and we are working in collaboration to ensure that our processes are fit for purpose and ensure safe and effective set-up of studies.

Objective 5: To build on external relationships (commercial companies, Clinical Research Network (CRN), University Keele etc.) in order to undertake further research and generate further income

- We continue to build on our relationships with Keele University and have been supporting the development and submission of our university hospital status application
- Commercial trials set-up has been slow this year, mainly due to sponsor delays. Despite this, SaTH has the potential of two vaccine trials in the pipeline for 2025/26 offering great treatment and prevention choices for our community.

Data Security and Protection Toolkit Attainment

The Data Security and Protection Toolkit is an online self-assessment tool that allows an organisation to measure their performance against the National Data Guidance's 10 data security standards. This is facilitated via NHS Digital. Compliance with the DSP Toolkit requires organisations to demonstrate that they are implementing the 10 data security standards recommended by the National Data Guardian Review as well as complying with the requirements of the General Data Protection Requirements (GDPR). All organisations that have access to NHS patient data and system must use this toolkit to provide assurance, on a yearly basis, that they are practicing good data security, and that personal information is handled correctly.

The DSPT submission for 2023/24, independently audited by our 3rd Part Auditor is (MIAA) achieved compliance '***Standards Met'***.

The Trust is due to submit its 24/25 submission in June 2025.

Implementing the Priority Clinical Standards for Seven Day Hospital Services

There are four priority Standards for Seven Day Hospital Services:

- Standard 2: Time to Consultant review
- Standard 5: Access to diagnostics

- Standard 6: Access to Consultant directed interventions
- Standard 8: Ongoing review

SaTH is partially compliant with the standards but still faces challenges in achieving these. The mitigations in place are increased Consultants at weekends, 56% increase in medical staff since 2019 and improvements in recruitment in Consultants and SAS doctors in Emergency Medicine. The Trust has an expectation to fully deliver these standards once the Hospital Transformation Programme has been delivered.

Learning from Deaths

The Shrewsbury and Telford Hospital NHS Trust (SaTH) considers mortality to be an important metric relating to the quality of services provided within the organisation. Quantitative and qualitative data is reviewed within the Learning from Deaths agenda including feedback provided from those who have been bereaved. The identification of both positive and negative learning contributes to wider improvement activity across the Trust including focused work relating to key safety priorities within the Patient Safety Incident Response Framework (PSIRF).

Oversight of all deaths across the Trust is provided through a weekly operational mortality meeting called the Mortality Triangulation Group (MTG). Mortality Screening and the use of Structured Judgement Review methodology is available to identify learning for adult deaths. Deaths of children are reviewed using the Child Death Overview Panel (CDOP) processes and, where appropriate, the Perinatal Mortality Review Tool (PMRT). When patient safety concerns are identified through the Learning from Deaths agenda, these are referred for management through the patient safety incident response system within the Trust.

Summary of mortality across the Trust

During 2024-2025, there were 2114 adult and child deaths recorded by the Medical Examiner Service within the Trust. Of these, approximately 82% were within the Medicine and Emergency Care Division, 18. % were within the Surgery and Cancer Care Division and 0.3% were within the Women and Children's Division. Inpatient deaths accounted for 81% of all deaths across the Trust, with the remaining 19% occurring within the Emergency Department, which includes deaths where a decision to admit the patient to a ward had been made but a delay in transferring the patient has been encountered. The distribution of deaths across the Trust in terms of inpatient / ED split and divisional data is broadly in line with 2023-2024.

In accordance with the national guidance relating to national-guidance-learning-from-deaths (NHS England, 2017) all patients the Trust identifies who have died with a confirmed learning disability or autism are reported externally to the national service improvement programme commissioned by NHS England called 'Learning from Lives – People with Learning Disability and Autistic People' (LeDeR). A mandated review of the care provided prior to the death is undertaken by clinicians within the Trust and used to inform the wider LeDeR

review which is completed externally. A mandated review of care is also undertaken for all patients who die with a confirmed serious mental illness.

During 2024-2025, 17 patients have died with a confirmed learning disability or autism and 11 patients have died with a serious mental illness which was confirmed by the specialist mental health nurse in the Trust.

There have been 7 deaths reported to the Board of Directors that were deemed more likely than not due to problems in healthcare and therefore potentially avoidable. Learning from these cases is presented at the Trust Review Actions and Learning from Incidents Group (RALIG) forum and relevant action plans are managed through the Divisional Quality Governance Teams. Learning from these investigations has included:

- Management of non-invasive ventilation
- Management of ambulance offload delays and capacity and flow within the Emergency Department
- Management of diabetes including staff education
- Management and oversight of the nutritional status of patients including fluid balance
- Bowel management
- Impact of multiple clinical teams reviewing patients and overall clinical 'story' being lost
- Listening to concerns raised by families
- Communication between clinical teams and with families

During 2024-2025 we said we would...

- Sustain the improvements made during 2023-2024 relating to Structured Judgement Review (SJR) completion
- Establish a wider multi-disciplinary team approach to SJR completion and the learning from deaths processes
- In collaboration with the Performance Team, continue to refine the Learning from Deaths Dashboard to include ward level mortality data and an enhanced dataset within the emergency department including deaths that occur in the emergency department following a decision to admit to a ward
- Continue to develop and sustain the regular programme of training and support available for SJR reviewers.

What we did during 2024-2025

- Maintained SJR completion in line with locally agreed targets. 14.6% of all deaths across the organisation were reviewed using SJR methodology against a target of 15% and 77% of the reviews were completed within 8 weeks of the patient's death, ensuring that learning identified is both relevant and actionable.

- Trained one additional senior nurse who is now a member of the reviewing team on an ad-hoc basis whilst maintaining a substantive position in the organisation. Establishing a wider multi-disciplinary team approach to SJR completion has been challenging over the 12-months due to resource challenges.
- In collaboration with the Performance Team and relevant clinical colleagues, the development of a 30-day mortality dashboard has progressed. This includes a review of the dataset required to support the oversight of mortality in the Emergency Department incorporating patients who have experienced delays and who die in the Emergency Department following a decision to admit to a ward. Progress with this work has been impacted by the Data Warehouse challenges and there is additional interdependency with planned upgrades to the Emergency Care Data Set (ECDS) which is coordinated by the Information Technology team.
- Re-established regular support and training for SJR reviewers to promote high quality SJR reviews Identified additional opportunities within the multi-disciplinary clinical teams to share learning arising from SJRs using 'simulation' training exercises based on real-life scenarios. Through the weekly Trust Mortality Triangulation Group (MTG), facilitated 276 learning opportunities with internal stakeholders and 99 with external stakeholders. Learning from Excellence certificates have been distributed to 89 individuals / clinical teams to further support a positive culture of learning across the organization.

Some of the key improvement targets and actions to be taken for 2025-2026

- Finalise and develop an appropriate dataset to support the review of mortality within the Emergency Department including a dashboard relating to 30-day mortality including where delays have been experienced.
- Review thematic analysis of identified learning from the MTG and SJR processes to promote consistency internally and within the wider PSIRF agenda, and to inform quality improvement initiatives within the organisation.
- Review and further develop the regular programme of training and support relating to learning from deaths which is available for SJR reviewers and the wider clinical teams within the organisation.
- Continue to explore and develop wider opportunities to learn from excellence identified through the learning from deaths agenda in collaboration with the wider Patient Safety Specialist teams and Divisional colleagues.

Medical Examiner Service

The Medical Examiner Service aims to review 100% of deaths that occur on both our hospital sites and issue Medical Certificate of Cause of Death (MCCD) for non-coronial cases within three calendar days to facilitate timely registration. This performance is measured on a quarterly basis to the national Medical Examiner, NHSE and is reported to the Trust Board. It is also monitored monthly following the development of a Medical Examiner performance dashboard, which is presented at the monthly Learning from Deaths meeting.

During 2024/25 the Medical Examiner service has undertaken reviews of 2094 hospital deaths which is 99% of the total deaths that occurred in the Trust during this period. The deaths not reviewed by the ME will have been reported to the Coroner prior to ME review.

Encouraging Staff to Speak Up

Freedom to Speak Up

The Freedom to Speak Up (FTSU) team is made up of a FTSU Lead and one FTSU Guardian. Supporting the team are approximately 40 ambassadors and growing whose role is to promote FTSU and signpost colleagues whose experience ranges from a variety of clinical and non-clinical backgrounds and who represent the diversity of the workforce across our Trust. The ambassadors undertake these roles on a voluntary basis in addition to their substantive posts.

During 2024/25, 218 contacts were raised to the FTSU team, only one higher than last year.

FTSU concerns raised by quarter and year

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

During 2024/25, 33% of the concerns brought to the attention of our FTSU teams had elements of worker safety and wellbeing; 28% of concerns raised were relating to inappropriate behaviours/attitudes; 21% of concerns were associated with systems and processes; 8% to bullying and harassment and 8% related to concerns about patient safety.

Of those speaking up, 23% were nurses and midwifery registered; 22% administrative colleagues; 21% additional clinical services; 11% allied health professionals; 10% medical and dental; 6% estates and ancillary; 6% unknown or other; and 2% healthcare scientists.

In the 2024/25 Staff Survey, raising concerns questions overall remained the same as last year. Those for clinical safety increased slightly and those for raising concerns about anything else decreased slightly.

Guardians of Safe Working

The Shrewsbury and Telford Hospital NHS Trust Guardian of Safe Working (GoSW) remains a member of, and regularly reports to the Medical Leadership Team.

The Shrewsbury and Telford Hospital NHS Trust Guardian of Safe Working (GoSW) In the past year has focused on:

- Supporting resident doctors and locally employed doctors maintaining visibility via attendance at forums, induction, and at drop-in sessions
- Continuing to champion safe working hours through regular meetings with key stakeholders
- Highlighting the importance of and promoting the use of a robust e-rostering software to enable visibility of safe working at all times
- Optimising the administrative processes to enable compliance with the exception reporting systems as mandated in the 2016 Terms and Conditions of the NHS Doctors and Dentists in Training Contract
- Working in collaboration with the Medical Peoples Services, the Director of Medical
- Education, the Medical Education Team, Supervisors and Divisions to ensure that the identified issues within exception reports, concerning both working hours and training hours, are appropriately addressed
- Regularly reporting and raising concerns regarding the compliance of safe working hours directly to the Board and Medical Directorate

2.3 REPORTING AGAINST CORE QUALITY ACCOUNT INDICATORS

All NHS Trusts are required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. These core indicators align closely with the NHS Outcomes Framework (NHSOF).

The majority of core indicators are reported by financial year, e.g., from 1 April 2024 to 31 March 2025, however some indicators report on a calendar year or partial year basis. Where indicators are reported on a non-financial year time period this is stated in the data table. It is important to note that some national

datasets report in significant arrears and therefore not all data presented are available to the end of the current reporting period.

Summary Hospital Level Mortality Indicator

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who died following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. The SHMI gives an indication for each non-specialist acute NHS trust in England on whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected', 'as expected' or 'lower than expected' when compared to the national baseline.

Indicator	**Summary Hospital-Level Mortality Indicator**				
Domain	Preventing people from dying prematurely				
SaTH 2024/25	Peer Comparator 2024/25	2023/24	2022/23	2021/22	2020/21
Awaiting data	Awaiting data	96.26	97.65	97.65	110.83
Data Source: CHKS iCompare based on Peer Distribution Group (rolling 12 months). HES data used against peer					

To note, in relation to this core quality indicator, at the time of the publication of the Quality Account for 2024/25 it has not been possible to provide updated 12-month rolling SHMI data for the period for 2024/25 for the Shrewsbury and Telford NHS Trust due to the ongoing challenges with the Data Warehouse. It is anticipated that this data will be available in July 2025 as the Data Warehouse issue resolves.

Percentage of Deaths Coded at either Diagnosis or Speciality Level

Palliative care indicators are included below to assist in the interpretation of SHMI by providing a summary of the varying levels of palliative care coding across non-specialist acute providers.

