NHS
The Shrewsbury and Telford Hospital
NHS Trust

Quality Account
2025/26

Moving to EXCELLENCE

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SECTION 1.0: INTRODUCTION

1.0 : STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OFFICER

Welcome to the Quality Account for the Shrewsbury and Telford Hospital NHS Trust 2025/2026.

I am pleased to present our Quality Account for the period 2025/2026. The Quality Account provides an opportunity to reflect on our progress over the last year; it shares our performance and outcomes with our patients, their loved ones, our public and local communities, and key stakeholders across our health economy for their scrutiny.

It outlines our performance against our key quality priorities set for 2025/2026, our local quality and safety metrics, and national metrics. It also details our quality priorities for 2026/2027 which includes reducing avoidable harms whilst in our care, ensuring all patients experience a safe and timely discharge, improving the experience of our emergency care pathways, elective and cancer pathways and improving the care of the deteriorating patient. These priorities were developed with contributions from our patients and staff and represent our key areas of focus over the coming year to improve patient experience and outcomes and continue to embed our culture of continuous learning and improvement.

Some of our improvements in 2025/2026 include:

- Reduction in the number of falls resulting in severe harm
- Reduction in the number of acquired pressure ulcers (total number of category 3 & 4 pressure ulcers) that result in the most significant harm to patients
- Improvements in both our 18 week and 52-week performance for patients treated on our elective care pathways
- Significant improvements in the number of patients having their diagnostic tests within the 6-week target
- Improvements in the number of patients who are assessed within 15 minutes of arrival at our Emergency Departments and improvement in our average ambulance handover times
- Improvements in our quality of care metrics in our Emergency Departments
- An increase in the number of diabetic patients receiving a foot assessment on admission, and implementation of care to prevent harm

Quality and safety remains a key priority for the Shrewsbury and Telford Hospital NHS Trust. We have worked closely with our Community Trust, and System partners in 2025/2026 to ensure that only patients requiring emergency care are attending our emergency departments, ensuring that ambulances do not have long waits

outside our hospitals and that we address delays in discharging our patients. We have continued to review the services we deliver to ensure more patients can access the right care and services at the right time.

We recognise that we need to continue to improve and are committed to making these improvements, working closely with our patients, public, staff, regulators, and our healthcare partners. With the formation of the new Group model on the 1st April 2026 between the Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Health NHS Trust, and through the development of our Neighbourhood Health models we are excited about the new opportunities we will have to continue this improvement work in 2026/2027.

Finally, I would like to thank all our dedicated staff who have worked so hard over the last year to ensure we continue to deliver high quality, patient centred care, that is kind and compassionate. I am truly grateful for their unrelenting determination to improve the care and experience for our patients, and they should be very proud of what they have achieved.

Jo Williams
Group Chief Executive
Date: 22 June 2026

SECTION 2: PRIORITIES FOR IMPROVEMENT AND STATEMENT OF ASSURANCE

This section outlines the detail behind each of the quality priorities previously agreed for 2025/26 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 2026/27 are outlined, why we have chosen these and the actions we will take to achieve these throughout 2026/27.

2.1 REVIEW OF THE PRIORITIES FOR IMPROVEMENT 2025/2026

The quality priorities for 2025/2026 were developed following a review of the 2024/25 priorities, the progress made in relation to achieving these and the ongoing key quality and safety challenges faced by the Trust. This meant that some of the 2024/2025 quality priorities were continued or revised in 2025/26. Some new priorities were also included for 2025/2026. We also looked for some of our priorities to reflect the joint quality working with System partners.

In 2025/2026 the Trust undertook a review of the Quality Strategy and commenced the development of a new Quality and Safety Strategy. We are awaiting the publication of NHS England National Quality Strategy before finalising this and will be working towards creating a Group Quality and Safety Strategy during 2026/27.

The quality priorities for 2025/2026 are outlined below. There was 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 all of our priorities reported in 2025/2026.

Progress with the quality priorities has been monitored at a number of levels in the Trust: through our monthly "Nursing Quality Metrics Confirm and Challenge" meetings, at Speciality and Divisional Level as part of the Performance Reviews and at a Trust level via regular reporting through to our the Quality Operational Committee and the Quality and Safety Assurance Committee as we continue our journey "***Moving to Excellence".*** This has enabled us to triangulate the work being undertaken for these priorities into the tangible benefits in relation to improved patient care and outcomes.