Indicator	**Percentage of patients whose death were included in the SHMI and whose treatment included palliative care (contextual indicator)**					
Domain	Preventing people from dying prematurely					
SaTH 2024/25	National Average 2024/25	Highest Score 2024/25	Lowest Score 2024/25	SaTH 2023/24 (Jan-Dec 2023)	SaTH 2022/23	SaTH 2021/22

Awaiting data	Awaiting data	Awaiting data	Awaiting data	31%	28.54%	20.65%
Data Source-CHKS iCompare FCE (Finished Consultant Episode) deaths with specialized palliative care code Z515. Based on peer distribution group (rolling 12 months), HES data used against peer						

To note, at the time of the publication of the Quality Account for 2024/25 it has not been possible to provide updated 12-month data for this core quality indicator for the period for 2024/25 for the Shrewsbury and Telford NHS Trust due to the ongoing challenges with the Data Warehouse. It is anticipated that this data will be available in July 2025 as the Data Warehouse issue resolves.

In 2023/24 a collaborative review was undertaken between the Clinical Coding team, the Palliative and End-of-Life Care (PEOLC) Team and the Learning from Deaths Team in response to consistently lower than average palliative care coding within the Trust. A programme of focused improvement work led by the PEOLC Team included the earlier recognition of dying to facilitate prompt referral of patients to the Palliative care Team for specialist support and managing fast track discharge to a patient's preferred place of care. This quality improvement work may impact on future palliative care coding.

The Percentage of Patients Re-admitted to Hospital Within 28 Days of Discharge

This data describes the percentage of patients readmitted to hospital within 28 days of being discharged. It is split into 2 categories: the percentage of people under the age of 16 years and the percentage of patients 16 years and over.

Indicator	**Readmission rate for patients admitted to hospital within 28 days of being discharged**					
Domain	Helping people to recover from episodes of ill health or following injury					
Age Band	SaTH 2024/25	Highest Performing	Lowest Performing	2023/24	2022/23	2021/22
0-15	Awaiting data	Awaiting data	Awaiting data	15.96%	14.90%	13.85%
16 and over	Awaiting data	Awaiting data	Awaiting data	8.25%	7.92%	8.53%
Data Source- CHKS iCompare HES data used. Readmissions with 28 days, patients filters where the age is less or equal to 15 and where the age is greater than or equal to 16. Rolling 12 months						

The Shrewsbury and Telford Hospital NHS Trust considers this data is as described as it comes from the CHKS, a well-established national data provider.

The data is collected so that Shrewsbury and Telford Hospital NHS Trust can understand how many patients discharged from the Trust are readmitted within less than a month to identify areas where discharge planning

needs to be improved and where the Trust needs to work more closely with its community providers to ensure patients do not have to return to hospital.

To note, at the time of the publication of the Quality Account for 2024/25 it has not been possible to provide updated 12-month data for this core quality indicator for the period for 2024/25 for the Shrewsbury and Telford NHS Trust due to the ongoing challenges with the Data Warehouse. It is anticipated that this data will be available in July 2025 as the Data Warehouse issue resolves.

Working both internally and with our community partners to improve our discharge processes and experience for patients who are discharged from our care is included as one of our Quality Priorities for 2025/26.

Percentage of Staff Who Would Recommend the Trust to a Friend or Family Needing Care

The NHS Survey is conducted annually. It asked NHS staff across England about their experience of working in their NHS organisation. The NHS staff survey asks respondents whether they strongly agree, agree, disagree, or strongly disagree with the following statement:

"*If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation*".

The percentage of staff who would recommend the Trust as a provider of care for their friends and family							
Domain	**Ensuring people have a positive experience of care**						
SaTH 2024	**National Average 2024**	**Best performing Trust 2024**	**Worst performing Trust 2024**	**SaTH 2023**	**SaTH 2022**	**SaTH 2021**	**SaTH 2020**
45.75%	**61.54%**	**89.59%**	**39.72%**	**44.98%**	**39.2%**	**43.5%**	**51.1%**
SaTH considers this data accurate as it is produced by the NHS Survey Co-ordination Centre in accordance with strict criteria. For every organization participating in the NHS Staff Survey a benchmark and breakdown is available. For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise.							

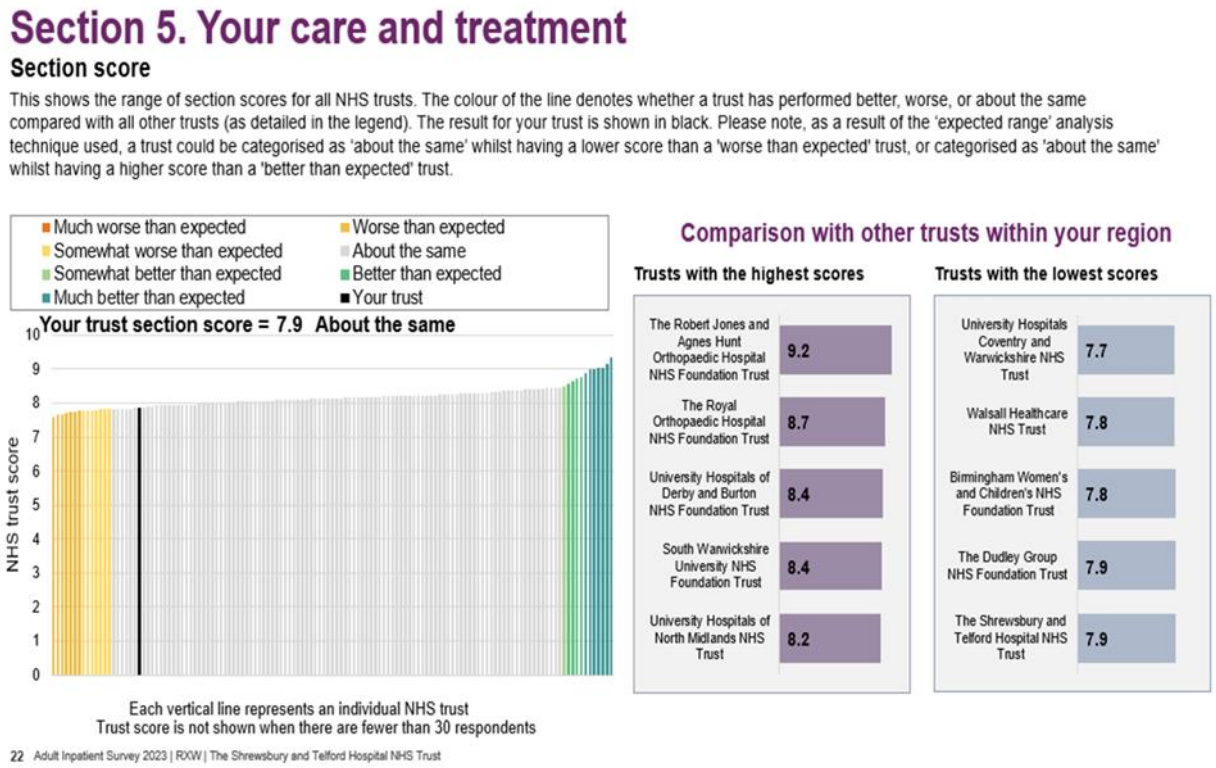
The percentage of staff who would recommend the Trust as a provider of care to their friend or family improved again 2024 to 45.75%. The Trust remains below the national average which declined in 2024.

The Trust will continue to implement actions to further understand the experience of our staff and improve the quality of its staff's experience of working at the Trust throughout 2025/26, this includes:

- Continue our leadership improvement journey
- Continue our cultural improvement journey
- Review and revise actions in our staff experience improvement plans at Corporate
- and Divisional level to ensure improvements continue moving forward
- Complete Quarterly Pulse Survey for staff so we can review progress and keep on track

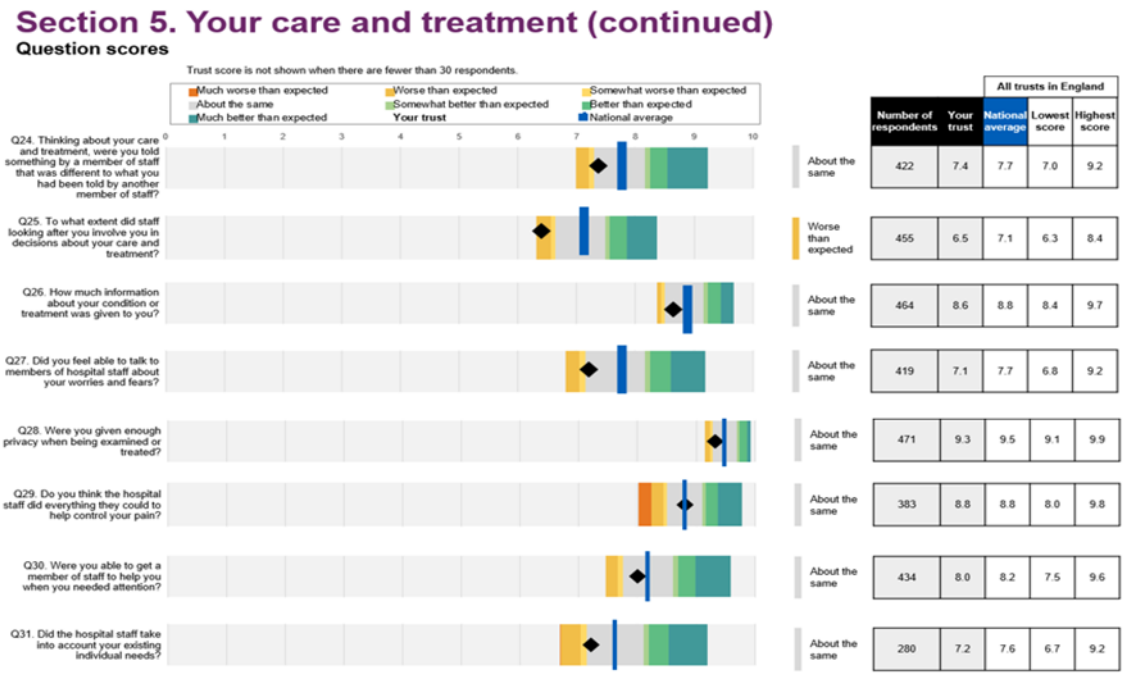
The Trust Responsiveness to the Inpatients' Personal Needs

The results for the National Inpatient Survey (2023) Inpatient Survey which were published in 2024 are included in the Quality Account. The graph below shows the Shrewsbury and Telford Hospital NHS Trust as the black line compared to the other individual NHS Trusts, with the Trust section score being - 7.9 meaning it is rated as "about the same" as other Trusts.



The Shrewsbury and Telford Hospital NHS Trust considers this data is accurate as it is taken from a well-established national source.

Comparison with other Trusts in the West Midlands region is also shown. It must be noted that as a result of the "expected range" analysis techniques used, a Trust could be categorised as "about the same" whilst having a lower score than a "worse than expected" Trust or categorised as "about the same "whilst having the same score than a "better than expected" Trust.



Actions in relation to the Inpatient Survey results and improvements are outlined in the National Survey section of this Quality Account.

Venous Thromboembolism (VTE)

The Trust performance for VTE has been consistently under the 95% target for the financial year of 2024-2025. Observation reinforces that we need cultural changes of a collective responsibility for all basic assessments including VTE as part of a multi-disciplinary approach to preventing harm. In addition to this there have been reporting challenges with the implementation of Careflow and problems with the Datawarehouse which are being methodically worked through.

The Medical Director, in collaboration with the Chief Nurse have ensured that VTE assessment performance is included in the Exemplar Ward Programme to reinforce the importance of this work and to improve the overall performance of VTE assessment completion. In addition, a member of the Medical Leadership Team is working with the Business Intelligence Team to resolve the reporting issues to ensure robust reporting is available.

VTE assessment completion will be aligned with the Trust Quality priorities 8 to reduce the risk of mortality in patients presenting to the Trust who are acutely unwell for 2025-2026.

Patient Safety Incidents and the Percentage Reported that Result in Severe Harm or Death

A Patient Safety Incident is an unintended or unexpected incident which could have or did lead to harm for patients receiving NHS care. In previous years data produced by the National Reporting and Learning

System (NRLS) was used to provide comparison nationally, however the National Reporting database changed in September 2023 to Learning from Patient Safety Events (LFPSE), validated comparator data is not available for 2024/25.

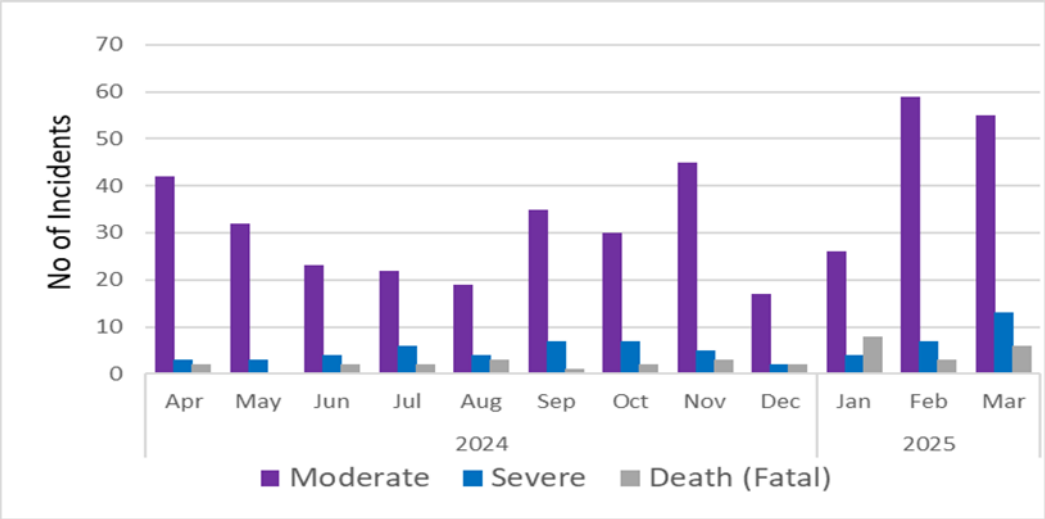
The number and the rate of Patient Safety Incidents reported within the Trust in 2024/25, and the number and percentage of Patient Safety Incidents that resulted in severe harm or death, are identified below:

Domain					
	SATH 2024/2025	SATH 2023/2024	SATH 2022/23	SATH 2021/22	SATH 2020/21
Number of Patient Safety Incidents	18,684	18,212	20,456	18,000	13,011
Rate of Patient Safety incidents per 1,000 bed days	61.50	61.35	70.35	74.75	65.06
Severe harm or death	90	52	79	56	35
Percentage of Patient Safety Incidents which resulted in severe harm or death	0.48%	0.29%	0.39%	0.31%	0.27%
Rate of Severe/death incidents per 1,000 bed days	0.30	0.18	0.27	0.23	0.16

Note: In September 2023 NHS England paused the annual publishing of comparator data whilst future publication, in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS is transitioned. NHS England LFPSE is not ready yet to produce any meaningful reports.

SaTH continues to be a high reporter of incidents which may represent a positive reporting culture. Important to note that SATH have not seen any reduction in incident reporting since the transition to the new LFPSE reporting system, which is positive.

The graph below identifies the number of incidents reported per month alongside the number resulting in moderate and severe harm, during 2024/25, February and March are still under review at the time of writing and are subject to change.



Rates of Clostridioides difficile

Clostridioides difficile (C. difficile) is a bacterium found in the gut which can cause diarrhoea after antibiotics. The Clostridioides difficile rate per 100,000 bed days for 2024/25 is shown, this figure is based on the Trust data rather than externally validated as this was not available at the time of collating the Quality Account.

Indicator	**The rate per 100,000 bed days of Trust apportioned cases of C.Difficile Infection that have occurred amongst patients aged 2 and over**		
Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm**		
	SaTH 2024/25	SaTH 2023/24	SaTH 2022/23
	36.9	34.5	20.1
Data Source - https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-byprior-trust-exposure			

The Trust considers this data to be as described for the following reasons: Every case is scrutinised and has an 'After Action Review with the Infection Control Team and Microbiology to determine whether the case was linked with an issue in the quality of care provided to patients. Common themes remaining similar to previous years include, antibiotics usage, timely obtaining of stool samples and isolation continue, however this year we have seen a theme around recurrence of infections/re-infection.

The Trust trajectory for C diff cases in 2024/25 was no more than 98 cases. There was a total number of cases of 112.

The Infection Prevention and Control Team have identified numerous areas of practice and infrastructure that can and should be improved. These have been included in our revised CDiff Improvement Plan, this plan strengthens ownership of actions at ward/Divisional level, and we will be implementing these actions through 2025/26. This is monitored via our Infection Prevention and Control Operational Group which meets monthly.

2.4 LOOKING FORWARD: OUR PRIORITIES FOR QUALITY IMPROVEMENT 2025/26

The quality priorities for 2025/2026 have been developed following a review of the last year's priorities, the progress made in relation to achieving these and the ongoing key quality and safety challenges faced by the Trust. This means that some of the 2024/2025 quality priorities have been continued or revised in 2025/26. Some new proposed priorities have also included for 2025/2026. We have also looked for some of our priorities to reflect the joint quality working with her System partners.

In 2024/2025 the Trust commenced a review of the Quality Strategy, and a new Quality and Safety Strategy will be finalised in Quarter 2 of 2025/2026 and inform future Quality Account priorities in 2026/2027.

The quality priorities for 2025/2026 are outlined below. There is only one priority identified under the domain of "Patient Experience". However, the experience of care provided to our patients is vital to our quality and safety improvement journey and is embedded within many of these priorities and will be reported as part of these in 2025/2026.

Alongside discussion with our Divisional Leadership Teams, the Quality Operational Committee and with our Executive Team and Non-Executives at the Quality and Safety Assurance Committee, we also consulted with our patient experience representatives as we finalise these for 2025/2026.

Progress with these priorities will be monitor at a number of levels in the Trust: through our recently revised monthly Nursing Quality Metrics Confirm and Challenge" meeting, at Speciality and Divisional Level as part of the performance reviews and at a Trust level via regular reporting through to our Quality Operational Committee and Quality and Safety Committee as we continue our journey "***Moving to Excellence".*** This will enable us to triangulate the work being undertaken for these priorities into the tangible benefits in relation to improved patient care and outcomes.

Domain	Priority	Key Actions
SAFE		
PRIORITY 1	PSIRF Priorities • The Deteriorating Patient	• Improve frequency of patient observation compliance • Strengthen governance and oversight of key metrics • Embed tools to support shared decision making and patient-centred care • Develop a standardized response model

		• Implement targeted training
	• Reducing Inpatient Falls	• Trial the bedside mobility assessment tool to increase early mobilisation in patients · • Increase the number of patients sat out at mealtimes and dressed in own clothes to prevent deconditioning associated with increased falls • Improve compliance with Lying and standing blood pressure recording • Increase awareness of falls prevention
	• Omitted doses of time critical medication	• Continual audits to identify numbers and themes of omitted dose audits and develop local and immediate action plans, monitoring these through the recently revised monthly Ward Quality Metric Confirm and Challenge meetings • Observation sessions by the Medicine Safety Officer using structured systems approach observation tool in various clinical areas, feedback to clinical and identify barriers to timely administration to identify further improvement opportunities • Complete staff focus groups by August 2025 and outline improvement actions supported by focus groups • Implement test of changes cycles on four wards (initial audit for baseline of missed doses of time critical medication and remeasure) • Based on tests of change outline ongoing improvement actions to roll out Trust wide as a longer-term improvement programme and ongoing measuring of omitted doses

		• Ensure improvement work is integrated into development plans including the development /implementation of EPMA and working group Time Critical Medication in Emergency Departments
	• Missed radiology reporting	• We will complete a review of the use of RadAlert/ICE (incoming IT order comms system) to track radiology results • We will compare this against the mapping we have done which indicates the risks and issues in the current system before the ICE system is operational • We will produce a revised risk assessment of the new process to demonstrate a reduction in risks/hazards in terms of radiology results not being actioned
PRIORITY 2	Reduce Hospital Acquired Pressure Ulcers	• Implement revised governance process for the monitoring and evaluation of learning from pressure ulcers, increasing accountability at ward level • Ensure all patients have a Purpose T skin assessment completed on admission and regular review • Improve compliance with pressure ulcer prevention care plan for all eligible patients • Ensure timely provision of pressure relieving equipment and mattresses
PRIORITY 3	Achieve best compliance with nutritional assessments and nutritional care planning	• Ensure all patients have a MUST assessment completed

		on admission and regular review • Deliver training around the updated MUST tool, weigh process, referral process to dietetics • Ensure all patients requiring Dietetics and/or Speech and language therapy receive timely referral and review • Update fluid balance policy and support improvements in completion in practice
EFFECTIVE		
PRIORITY 4	Improve the experience of our elective care pathways: • reducing our radiology waiting times reducing radiology reporting delays	• Review of scanning templates in all modalities to maximise outpatient scanning capacity. • Expand use of MRI acceleration software to reduce scanning times where appropriate. • Temporary insourcing/outsourcing support for MRI and NOUS while sustainable plan is developed. • Further roll out of Home Reporting workstations for Radiologists to reduce interruptions to reporting sessions. • Onboarding a second outsourcing reporting provider, to address gaps in our current outsourcing provider, and provide resilience during busy periods.
PRIORITY 5	Improve the experience of our emergency care pathway: • Improving time to triage/initial assessment	• Ensure 80% of patients receive Initial Assessment within 15 minutes of arrival to our Emergency Departments • Continue to develop and embed our ambulance

	• Improve the timeliness of handover for patients arriving by ambulances • Reducing the number of patients who spend more than 4 hours and more than 12 hours in our departments • Improve the number of patients reporting a positive experience of care in our EDs	handover assessment model (Offload To Assess) · • Increase streaming of patients to our SDEC services to increase the proportion of non-elective admissions managed as 0-day length of stay • Implement the provision of additional funded bed capacity at both hospital sites in Q3 2025/26 • Improve the number of patients reporting a positive experience of care in our EDs o Thematic review of complaints and develop overarching action plan o New patient experience team lead monthly patient experience survey o Achieve >90% compliance for Quality Audits in ED
PRIORITY 6	Implement System-wide working to improve the discharge planning processes and our patients experience of involvement in their discharge plans	• Set up joint Discharge improvement group chaired by Chief nurse SaTH/Shropcomm to drive forward improvements • Embed Criteria-Led discharge across SaTH • Increase number of patients: o discharged pre midday and 5pm. o Reduce number of patients discharged after 10pm • Improve discharge processes including: o Number of patients who have discharge letter &

		medications prescribed day prior to discharge o Ensure all patients have medications explained prior to discharge o Increase number of planned discharges in discharge lounge by 8am
PRIORITY 7	Improve Foot care for people with Diabetes (PWD) who are admitted to the Trust	• Ensure that compulsory foot assessment for people with diabetes (PWD) is embedded on all wards • Monthly audit of Foot assessments as part of the Matron Quality audits, agreed actions for improvement will be monitored via the recently revised monthly Ward Quality Metric Confirm and Challenge meetings • Assessment of all PWD with foot wounds by Podiatry team • Ensure that all relevant clinical staff have completed the diabetes foot education on LMS to achieve > 90% compliance • To re-audit against NICE (NG19) in July 2025 to review improvements and highlight findings to all matrons and nursing staff. • Wound conference for staff June 17th to introduce "*Lift the sheet check the feet"* campaign
PRIORITY 8	Reduce the risk of mortality in patients presenting to the Trust who are acutely unwell.	• Ensure VTE assessments completed and comply with national standards. • Understand and put in place interventions to address the increased ED mortality seen in the mortality figures • Implementation of Martha's rule

PATIENT EXPERIENCE		
PRIORITY 9	Improve the experience of patients and their loved ones who have a learning disability and/or autism	• Undertake the Learning Disabilities Improvement Standards Self Improvement tool and create an action plan based on the findings. • Implement the reasonable adjustments digital flag on EPR. • Achieve compliance with LD training for clinical staff. • Embed the Hospital Passport process. • Implement the actions from LeDeR and Clive Treacey. • Continue the LD/ Autism patient experience group and act upon the issues raised.

3.0 OTHER INFORMATION RELEVANT TO THE QUALITY OF CARE

National Patient Safety Alert Compliance

Patient safety alerts are issued via the Central Alerting System, a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations. Failure to comply with actions in a patient safety alert may compromise patient safety and lead to a red performance status on the NHS Choices website. The publication of the data is designed to provide patients and carers with greater confidence that the NHS is proactive in managing patient safety and risks.