QUALITY PRIORITIES		
SAFE	Priority 1	PSIRF Priorities: 1. The Deteriorating Patient 2. Reducing Inpatient Falls 3. Omitted doses of time critical medication 4. Missed radiology reporting
	Priority 2	Reduce Hospital Acquired Pressure Ulcers

EFFECTIVE	Priority 3	Achieve best compliance with nutritional assessments and nutritional care planning
	Priority 4	Improve the experience of our elective care pathways: reducing our radiology waiting times and reducing radiology reporting delays
	Priority 5	Improve the experience of our emergency care pathway: • Improving time to triage initial assessment • Improve the timeliness of handover for patients arriving by ambulance • Reducing the number of patients who spend more than 4 hour and more than 12 hours in our department • Improve the number of patients reporting a positive experience of care in our EDs
	Priority 6	Implement System-wide working to improve the discharge planning processes and our patients' experience of involvement in their discharge plans
PATIENT EXPERIENCE	Priority 7	Improve Foot care for people with Diabetes (PWD) who are admitted to the Trust
	Priority 8	Reduce the risk of mortality in patients presenting to the Trust who are acutely unwell
	Priority 9	Improve the experience of patients and their loved ones who have a Learning Disability and/or autism

The priority actions for 2025/26 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 2025/26 work has continued to be undertaken to progress these priorities and provide the foundation for ongoing improvement work in 2026/27 with an ongoing focus on the outcomes this improvement work has in relation to safer, high quality patient care.

1. **The Deteriorating Patient: Continue to work to identify, escalate and ensure timely intervention for deteriorating adults and children.**
    - 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 standardised response model
    - Implement targeted training

2. **Reducing Inpatient Falls: Reduce the number of inpatient falls and the level of harm**
    - Trial the bedside mobility assessment tool to increase early mobilisation in patients and increase the number of patients sat out at mealtimes and prevent deconditioning associated with increased falls

- Improve compliance with Lying and Standing blood pressure recording
- Increase awareness of falls prevention

3. **Omitted Doses of Time Critical Medicine: Understand and reduce the number of omitted doses of time critical medication**
    - Continue audits to identify numbers and themes of omitted doses and develop local and immediate action plans, monitoring through Ward Quality Metric Confirm and Challenge meeting
    - Observation session by the Medicine Safety Officer using structured systems approach observation tool in clinical areas
    - Complete staff focus groups by August 2025 and outline improvement actions
    - Implement test of change cycles on four wards
    - Based on test of change outline ongoing improvement actions to roll out Trust wide
    - Ensure improvement work is integrated into implementation of EPMA

4. **Missed Radiology Reporting: Improve reporting and missed radiology results**
    - Complete a review of the use of RadAlert/ICE to track radiology results
    - Compare this against mapping to indicate the risks and issues in the current system before the ICE system is operational
    - Produce a revised risk assessment of the new process to demonstrate a reduction in risks/hazards in terms of radiology results not being actions

What we have achieved

1. **Deteriorating Patient: Continue to work to identify, escalate and ensure timely intervention for deteriorating adults and children**

Throughout 2025/26, the Trust has continued to strengthen a coordinated, Trust-wide approach to the recognition, escalation and management of deteriorating patients. This work remains central to patient safety, quality improvement and the Trust's commitment to delivering safe, reliable and compassionate care.

The approach is underpinned by the PIER framework (Prevention, Identification, Escalation and Response) and has focused on improving reliability, visibility and accountability across all services. Delivery has been collaborative, aligning corporate oversight with divisional ownership and frontline engagement, and embedding improvement within existing governance and transformation structures.