Within SaTH there is a robust accountability structure to manage patient safety Alerts. The Medical Director and Chief Nurse oversee the management of all patient safety alerts. Any new NPSA alerts go to the weekly Review, Action and Learning from Incidents Group (RALIG) and an Executive lead is nominated by the Medical Director (Chair of RALIG), to link in with the relevant team; the NPSA alerts are then presented at RALIG and approved for closure. The Medical Director and Chief Nurse monitor the NPSA alerts via a Quarterly report presented at the Quality Operational Committee.

During 2024/2025 the Trust received 11 National Patient Safety Alerts (to date). All have been actioned; none have breached their deadline.

Alert Identifier	Alert Title	Issue Date	Closure Target Date	Closed Date	Open/ Closed
NatPSA/2024/004/MHRA	Reducing risks for transfusion-associated circulatory overload	04/04/2024	04/10/2024	18/09/2024	Closed
NatPSA/2024/005/MVA	Shortage of Erelzi® (etanercept) 50mg solution for injection in pre-filled pen	03/05/2024	10/05/2024	07/05/2024	Closed
NatPSA/2024/006/DHSC	Shortage of Orencia® ClickJectTM (abatacept) 125mg/1ml solution for injection pre-filled pens	23/05/2024	06/06/2024	04/06/2024	Closed
NatPSA/2024/007/DHSC	Shortage of Pancreatic enzyme replacement therapy (PERT)	24/05/2024	10/06/2024	06/06/2024	Closed
NatPSA/2024/008/DHSC	Shortage of Kay-Cee-L ® (potassium chloride 375mg/5ml) (potassium chloride 5mmol/5ml) syrup	26/07/2024	12/08/2024	07/08/2024	Closed
NatPSA/2024/009/DHSC	Shortage of Human Albumin 4.5% and 5% dose vials	30/07/2024	07/08/2024	07/08/2024	Closed
NatPSA/2024/010/NHSPS	Risk of oxytocin overdose during labour and childbirth	24/09/2024	31/03/2025	28/03/2025	Closed
NatPSA/2024/011/DHSC	Discontinuation of Kay-Cee-L® (potassium chloride 375mg/5ml) (potassium chloride 5mmol/5ml) syrup	21/10/2024	31/10/2024	29/10/2024	Closed
NatPSA/2024/012/DHSC	Shortage of Molybdenum99/Technetium-99m generators	25/10/2024	08/11/2024	08/11/2024	Closed
NatPSA/2024/013/DHSC	Shortage of Pancreatic enzyme replacement therapy (PERT) – additional actions	18/12/2024	31/01/2025	28/01/2025	Closed
NatPSA/2025/001/DHSC	Discontinuation of Promixin® (colistimethate) 1-million unit powder for nebuliser solution unit dose vials Date of issue: 17-Mar-25	17/03/2025	30/04/2025	15/03/2025	Closed

Patient Safety Incidents

All Patient Safety Incidents (PSI) are reported on the hospital electronic incident management system (Datix). All PSIs are reported, monitored, and reviewed to identify learning that will help prevent reoccurrence, through the daily datix triage process.The Patient Safety Incident Review Framework (PSIRF) policy and plan is in place in the Trust.

Review, Action and Learning from the Incidents Group (RALIG) is now well embedded and is chaired by the Medical Director and Chief Nurse. This multidisciplinary group meets weekly to review incidents that have been escalated by the Incident Review Oversight Group (IROG) and make the decisions in relation to the level of learning response required.

During 2024/25 there have been the following learning responses raised:

- 17 PSII – Patient Safety Investigations
- 11 After Action Reviews
- 10 MDT Reviews

All learning and outcomes are signed off at RALIG and reported through to Quality Operational Committee.

Never Events 2024/2025

In the NHS Never Events are defined as Patient Safety Incidents (PSIs) that are 'wholly preventable' because of the existence of strong systematic protective barriers at a national level (NHS England 2024). These serious, largely preventable Patient Safety Incidents (PSIs) should not occur if the available preventative measures have been implemented. In 2024/2025 SaTH had one incident which met the definition of a Never Event. Thorough investigations are undertaken for Never Events and robust action plans are developed to prevent similar occurrence.

The following table gives a description of the incident. The patients and their family were informed of the investigation and kept informed throughout the investigation and offered the opportunity to discuss the investigation findings and recommendations.

Never Event			
SATH 2024/25	**National Average 2024/25**	**Best Performing Trust 2024/25**	**Worst Performing Trust 2024/25**
1	2.3	1	9

Date	Description of Never Events 2024/25 at SATH
August 2024	Wrong Site Surgery - Biopsy

Learning from this Never Event in 2024/2025 included:

- Additional steps in patient processes for checking patients as a further safety net

Learning from Patient Experience

A. Friends and Family Test

The Friends and Family Test (FFT) is a national survey designed to provide an easy method for people accessing services to provide feedback. The feedback measures how satisfied the person was with their experience of the service. FFT scores are available for each ward and department, by Division, and for the Trust, which allows for comparison to be made both locally and on a national scale.

A national standard question is asked:

'Thinking about [the area accessed], overall, how was your experience of our service?'

Emergency Department FFT

	National performance 2024/2025 (based on national data available April 2024 to January 2025)			Trust performance 2024 / 2025 (based on data submitted April 2024 to March 2025)			Trust performance 2023/2024	Trust performance 2022/2023
	Mean	Best	Worst	Mean	Best	Worst		
Score	79.0%	83.0%	76.0%	68.2%	78.0%	53.1%	64.8%	67.2%

	PRH performance 2024/2025		
	Mean	Best	Worst
Score	60.7%	83.0%	76.0%

	RSH performance 2024/2025		
	Mean	Best	Worst
Score	75.7%	89.0%	65.0%

A pilot has been undertaken within the Emergency Departments, using (SMS) to gain broader and more representative feedback from people accessing the service. The pilot commenced in October 2023, and stopped at the end of January 2025, demonstrating an increase in response rates during this period. Themes of feedback have been shared with the service and Urgent and Emergency Care Patient Experience Group, to support targeted improvements.

Inpatient FFT

Inpatient services collected feedback from 15,482 people, achieving an average response rate of 16.1%. This is lower than both the national average (20.5%), and the Trust response rate in 2022/2023 (18.2%). There is variation between response rates at each hospital site, with an average response rate of 23.2% at the Princess Royal Hospital, and 9.6% at the Royal Shrewsbury Hospital.

	National performance 2024/2025 (based on national data available April 2024 to January 2025)			Trust performance 2024 / 2025 (based on data submitted April 2024 to March 2025)			Trust performance 2023/2024	Trust performance 2022/2023
	Mean	Best	Worst	Mean	Best	Worst		
Score	94.3%	94.6%	93.9%	98.4%	99.2%	97.8%	98.5%	98.5%

	PRH performance 2024/2025		
	Mean	Best	Worst
Score	98.4%	99.9%	96.9%

	RSH performance 2024/2025		
	Mean	Best	Worst
Score	98.4%	99.8%	97.0%

The Trust has achieved an average satisfaction rate of 98.5% over the last three years, demonstrating a consistent level of achievement and assurance.

Outpatient Department FFT

Outpatient services collected feedback from 14,441 people, providing insight into their experience. Outpatient satisfaction rates have remained consistent between 98.5 and 98.7% over the last three years.

	National performance 2024/2025 (based on national data available April 2024 to January 2025)			Trust performance 2024 / 2025 (based on data submitted April 2024 to March 2025)			Trust performance 2023/2024	Trust performance 2022/2023
	Mean	Best	Worst	Mean	Best	Worst		
Score	94.0%	100%	25%	98.6%	99.5%	97.9%	98.7%	98.5%

Listening to feedback obtained through the Friends and Family Test (FFT) and free text questions, provide insight into what we do well, and opportunities to improve. The trust additionally obtains feedback through a range of sources which include:

- Local surveys
- National surveys
- Patient and Carer stories
- Concerns
- Formal Complaints
- Compliments

- Feedback Hub contacts
- Healthwatch community engagement and enter and view visits
- Care Opinion

B. National Inpatient Survey

The National NHS Adult Inpatient Survey (2023) was undertaken between January and April 2024 and included patients meeting the eligibility criteria who were discharged from the Trust in November 2023. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. The Trust had a response rate of 42%, which was 2% above the 2022 Trust response rate and comparable to the national average (42%). Of the completed responses, 85% relate to urgent/emergency admissions and 15% to planned inpatient admissions.

The best and worst performance relative to the Trust average are calculated comparing the Trust results against the national average across England, identifying the bottom and top five scores. The bottom and top results for the Trust are displayed in Figure 2.

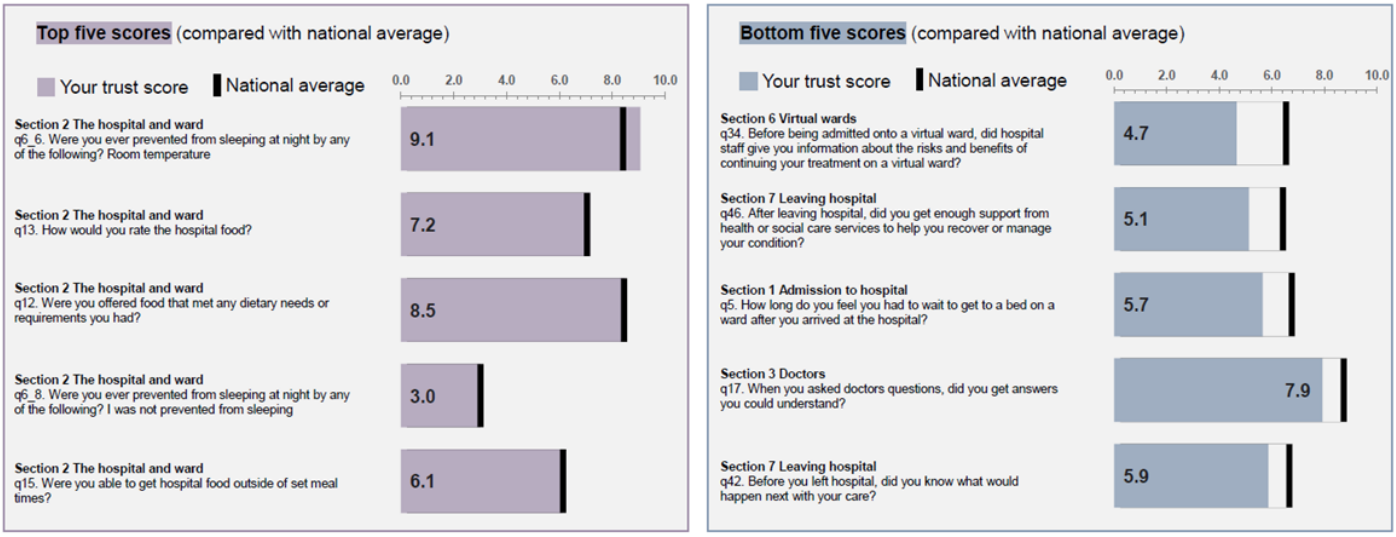


*Figure 2 – Top 5 and Bottom 5 Ranking Scores Compared with Trust Average (*National NHS Adult Inpatient *Survey, 2023)*

The Trust performed 'much worse' than expected in 1 question, 'worse than expected' in 5 questions, and 'somewhat worse' in 6 questions, and 'about the same' as other Trusts in 37 questions.

Following the Adult Inpatient Survey (2023) which was published in 2024 the subsequent actions have been taken:

- An Elective Surgery Hub has been established to improve elective pathways and optimise performance.

- Measures to reduce ambulance handover through introducing a Hospital Ambulance Liaison Officer at each hospital, and implementation of a revised ambulance Offload to Assess model.
- Measures to reduce waiting times for a bed including the introduction of a front door community team, the Next Patient initiative, Test of Change Week, and MADE events have been introduced to support work being driven by the ED Transformation Project.
- To facilitate access to frequently prescribed medications and discharge medicines, pharmaceutical vending machines have been introduced across the Trust.
- The Trust continues to work with system partners to maximise the use of Virtual Ward capacity, Outpatient Parental Antimicrobial Therapy, and alternative pathways of care, enabling patients to be cared for in the most appropriate environment to meet their needs.
- Implementation of additional domiciliary care supporting a reduction in length of stay, continued focus on therapy processes and the Integrated Discharge Team.
- Health literacy awareness training is being delivered across a range of staff groups including junior Doctors, focusing upon teach-back and chunk and check methodology.
- Results have been shared with Specialist Patient Experience Groups to inform improvement work. Key questions from the national survey are incorporated in local surveys within the Trust to inform focused work and measure improvements at a local level.

C. National Maternity Survey

The NHS National Survey of Women's Experiences of Maternity Services (2024) was undertaken with patients meeting the eligibility criteria who were aged 16 years or older, who had a live birth during February 2024. The Trust had a response rate of 53%, which was 2% above the 2023 Trust response rate and above the national average (41%). The results of the survey provide the Trust with two important measures of how they have performed. Firstly, a comparison of the Trust's score for each question compared to the previous year and secondly a comparison of how the Trust performed compared to other participating Trusts. The survey had 57 scored questions, with additional filter questions and demographic data. These were divided into 10 focused sections covering Antenatal care, Labour and birth, Postnatal care and Complaints.

Responses are rated as "about the same" as other Trusts, if they fall within the expected range. Responses falling outside of the expected range are rated on a continuum ranging from "much better than expected" to "much worse than expected".

- Of the 10 sections included in the 2024 survey, SaTH's performance was rated "about the same" as other Trusts for all 10 sections.
- Of the 57 scored questions, SaTH's performance was "somewhat better than expected" for 1 question. The national average score for this question was 7.4.
  "Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?"

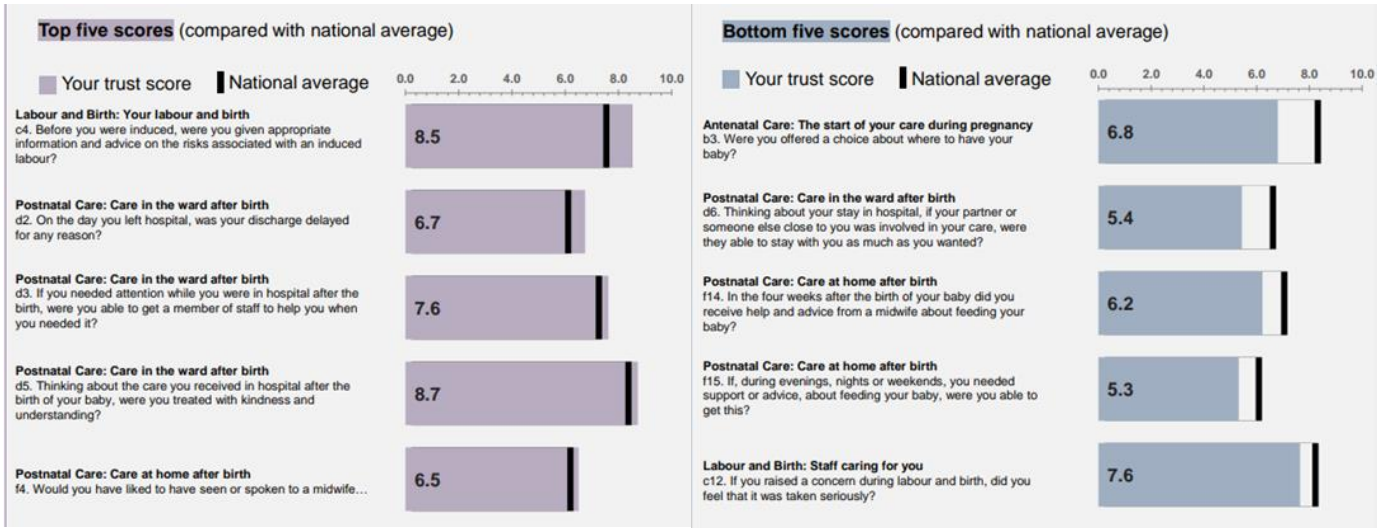
- Of the 57 scored questions, SaTH's performance was "somewhat worse than expected" for 1 question. The national average score for this question was 6.8.
  "Were you offered a choice about where to have your baby?"

SaTH's performance was "about the same" as other Trusts for the remaining 55 scored questions. Performance is also measured by comparison with SaTH's results from the previous year (2023). Slight variations in score may occur year on year by chance, therefore only scores that are significantly better or worse than those for the previous year are highlighted.

- There were no statistically significant changes to SaTH's performance when compared with the results from last year.
- The 2024 findings are positive, indicating that overall, SaTH performed 'About the same' as other Trusts in all 10 sections of the survey.
- Performance rated favourably to other Trusts in 1 question, with results showing SaTH performed "somewhat better". However, SaTH scored "somewhat worse" than other Trusts in 1 question.

Comparisons between 2023 and 2024 survey results, demonstrated no statistically significant changes in scores for any of the sections or questions. When reviewing the top and bottom five scores, the Trust scored highest in the sections covering 'Labour and birth' and 'Care in the ward after birth'. The lowest scoring question being the section relating to 'Care at home after birth'. (Compared with national average).

The tables below show the five results for SaTH that scored highest when compared with the national average and the five results for SaTH that scored lowest when compared with the national average. If none of the results for the trust were above the national average, the results closest to the national average have been chosen.



Whilst the Trust's performance showed a result lower than national average for five questions it is important to note that these will be key areas of focus for improvement by the maternity leadership team. As part of next steps, and in-line with the NHS Resolutions Clinical Negligence Scheme for Trust's Maternity Incentive Scheme, (CNST MIS), a gap analysis has been undertaken by the Maternity and Neonatal Voices Partnership (MNVP) on the qualitative and quantitative data to ensure we have a co-produced action plan that addresses our service user feedback with a specific focus on feeding and increasing awareness on choice and listening to families.

D. Experience of Care Strategy

In 2024 the Trust co-produced a five year 'Experience of Care' Strategy. The strategy and delivery plan set out how the Trust will work in collaboration with people who have lived experience and key stakeholders.

The strategy has a delivery plan outlining actions that will be taken to deliver on strategic objectives and commitments to address the four areas of priority:

E. Working in Partnership with our Patients

Working in partnership with patient partners and people with lived experience is fundamental in improving services, examples of collaborative work undertaken in the last year are:

- An Experience Based Design survey has been undertaken in the Community Diagnostic Centre, working collaboratively with patient partners to obtain feedback from people using the service, consider the findings, and identify improvements that could be made in response to the feedback.
- The Patient Information Panel is established through staff and patient partners, who work in partnership to review patient information, with a focus on health literacy to ensure information can be easily understood by patients and the wider community.

- Co-delivery of health literacy training within the Trust, in addition to raising awareness and insight across the wider system.
- The Trust worked in collaboration with the Maternity and Neonatal Voices Partnership (MNVP) to host a focus group, seeking feedback on the neonatal expressing room environment, supporting improvements being made.
- Working with teams across the Trust in the delivery of projects, providing a user perspective, such as introduction of the digital patient portal.
- Co-production and design of materials supporting an 'Its OK To Ask' pilot within an Outpatient area, encouraging people accessing services to ask questions to gain greater understanding and involvement in their health problems and treatment options.
- Establishment of a Learning Disability and Autism Patient Experience Group.
- Involvement in procurement reviews, providing a user perspective.
- Patient Led Assessment of the Care Environment (PLACE) assessments.
- Recruitment through participating in stakeholder groups.
- Reviewing how the Trust meets the needs of people from different demographic groups which reflect the local community using the Equality Delivery System 2022.
- Involvement in Hospital Transformation Programme (HTP) workstreams, helping to shape our future hospital buildings.

Maternity Improvement

Saving Babies Lives Care Bundle v3 (SBLCBv3)

The SBLCBv3 was published in May 2023. The Trust was required to achieve a minimum of 50% for all six elements, and at least 70% overall by 30 November 2023 in order to meet the requirements of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS). Additionally, all providers were required to work towards full implementation of all six elements by 31 March 2024. The Trust declared full implementation of SBLCBv3 in 2024.

The table below confirms the Trusts position in 2024; In keeping with the validation process, the Trust's position is externally verified at the quarterly review meetings chaired by the ICS prior to uploading to the NHS Futures platform. Quarterly meetings are in place to verify the Trust position measured against the standards. Any area that demonstrates a decline will trigger an improvement plan to bring the element back in line with the required standard.

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%	CNST Met
Element 6	Diabetes	Fully implemented	100%	Fully implemented	100%	CNST Met
All Elements	TOTAL	Fully implemented	100%	Fully implemented	100%	CNST Met

Clinical Negligence Scheme Trusts Maternity Incentive Scheme Year 5 (CNST MIS)

The Trust is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care. The scheme incentivises 10 maternity safety actions. Trusts that can demonstrate they have achieved all 10 safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

The Trust declared compliance against all 10 safety actions, with the evidence repository reviewed by Mr Simon Mehigan who is the Trust link for NHS England's Maternity Safety Support Programme prior to submission of the Board Declaration. NHS Resolution has since confirmed our position for Year 5 and the Trust has received the funds. Year 6 self-verification has been submitted declaring compliance against all 10 safety actions, the final position is embargoed and will be published later in 2025.

By 1 February 2024, the Trust had declared compliance with year five of the Clinical Negligence Scheme for Trusts safety actions, and delivered fully on all elements of the Saving Babies Lives Care Bundle (version Three) by the end of March 2024.

Ockenden Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. Implementing the Recommendations.

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

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

The Review found repeated failures in the quality of care and governance, as well as failures of external bodies to monitor the care provided effectively. These failures included there not being enough suitably experienced staff, a lack of ongoing training, a lack of investigation and governance at the Trust, and a culture of not involving or listening to the families involved.

The combined reports included 210 actions, 93 'Local Actions for Learning' to be implemented solely by the Trust, and 117 'Immediate and Essential Actions' for implementation of all providers of maternity care in England.

Based on a rigorous assurance validation process, progress with delivering the actions as of 30 March 2025, is, as follows (rounded percentages):

- 190/210 (91%) have been delivered fully, and evidenced and assured as working as they should be
- 10/210 (4%) actions are on track to be delivered within their expected timeframes
- 7/210 (3%) actions are descoped. This means they are outside of the Trust's control to deliver, and they are dependent upon the actions of third parties, such as NHS England or the Care Quality Commission. These continue to be reviewed with the respective agencies.
- 3/210 (2%) actions are at risk, comprising:

A new Integrated Maternity Report is now in place and will continue to report on progress against actions from the Independent Maternity Review to the Board of Directors each time it meets in public. In addition, this report consolidates relevant maternity matters into one report and includes progress in relation to The Clinical Negligence Scheme for Trusts (CNST), which manages all clinical negligence claims against member NHS bodies), and the Three- year Delivery Plan for Maternity Services.

The CQC maternity survey 2023 results were overall positive for the Trust and its service users. There are some areas of improvement required, and the Trust is working alongside the Maternity and Neonatal Voices Partnership to address these.

Notwithstanding the improvements made, there is still further work to do to continue to improve and assure the care and services we deliver to women and families. We owe it to those families we failed, and to those we care for today and in the future, to continue to make improvements, so that we are delivering the best possible care for the communities that we serve.

Maternity Quality Priorities 2025/2026

- Continue to deliver the outstanding Ockenden actions as part of the Maternity Transformation Plan
- Deliver NHS Resolutions Maternity (and perinatal) Incentive Scheme Year 6

- Work towards full implementation of the single delivery plan (incorporating the maternity and neonatal three-year plan and the Quality and Equity Strategy)
- Continue to increase the workforce and developing future leaders
- Introduction of advanced clinical practitioners (ACPs) into maternity

Equality, Diversity and Inclusion (EDI)

The Trust recognises the unique contribution that individual experiences, knowledge and skills make in the delivery of safe, high quality, patient centred healthcare and the importance of fulfilling the People Promise. Throughout 2024/25 we have continued to promote equality and challenge discrimination wherever it may occur across our organisation, striving to meet the needs of our diverse communities, and seeking to better understand and address health inequalities.

Work that has been undertaken in 2024/2025 include:

EDI Champions

This year we have recruited and trained over 60 champions across both sites and from different services. Equality, Diversity, and Inclusion (EDI). Champions play a crucial role in fostering a fair, accepting and inclusive workplace culture within our Trust. By championing EDI principles at the service level, they help to reduce the risk of discrimination and ensure that all employees feel welcome, cared for, valued and safe.