Progress during the year has continued through the focused workstreams aimed at addressing the following key areas:

- Improved frequency of patient observation compliance
- Strengthened governance and oversight of key metrics

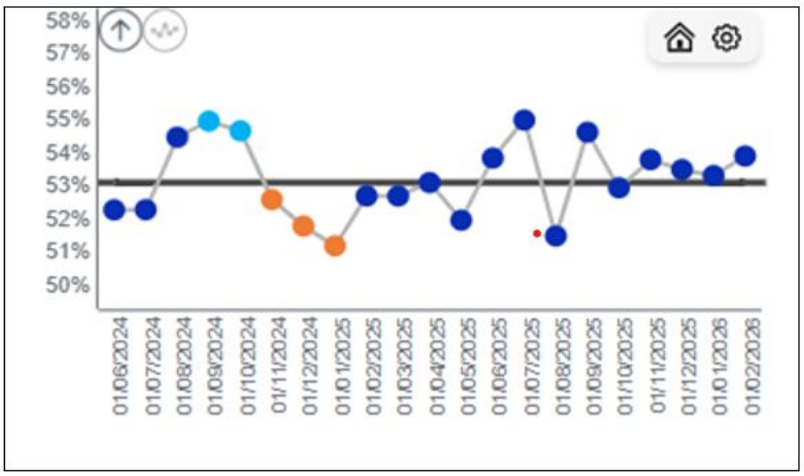
- Embed tools to support shared decision making and patient-centred care
- Develop and embedded a standardised response model
- Implement targeted training

Delivered across divisions in partnership with nursing, clinical and digital teams alongside operational leaders, this has reinforced a consistent Trust approach.

- **Improved frequency of patient observation compliance.**

Reliable physiological monitoring remains fundamental to the early identification of deterioration. During 2025/26, face to face teaching with teams on expected standards of observations and prioritising timely patient observations has commenced. Performance against this target is shown below in Figure 1.

Figure 1.0: % Observation compliance for patients at risk of deterioration

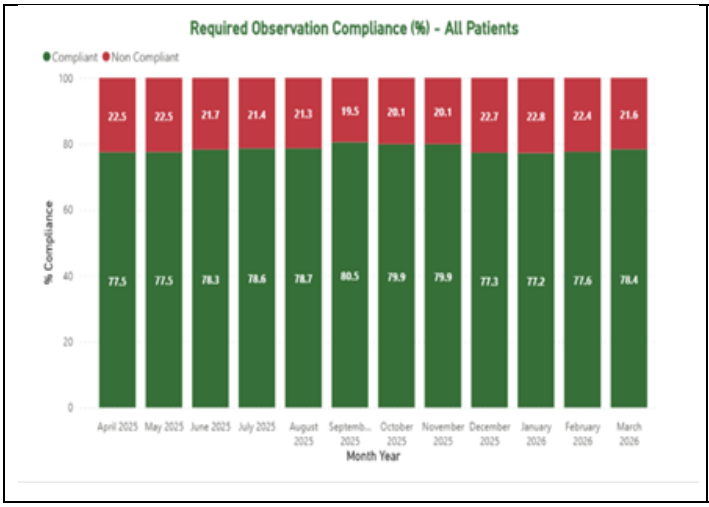


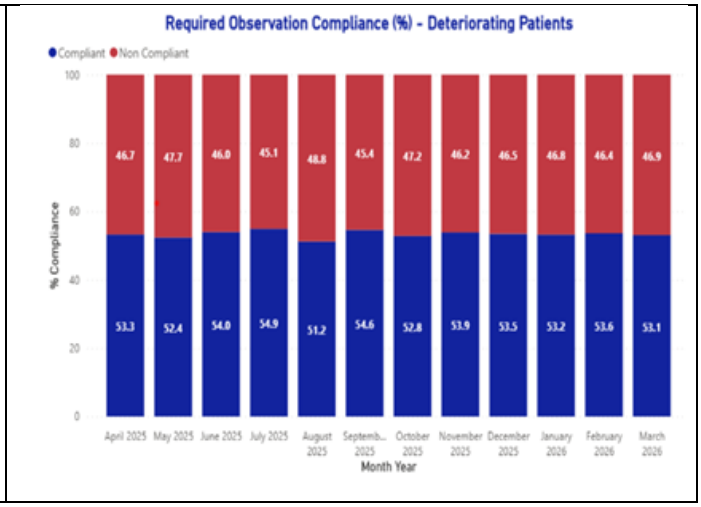
The ambition over the next 12 months is to achieve and sustain compliance levels of at least 95%.