What do EDI Champions do?

- Raise awareness: Educate colleagues about EDI issues and identify areas for improvement within their department
- Provide support: Act as a point of contact for staff with EDI-related questions and guide them to appropriate resources or support services.
- Disseminate information: Share information about EDI initiatives, activities and best practices within their department.
- Promote staff networks: Encourage colleagues to participate in relevant staff networks within the Trust.

Training and Development

Senior clinical leaders, including nurses, midwives and allied health professionals, play a pivotal role in fostering a healthcare environment that is not only just and equitable, but also effectively addresses the diverse needs of both patients and staff. As leaders and role models, they are responsible for setting the tone for their teams by championing EDI principles.

In 2024/25, 220 clinical leaders' Band 7-8C in the nursing, midwifery and AHP workforce have been determined as a priority group to receive additional EDI training with a view to equipping these leaders with the critical knowledge and skills to:

- **Recognise and challenge unconscious biases:** Identify and address systemic and individual biases that may impact patient care and staff experiences
- **Advocate for marginalised groups:** Champion the needs of marginalised groups within the healthcare setting and advocate for equitable access to care
- **Create inclusive practices:** Develop and implement inclusive practices that accommodate the diverse cultural, social and individual needs of all staff and patients
- **Civility and Respect:** Enhance understanding and sensitivity towards the diverse needs of our patients and staff.

Equality, Diversity and Inclusion Advocates Group

The Equality, Diversity and Inclusion Advocates support and challenge SaTH in identifying existing health inequalities, developing action plans to tackle and eliminate issues. The aim is to ensure everyone at SaTH has a great patient experience, no matter their age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity.

The group was relaunched in April 2024 and is made up of diverse and passionate individuals with varied areas of interest. The group has been involved in projects such as the co-production of a patient information poster for planned improvements to signage at the RSH site, the Sunflower Lanyard initiative, Veteran Awareness and stakeholder focus sessions reviewing services as part of the Equality Delivery System review.

In 2025/26 the group intend to be involved in further co-production with patient information and plans for additional patient focused digital projects, along with many other projects that will improve service access and patient experience.

Reducing Health Inequalities

The Trust is a key stakeholder in the NHS Shropshire, Telford & Wrekin commitment to reduce healthcare inequality and the differences in health between different population groups in our society.

Priority objectives were identified for 2024/25:

- **Restoring Services Inclusively.** Using local data to plan the inclusive restoration of healthcare services
- **Mitigating Against Digital Exclusion.** Identify which populations are accessing face-to-face, telephone and virtual consultations to understand those groups who cannot afford an appropriate

digital device or mobile data, or who do not have Wi-Fi or internet access and people who do not have sufficient digital or language skills.

- **Ensuring Datasets are Complete and Timely.** To improve the collection and recording of ethnicity data to identify need and inform local targeted action based on identified need.
- **Accelerating Preventative Programmes.** Driving initiatives which focus on the prevention of long-term conditions including those focused on lifestyle-related risk-factors and the clinical areas outlined in the Core20PLUS5 for Adults and Children & Young People. **Core20** – those living in the 20% most deprived areas as defined by the Indices of Multiple Deprivation (IMD). **PLUS** – additional population groups identified by local intelligence who are likely to experience inequality in access, experience and health outcomes. For example, people with Learning Disabilities or Autism, ethnic minority communities, socially excluded groups (asylum seekers, Roma and Traveller communities, people experiencing homelessness or rough sleeping), Drug and Alcohol users or people living in rural areas.
- **Strengthening Leadership and Accountability.** Ensuring named executive leads are appointed for tackling health inequalities, improving awareness and knowledge of the workforce and supporting access to relevant training and development.

Our Digital Transformation Journey

The Shrewsbury and Telford Hospital NHS Trust continues to prioritise digital transformation as a key component of our Trust and digital strategies to enhance patient care, improve operational efficiency, and foster innovation. Building on the progress made in 2023/24, we further developed our digital solutions and capabilities across multiple service areas.

Key Achievements for 2024-2025

In 2024/2025 the digital team have completed the implementation of some major components of our CareFlow Electronic Patient Record (EPR). This included CareFlow PAS across inpatient and outpatient areas, CareFlow ED in both of our emergency departments, and Patient Flow boards on all wards. We also started our digital records journey with the introduction of a digital record in both emergency departments.

Additional schemes included:

Digital Improvements in 2024/2025	Benefits
Paediatric Vitals	Paediatric Vitals is a new flexible observation module that launched within Vitals 4.3 to meet national paediatric early warning score (PEWS) requirements. This allows the digital recording of Paediatric Observations in inpatient settings, including Emergency Care and Children's Assessment areas.

Paediatric Sepsis Assessments within Vitals	This is a function within paediatric vitals allowing nursing staff to complete sepsis screening electronically which is then signed off by the clinician reviewing the patient.
Patient Engagement Portal (DrDoctor Pilot)	When a patient is given an appointment at our hospital, they will start to receive a text to let them know that an appointment letter is available via an online Patient Portal. They will also receive text reminders about their appointments and short notice appointment offers. This project has reached its pilot stage within the ENT department and roll out to further clinical areas is expected in late 2025.
Secretaries Workstation (SEW 2)	Secretaries' workstation (SEW) 2 is the upgrade from SEW 1 and includes standardised letter templates, audit trails and is integrated with the Clinical Portal. Patients and General Practitioners will receive letters more rapidly with this system.
Surgical Assessment Unit (SAU) Electronic Whiteboard	A digital whiteboard to track patients and their care. The additional functionality includes integration with CareFlow PAS and tracking/prioritisation of patients, ensuring safe, co-ordinated care.
Windows 11 upgrade	The upgrade from Windows 10 to Windows 11 is mandatory to comply with NHS England security requirements.

Ambitions for 2024/2025

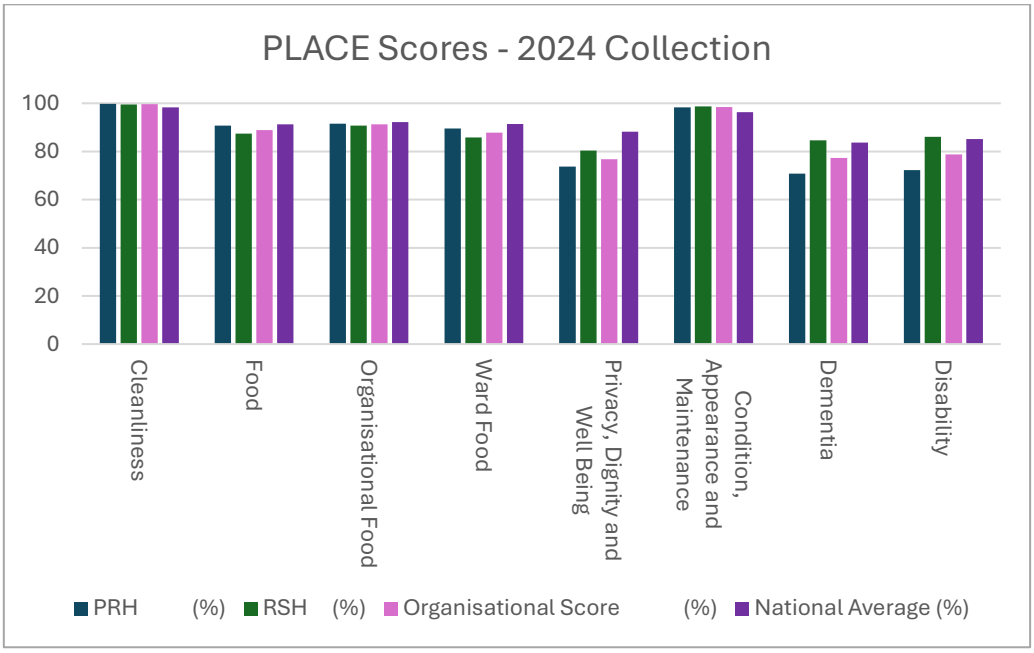
We want to continue to give our staff the right tools to deliver excellent care. In 2025/26 we will be:

- Giving patients access to more information through a patient portal and NHS app. Starting with electronic appointment letters and rescheduling requests
- Supporting teams to better manage supplies and reduce waste, with a new Inventory Management System
- Improving access to Radiology test requests and results across Primary and Secondary Care, with a more modern system (ICE Order Comms) in early 2026
- Purchasing a new bleep system for doctors improving safety and communication
- Implementing Medilogik Endoscopy Management System application enabling the electronic management of endoscopy referrals, vetting, booking & scheduling of procedures.
- Proactively explore new technologies, such as AI and digital records – supporting the sharing of information between systems and optimising resources
- Developing our data warehouse and analytical platforms through the nationally recognised Federated Data Platform enabling opportunities for innovative and enhanced care
- Continuing the adoption and optimisation of the CareFlow EPR through the further development of Clinical Narrative and our readiness to implement CareFlow Connect and Medicines Management systems

Patient Led Assessment of Care Environment (PLACE)

Patient Led Assessment of Care Environment (PLACE) reviews are assessments of the non-clinical aspects of NHS healthcare settings, undertaken by teams made up of staff and members of the public (known as Patient Assessors). The teams look at the environment's cleanliness, maintenance and condition, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or disabilities. Assessments took place during October and November 2024 and the results were issued in February 2025.

A summary of the Trust's results can be found in the graph below:



The Trust achieved scores which were above the national average in the cleanliness and condition, appearance and maintenance domains and day to day issues in these areas were addressed soon after the assessment if possible.

Domains that scored below the national average were food, privacy dignity and wellbeing, dementia and disability.

The longer-term actions will be discussed and prioritised at the PLACE Group which is a multi-disciplinary group including the Patient Representatives. However, following the previous PLACE audit improvement work has already commenced to improve the experience for patients with dementia and disability.

A small social area has been developed on a frail and complex ward at the Royal Shrewsbury Hospital. The area has been painted in the dementia friendly colour pallet, with comfortable chairs, and table to support a

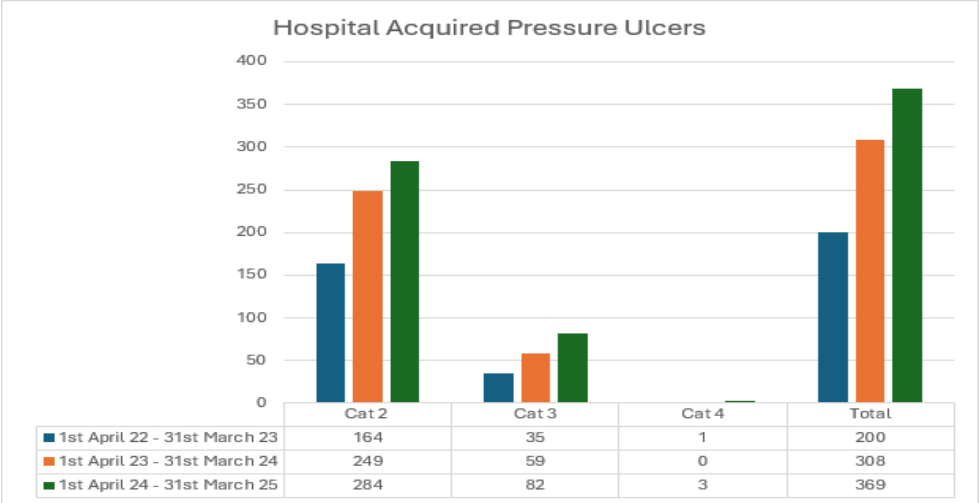
range of activities. The space has a range of resources including books and records, for patients to use. A group has been established to develop a programme of activities within the ward, which will be made available within the patient's social area. The area is presently being used by patients prior to the official opening by Professor Brian Dolan when he visits the Trust in June 2025. Plans are in place to create a similar space on the frail and complex ward at the Princess Royal Hospital.

Accessibility

The Trust recognises the needs of individuals with complex disabilities and has made progress in improving accessibility. A location has been identified for the development of a Changing Places facility at the Princess Royal Hospital. This space will provide a fully accessible toilet and washing facility, ensuring dignity, safety and comfort for patients, visitors and carers. The installation of a Changing Places facility has additionally been built into the HTP design for the building work underway at the Royal Shrewsbury Hospital.