Whilst this target has not been achieved in 2025/2026, overall Early Warning Score (EWS) aligned observation frequency has continued to show some improvement this year.

Concurrently digital reports have been developed to provide clear and timely performance information to both the clinical and operational teams (Figure 2). These digital reports give real-time visibility of compliance across the Trust, and at divisional and department level. It also outlines trends to be explored in detail, helping teams better understand where improvements are needed and supports focused actions to improve patient care and safety.

Figure 2 Observation Compliance -Trust-wide All patients & Deteriorating patients





Analysis indicates that these trends reflect competing priorities within ward areas rather than staffing shortfalls in isolation. By embedding real time reports visible to the ward managers, we aim to strengthen the focus on patient safety, adapting the routine of the ward by introducing set timed observation rounds, and establish a continuous feedback approach that enables sustained quality improvement across the organisation.

- **Strengthened Governance and Oversight of Key Metrics**

Over the past 12 months, this work has been embedded into routine governance processes. Key deterioration indicators are now regularly reviewed at monthly nursing metric meetings with ward matrons and operational leads, supported by audit and exemplar ward processes.

This ensures clear oversight and accountability, supports early identification of risk, and enables timely action helping to deliver safer, more consistent, high-quality patient care.

- **Embed tools to support shared decision making and patient-centred care.**

A review of existing processes has focused on strengthening shared decision-making, ensuring escalation pathways support timely review by the right clinician, while remaining aligned with patient-centred treatment goals.

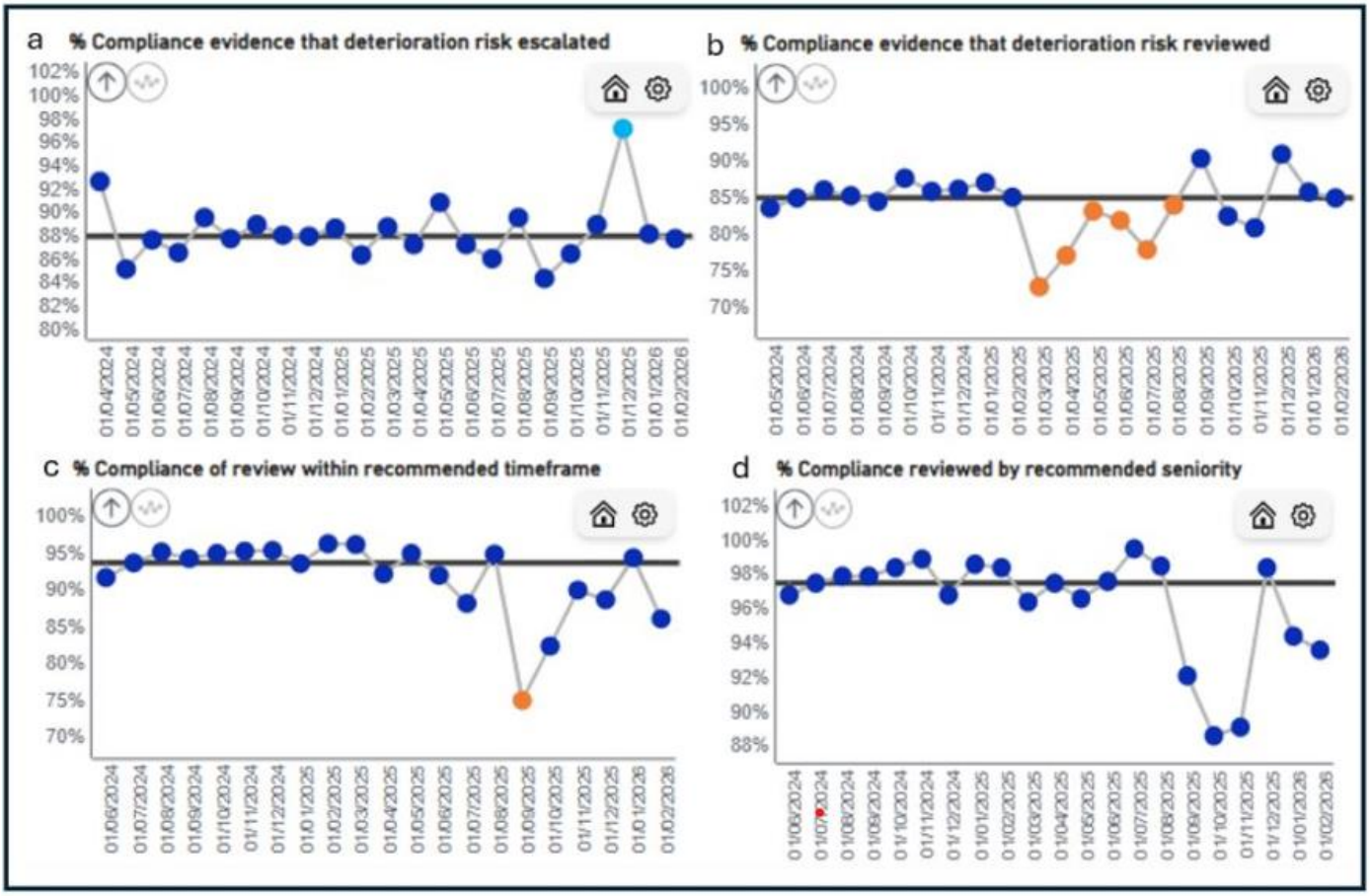
Over the past 12 months, this complex area has been progressed through Plan-Do-Study-Act (PDSA) cycles, refining approaches to urgent escalation, documentation, communication, and personalised escalation planning. This work is essential to support the delivery of safe, patient-centred care but requires further development to ensure consistent practice, aligned with Martha's Rule and the Hospital Transformation Programme (HTP) planning, and integrated with digital solutions such as CareFlow Connect.

- **Develop a Standardised Response Model.**

During staff training, ward visits by the deteriorating patient team and the use of visual aids in wards/departments, escalation pathways are clarified to optimise timely clinical response.

Data regarding escalation compliance is averaging 85% (Fig 3.0 a). Current data on responsiveness to deteriorating patients in Fig 3.0b shows during 2025/26 there were fluctuations, at its lowest the compliance dipped to 75%, at the end of Q4 we were able to demonstrate an improved compliance of 85%.

Figure 3.0 Escalation and Response Trust Performance

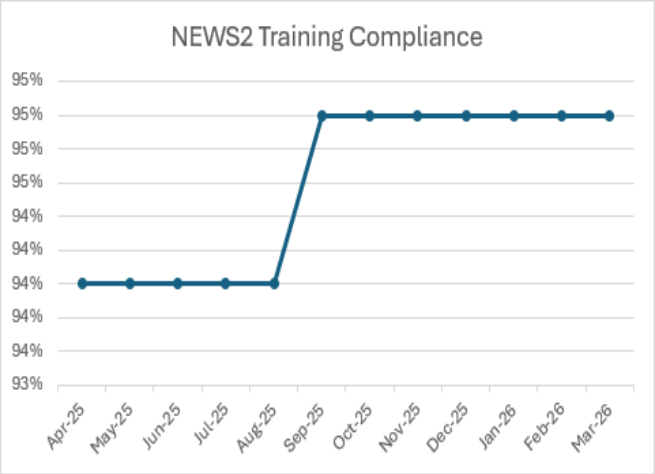


In 2025/2026 the Deteriorating Patient Team have engaged and worked with clinical teams to understand the challenges. There has been focused work on designing a response form (which standardises and ensures consistency in documented response). This work is ongoing and will be formally introduced later this year. Further documents which support decision making aligned to patient centred treatment goals are also in development (e.g. Treatment Escalation Plan TEP) and form ongoing improvement work in our clinical areas. This has been complemented in 2025/2026 by wider trust improvements, including development of a 24/7 Critical Care Outreach service (at RSH) and work to establish consistent Hospital at Night (H@N) provision across adult inpatient services on both sites. Together, these initiatives have strengthened the Trust's ability to deliver a reliable and timely response to patient deterioration.

- **Implemented Targeted Training.**

NEWS2 training compliance has shown improvement to 95% across the Trust in 2025/2026. The new 'Clinical Skill.net Sepsis training' was implemented in August 2025, and we have seen compliance improve (Fig 4.0).