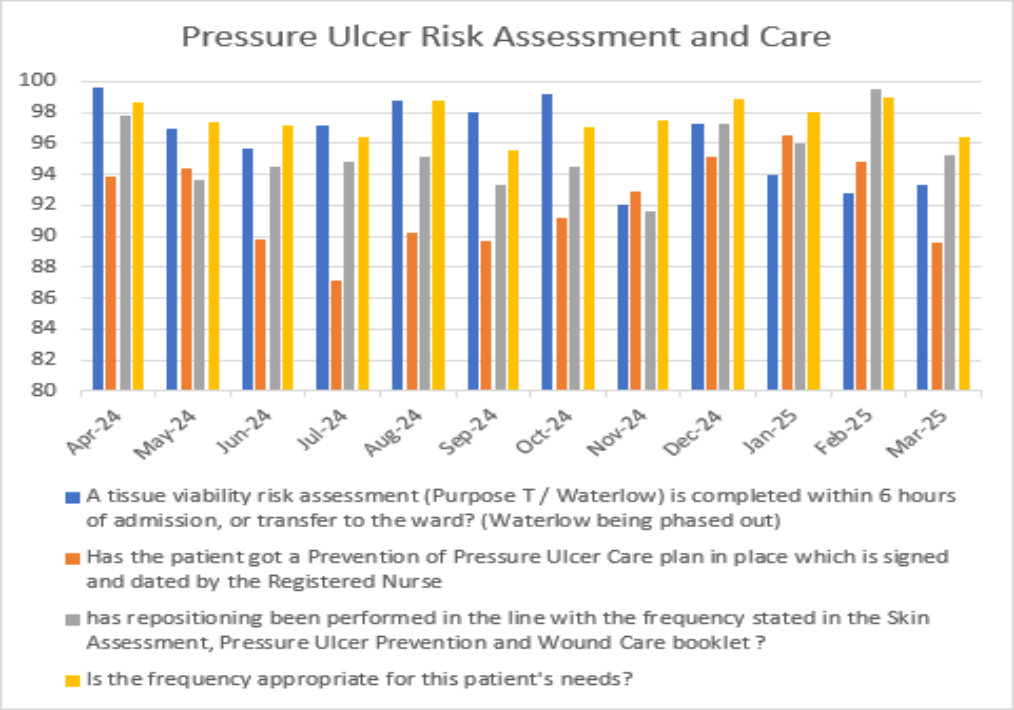
Pressure Ulcers.

The Trust has seen an increase in hospital acquired pressure ulcers year on year in the last 3 years as well as an increase in the number of category 3 and 4 (those pressure ulcers causing more severe harm to our patients).



	Cat 2	Cat 3	Cat 4	Total
1st April 22 - 31st March 23	164	35	1	200
1st April 23 - 31st March 24	249	59	0	308
1st April 24 - 31st March 25	284	82	3	369

Tissue viability documentation and care is reviewed monthly by the matrons as part of their Nursing Quality Metrics Reviews in each adult inpatient area.



A review of these audits shows common themes around:

- Timely completion of Skin assessments on admission
- Skin assessments being completed throughout the patient's episode of care
- Implementation of a Pressure Ulcer Prevention Care Plan
- Timely requesting and availability of pressure relieving equipment
- Adherence to planned re-positioning regimes

As outlined in Section 2.4, the reduction of hospital acquired pressure ulcers is a key quality priority for 2025/26. We have already reviewed and strengthened the governance and accountability at ward/department level around our pressure ulcer prevention management and some other actions we will be undertaking in 2025/26 have been outlined.

4.0 STATEMENTS FROM EXTERNAL ORGANISATIONS

1. Healthwatch Telford & Wrekin

Healthwatch Telford and Wrekin Quality Account Response 2024-25

We thank the Shrewsbury and Telford Hospital NHS Trust (SaTH) for the opportunity to comment on its Quality Account for 2024 to 2025. There were many points to consider this year. Rather than provide a lengthy narrative response we have decided to provide a theme-by-theme response, comment or observation where necessary and reference the page it is on. We hope this provides a better way to consider our points.

We note there are no references within the report to how many safeguarding issues have taken place that relate to failures in care or treatment i.e. neglect or physical abuse which could then impact the issues encountered in some aspects of the quality account reporting.

We look forwards to seeing the improvements listed within the account in next year's publication and are hopeful for even more improvements than shown in this one in making peoples experiences and journeys through their care better

Page	
5	Chief Execs statement not included
7-8	Look forward to seeing the results at the end of 2025/26 to see what difference the implementation of the Patient Safety Incident Response Framework has had as no demonstrable outputs included that show improved outcomes from learning.
8-10	We note the planned workstreams in 'Work to identify, escalate and ensure timely intervention of deteriorating adults and children'. We see the implementation of the 'digital Sepsis Screening assessment was implemented in the paediatric areas and ED departments on the 10th of September.' has achieved 100% compliance from November 2024. It would give the public and system partners confidence if the dashboard referred to are made available so that the performance can be observed.
10-11	It is concerning that despite the work to 'Reduce the number of inpatient falls and the level of harm' the figure has risen by 199 a 17% increase. It is important the trust has acknowledged 'any fall with significant harm is unacceptable and we aim to reduce this in 2025/26'. We look forward to seeing the results of this work. We hope the additional activity programmes cited support the improvements as intended. A cautionary note re the 'Compliance for completion of Falls Risk Assessment and Falls Prevention Actions' being referenced as compliance at over 90% does raise a question as to how the falls figures have then increased. The two do not sit well together and this should be factored into this year's work. We feel a further overall of the awareness training and a forensic evaluation of the falls risk tool to ensure it is adequately measuring risks when dealing with multiple factors such as age, capacity, mobility, decrease of mobility due to hospital stay on a sliding scale etc. and it to be a dynamic assessment so if a condition changes or another period of hospital stay is completed (number of bed days or weeks in hospital for example) impacts the score and flags additional steps needed. Additionally, a themes log after each recorded fall to try and establish why the numbers are increasing.
14	The work to 'Understand and reduce the number of omitted doses of time critical medication' is like others being stretched over into this following year – updated could be published at the end of quarters 1 and 2 if this year to again give confidence that these are being tackled as hoped. An inclusion of the rates of omitted doses would give greater insight into this concern and transparently show the scale of the problem. Also, would omitting some doses of critical medicines not be reportable as a safeguarding concern if there was a risk to life or life changing consequences?
15	The work to 'Improve reporting and missed Radiology results' is another action being stretched over into this following year. The trust needs to get to a position whereby actions can be achieved in the year they are first set so that it maximises its improvement journey.

16	It is concerning that the Trust has missed its target to screen over 75% of patients over 75 admitted for at least 3 days, by a sizeable margin. We note there are no plans to address this and raises a question of how this being part of a ward quality dashboard will help seeing as the results have been low since December 2024.
17-20	We acknowledge the work being undertaken to improve patient experience within the Emergency Departments. We note the improvements in handover times from ambulances though still below target and a cautionary note that this performance is dropping again and hope this can be reversed. Similarly, the improvements to initial triage, if representative only of pediatrics, shows improvements but residual drops after peaks reached, hopefully this can be further improved and a greater consistency achieved. The diversion for people who can be treated within Same Day Emergency Care is achieving well. We hope this continues to relieve pressure on the Emergency Department. We look forward to seeing further results showing improvements in the different strategies being applied. The results of the new Patient surveys show promising results though we note none of the graphs touch on people's experiences of their journey of access to see health professionals i.e. waiting times. Disappointing that the results of the Healthwatch A&E survey have not been used to at least create a benchmark with which to use for measuring improvements in this important aspect.
20-25	We note the work being undertaken to improve discharges, while there have been some tangible improvements in PRH with pre 5pm discharges for example, there remains much to do.
25-26	Improving care for people with Diabetes. Still much to do and supporting statistics to illustrate the impact the initiatives mentioned have had.
26-29	Improving diabetic foot care. We note success in the wait from referral to first assessment, the many other initiatives mentioned lack statistical metrics to gauge achievements or otherwise. We note the increase of people accessing the Diabetes foot team and of them more remaining in service.
29-33	'Demonstrating that as a Trust we are learning and improving patient, carer and public experience through complaints, patient surveys, feedback and compliments' – Multiple initiatives to meet this though a lack of metrics to illustrate the range and number of instances each initiative delivers an impact. We feel the trust is 'selling itself short' to coin a phrase as the narrative illustrates some well-intentioned improvements across all five areas of work though we note the slight improvement in staff being happy if a friend or relative was being treated, still far behind the national average but bucking the downward trend to be fair.
33-34	'Improve Quality Standards and demonstrate NICE guidance for Mental Health Training' – many new approaches mentioned but still no metrics to judge performance, aid transparency and hopefully illustrate opportunities to be applauded.
35-36	'Improving the care of patients with a learning disability and/or autism cared for in the Trust' – We note 86.3% in 2024/25 have undertaken the e-training – needs splitting for how many eligible staff for level 1 and or level 2 to then judge success rate. We acknowledge the transparent results of staff knowing about Patient Passports in relation to LD, much to do and hopefully we can celebrate success next year.
39	We note the performance of the trust in how it is achieving against the CQC report and look forward to next year's figures to illustrate all met. Likewise, we hope the feedback we collect from the public will echo the implementation of the actions to address the CQC findings.
48	'UK Comparative audit of Acute Upper…' - excellent results with 3% mortality rate compared to 8.7% nationally.
47-49	Metrics or statistics of performance prior to and since implementation would add value to the public to gauge the level of impact from participation in national audits.
49-57	Metrics or statistics of performance prior to and since implementation would add value to the public to gauge the level of impact from undertaking 294 local audits. Only 1 states a 5% improvement but nothing else. Many say standards being met, again is that a % or a clinical standard and how they may be met out of so many treated.
58-62	Metrics or statistics of the significant under-performance are needed to gauge the potential impact of non-compliance.

67-69	'Summary of mortality across the Trust' – It would give assurance to say how the trust compares against other comparator trusts across England to give assurance of performance. The Quality account could be further strengthened to say how the learning listed on page 68 is being implemented especially in light of other priorities where the trust is still facing issues with performance like for Diabetes care and delays in ambulance offloading for example. Whilst it is important to see that Structured Judgement Reviews are being strengthened with further people to support, it's about how each review goes on to inform process/care/treatment to avoid a similar further death that give the public confidence.
72-73	No data – unable to comment
74	'Percentage of Staff Who Would Recommend the Trust to a Friend or Family Needing Care' - It is true that the percentage of staff who would be happy to see their friend or family member treated within SaTH has increased, by 0.77%. Yes, ahead of the worst performing trust at 39.2% but still more 15% behind the England average of 61.54%. We hope to see better figures next year based on the planned work to improve this.
74-75	'The Trust Responsiveness to the Inpatients' Personal Needs' – statistically this can be seen as positive, that SaTH isn't lower is so, however, it is well towards the lower end of the 'About the same' score. We look forward to seeing this position increase substantially with all the actions detailed within the Quality Account.
76	'Venous Thromboembolism' – it would aid transparency to see how much under the 95% target the trust is. We look forward to seeing improvements based on the actions next year.
76	'Patient Safety Incidents and the Percentage Reported that Result in Severe Harm or Death' – it is assuring to see the new system 'Learn from Patient Safety Events' to relace the former one. Whilst the Trust says the national figures are not being published yet it would be useful to note what the latest set of those figures were to give an aspirational target for required improvements or maintained performance.
77	'Rates of Clostridioides difficile' – It is concerning that the rates have gone up and whilst reflective of the themes of previous years it adds a higher level of concern with the emerging theme 'around recurrence of infections/re-infection'. This is 14% increase on target numbers. It is good to see the Trust is able to establish themes to address this, more transparency could show if its certain departments/specialities or a Trust wide issue. We look forward to seeing an improvement next year based on the actions.
78-84	We note the priorities for Quality Improvement for 2025/26. Where possible it would be good to see more specific targets rather increase or decrease so performance can be better judged with some realistic targets. We look forward to seeing an improvement next year based on the actions.
85	We note the successful compliance with the 11 national patient safety alerts received.
86	We note that the 'Review, Action and Learning from the Incidents Group' reference 38 cases. This seems out of kilter with the Patient Safety Incidents on page 76 which appears to indicate there were 90 cases of 'severe harm or death' – some mutual explanation of how the two sets of figures inter-relate would be useful.
87	It is good to see the Trust well below the national average of 2.3 never events recording only 1.
87	'Emergency Department FFT' – the trust is some way behind the national 'mean' performance indicator – more concern is the gulf between the Royal Shrewsbury Hospital scoring 75.7% but the Princess Royal Hospital scoring 60.7% - a full 15% lower. It would be helpful to see what targeted improvements have been implemented or are intending to be so that the Trust can moderate its own performance for this item next year and aid public scrutiny.
88	'Inpatient FFT' – is good to see one area scoring well, though it has to be acknowledged the low response rates.
88	'Outpatient Department FFT' – performing really well – what lessons can be learned from this to adopt in departments like emergency care?
89	'National Inpatient Survey' – concerning to see people didn't feel they got enough support from health or social care and in not knowing what would happen with their care when they left. Also concerning is the lower score for virtual wards along with admissions and understanding doctors. It

	will be good to see how the improvements, listed on page 90, impact on the results for the following years survey.
90	'National Maternity Survey' – reassuring to read the narrative on pages 90 and 91 bar the last paragraph. It does raise questions if the trust is scoring much the same as other trusts in all 10 areas to then see the five worst scoring questions on page 92 showing poorer performance. This might confuse the reader as on one part we're doing much the same but the next shows demonstrable differences. It's vital that public confidence is maintained especially in light of recent media release by West Mercia Police. A more transparent inclusion of all the scores might do well to support that and back up the actions described so the impact can be seen next year.
93	'Maternity Improvement' – the first two sets of actions 'Saving Babies Lives Care Bundle v3' and 'Clinical Negligence Scheme Trusts Maternity Incentive Scheme Year 5' declared compliance with both sets is very encouraging as is the progress in addressing the 210 actions from 'Ockenden Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust. Implementing the Recommendations'. We note the three actions at risk as per the last bullet point on page 95 are missing, so we cannot comment on these. We look forward to next years updates and seeing full compliance where it is possible.
100	We note the scores of the 'Patient Led Assessment of Care Environment' which give cause for concern in relation to PRH regarding 'Privacy, Dignity and Wellbeing', 'Dementia' and 'Disability'. We see actions for the Royal Shrewsbury Hospital but none for the Princess Royal Hospital that fared worse, bar copying the small social area which has been created and being opened by Professor Brian Dolan. Good for Shrewsbury but not so good for Telford.
101	'Pressure Ulcers' – concerning to see an increase in the number of category 3 and 4 hospital acquired pressure ulcers in addition to a sustained increase for all categories for the last 3 years. We look forward to seeing a significant improvement next year based on the actions within this Quality account.

Simon Fogell, Chief Executive – Healthwatch Telford and Wrekin

2. Healthwatch Shropshire

Healthwatch Shropshire response to the SaTH Quality Account 2024-25

Healthwatch Shropshire (HWS) has a statutory role as the champion for the people of Shropshire and we rely on the 'patient's voice' to tell us of their experiences of health and social care services. We welcome the opportunity to comment on SaTH's Quality Account for 2024/25.

Priorities for Quality Improvement 2024-25

1. PSIRF

Learning from incidents: we were pleased to learn of the establishment of the Family Liaison Team, which we hope will prove a valuable support for patients and their families, as well as staff, in explaining what led to an adverse situation, and what will be done to ensure it does not recur.

System-wide approach to improving **the recognition and management of deteriorating patients.** Introduction of real-time, electronic measures of ill children (Paediatric Vitals) has obviously been very successful in improving the care of very sick children (the increased screening for sepsis – from 30% to a sustained 100% - following its introduction is particularly noteworthy). However, it is unclear whether similar improvements have been achieved with adults.

Inpatient falls: In 2024/2025 the number of inpatient falls increased to 1365 from 1166 in 2023/24 The increased number of people suffering moderate or severe harm as a consequence of a fall is

of concern (41 people in 2023/24 and 52 in 2024/25). Although you say no themes have been identified within the overall pattern of falls, it would be helpful to know what factors contribute to these more serious outcomes that you have identified through the PSIRF process.
Improve reporting and missed Radiology results. HWS is aware of the national shortage of radiologists, but we are also very aware, though the comments we receive, of the huge distress caused by the long waits (commonly three months or more) for an MRI report in cases of suspected cancer. It is unclear to us how the actions listed on page 15 will address these delays.

2. Cognition screening
The references to screening for delirium (also on page 49), should surely be for dementia?

3. Patient experience in A&E departments.
At its Enter and View RSH visit in July 2024, HWS recorded positive experiences from the patients and visitors we spoke to. https://www.healthwatchshropshire.co.uk/report/2024-08-22/royal-shrewsbury-hospital-emergency-department-enter-view-visit-report The graphs of the Trust's own surveys, indicate these are generally being sustained. We are also pleased to see there has been a significant improvement in reducing delays in the handover of ambulances arriving at the Emergency Department in Quarter 3 and 4 of 2024/25 compared with the same time the previous year, following our report, Calling for an ambulance in an emergency | Healthwatch Shropshire. The improvements in response times to complaints about ED are also noted.

4. Admissions and Discharges processes
An average of three hours in the discharge lounge appears an improvement on earlier years, but it is concerning to read that some people remain in the discharge lounge overnight.

5 and 6. Diabetes Care, including hospital foot care
Address and improve care with people with diabetes through close working with system partners.'
We were keen to see the outcome of this work and hoped it might address some of the issues we raised in our October 2023 report Diabetes Care and Support in Shropshire. We are disappointed at the slow rate of progress made by the system as a whole, although we note the introduction of a hot clinic for patients presenting to the Emergency Department and Urgent Care Centres with diabetic foot complications, enabling next day access for patients with diabetic foot issues.

7. Learning from Experience
We are particularly pleased to see the progress made in speedier and more personal responses to families concerned about the end of life care of their loved ones, and other related initiatives. You will recall these were particular concerns raised by respondents in our report https://www.healthwatchshropshire.co.uk/report/2023-10-18/nhs-and-social-care-complaints-report At a more general level we were of course pleased to note the most recent CQC inspections on End of Life Care (at both sites) and Children and Young People services moved from a previous overall rating of 'inadequate' in the 2021 inspection to 'good' across all 5 CQC domains and a 'good' rating overall.

8. Quality standards and NICE guidance for mental health
The work of the Dementia Team with those people that are recognised with dementia is to be commended but the screening deficiencies mean that there may be many vulnerable people not getting the care and support they need. Patient experience we have received and shared with the Trust highlights the issues and impact on patient care that can occur where patients are not identified.

9. Care of people with learning disabilities and autism

There continues to be a general lack of awareness of the Learning Disability patient passport, and a disappointing uptake of LD awareness training.

We would also like to comment on your processes for **clinical governance and measuring outcomes**. Despite the challenges facing SaTH in 2024/25, the commitment to Research and Innovation remains impressive. Through HWS's regular meetings with the Nursing and Quality Directorate we have also been aware of the improvements in investigation of incidents and follow-up through your RALIG processes.

Priorities for Quality Improvement 2025 - 26

Healthwatch Shropshire supports the Trust in the choice of priorities for the coming year and are encouraged to see the continued focus on areas highlighted in this Quality Account where improvements are still sought. The new priority around Radiology is welcomed, patients have shared their anxieties and frustrations around delays in radiology reporting with us.
We look forward to working collaboratively with the Trust in the coming year to improve patients' experiences.

1. PSIRF deteriorating patient, reducing falls, omitted doses, missed radiology reporting.
2. Reduce hospital-acquired pressure sore ulcers
3. Nutritional assessments and care planning. HWS plans to undertake a programme of visits in 2025/26 to acute, mental health and community hospitals as well as care homes to discuss people's experiences of nutrition and food quality.
4. Reduce radiology wait times and reporting delays
5. Emergency care pathway
6. Discharge processes. In 2025/26 HWS will be undertaking (with ShropComm) a survey of patients' experiences of Virtual Wards.
7. Diabetes foot care
8. Reduce risk of mortality in acutely ill patients
9. Care of people with LD and autism.

3. Shropshire Telford and Wrekin ICB

NHS Shropshire, Telford and Wrekin

Integrated Care System
Shropshire, Telford and Wrekin

SaTH Quality Account Statement from Shropshire Telford and Wrekin ICB 2024/25

Our Ref: VW

Dear Paula

Re: Quality Account 1 April 2024 - 31 March 2025

Please find below the ICB response to the SaTH Quality Account 24/25. Thank you for the opportunity to comment on this.

NHS Shropshire Telford and Wrekin Integrated Care Board (the ICB) are pleased to have the opportunity to review the Shrewsbury and Telford Hospital (SaTH) NHS Trust Quality Account for 2024/25. The account

demonstrates how SaTH has worked with their teams and collaborated with partners in the integrated care system (ICS) and external agencies and regulators to address the needs of the population and improve the quality of healthcare services offered by the Trust and ICS.

SaTH have successfully transitioned to the Patient Safety Incident Framework (PSIRF) methodology during 2024/25 which is strengthened by the adoption of new ways of investigating incidents and sharing learning though the use of the framework's tools. This has resulted in collaborative working across the system which supports shared learning and improvements. This is highlighted by the reference to a never event in the quality account which was managed with transparency and used a systems engineering initiative for patient safety (SIEPS) framework to enhance learning and safety improvements.

The introduction of the Family Liaison Team to support patients and families involved in incidents is a welcome addition to enhance a compassionate approach to managing incidents and a similar approach, adopted in complaints management, whereby matrons are contacting patients and families directly to support with concerns.

Reducing inpatient patient falls and hospital acquired pressure ulcers are both areas that are raised in the quality account as aspects of care that require continued work and monitoring to improve. These are regularly discussed at SaTH quality meetings which the ICB is pleased to contribute to. There is transparency in the reporting of these incidents, and the report outlines the improvement projects that SaTH are supporting to reduce these harms. The prevention of deconditioning in the frail elderly is also a positive initiative in not only reducing the risk of falls and pressure ulcers, but also of improving the likelihood of patients returning to their usual place of residence.

We note the Trust's response to the challenges of achieving national infection prevention and control objectives, reporting 112 cases *Clostridioides diffiicile* against an agreed objective of 98. We are supportive of actions to address this, and other healthcare associated infections, as well as the part SaTH plays in support of the system approach to controlling infection.

Urgent and Emergency Care UEC, which includes the Emergency Departments, has been a high priority focus during the last year. The ICB would like to congratulate SaTH on the improvements so far which contribute to improved quality of care, including the Hospital Transformation Work, Category 2 ambulance response times. In particular, the ICB would like to acknowledge the commitment of the team to improve quality in relation to both CQC findings and following the Dispatches programme as referred to in the account.

We note the progress with maternity and neonatal services and the steps taken to address the independent maternity review while driving quality improvements. The account acknowledges the duty to those families who were failed as found in the enquiry, and the commitment by the Trust to ongoing actions to improve maternity and neonatal care and family involvement.

In summary, the account focusses on a review of the nine quality priorities under the domains of safety, effective and patient experience. It is the ICB view that the account accurately reflects the achievements made by SaTH in 2024/25 as well as demonstrating an awareness for further improvement for 2025/26 period. The ICB looks forward to working with SaTH as a system partner into 2025/26.

Best wishes

Vanessa

Vanessa Whately
Chief Nursing Officer
NHS Shropshire Telford and Wrekin

The Shrewsbury and Telford Hospital NHS Trust

Feedback Form

We hope you have found the Quality Account useful.

In order to provide improvements to our Quality Account we would be grateful if you would take the time to complete the feedback form

How useful did you find this report?	Very useful ☐ Quite useful ☐ Not very useful ☐ Not useful at all ☐
Did you find the context?	Too simplistic ☐ About right ☐ Too complicated ☐
Is the presentation of data clearly labelled?	Yes completely ☐ Yes, to some extent ☐ No ☐
Is there anything in this report you found particularly useful?	
Is there anything you would like to see in next year's Quality Account?	

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