Fig 4.0 Compliance NEWS2 training



The Deteriorating Patient Team have been working collaboratively with clinical and education teams to develop a more comprehensive training programme specifically focusing on deteriorating patients.

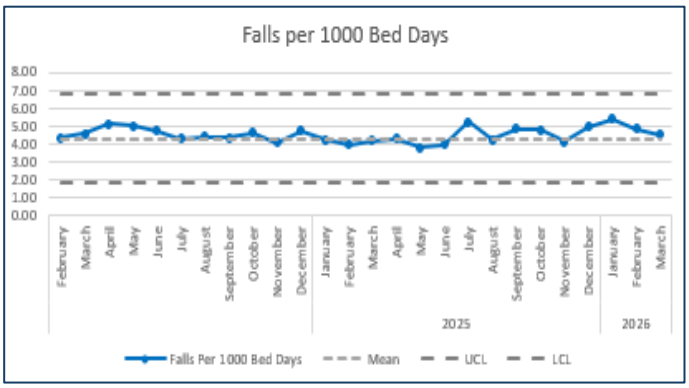
This training focuses on early identification and management of the deteriorating patient using e-learning modules and simulation-based methods to build knowledge, confidence. This training will begin in 2026/27.

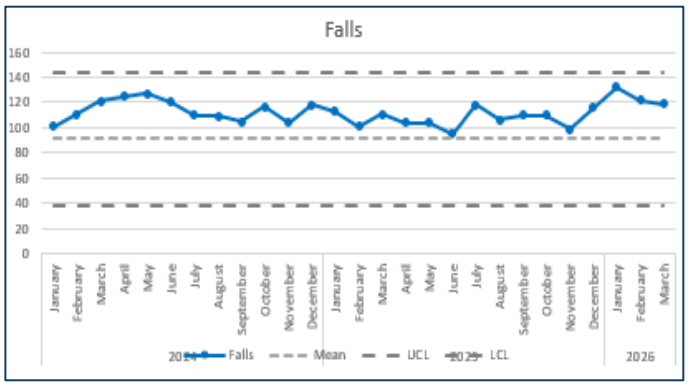
Looking Ahead

The identification, escalation and timely management of deteriorating adults and children will remain a core Quality Priority in 2026/27. The Trust will continue to focus on improving reliability of observation monitoring, strengthening escalation pathways and optimising clinical response, supported by digital capability and robust governance.

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

During 2025/26 one of our main objectives, through a targeted approach, was to reduce the number of inpatient falls following an increase in the total number of falls to 1360 during the previous year, 2024/25. This was achieved with a reduction of in inpatient falls to 1335 representing 1.84% reduction.





To note the graph showing falls per 1000 bed days is based on estimated bed days not actual; the Trust has actually seen an increase in the bed base from December 2025 with the opening of 56 additional beds at the

Royal Shrewsbury Hospital site and additional assessment spaces and medical beds at the Princess Royal Hospital.

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
2025/26	694	599	37	5

In 2025/26 the Trust inpatient falls resulting in severe harm decreased by 66%. However, our aim is that no patient suffers serious harm as a result of a fall whilst in our care. The Trust aims to continue to reduce this further in 2026/2027 through undertaking ongoing work in relation to falls risk assessments, care planning, cohorting of patients at high risk of a fall and reconditioning work.

Falls Reviews

A full review of falls with harm was completed to identify any themes. All pre- falls documentation and interventions were in place to mitigate against a fall occurring in the cohort of patients who experienced harm. Lying and standing blood pressure was not consistently recorded following a fall, on most occasions, this was due to the patient's condition following a fall, but this was documented in the nursing evaluation and undertaken as soon as the patient was able to stand.

New to the falls reviews in 2025/2026 was the addition of a Parkinson's question to correlate if the fall was due to late or missed doses of Parkinson's medication. The chart below shows full compliance in relation to the administration of Parkinson's medication for all patients who had a Parkinson's diagnosis and experienced an inpatient fall who fell.

Mth	Number of Parkinsons Patients who fell	Pre-Fall Parkinsons medication given on time
Jan	2	100%
Feb	1	100%
March	3	100%

Compliance for completion of Falls Risk Assessment and Falls Prevention Actions

Throughout 2025/26 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 the 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. Weekly re-assessments or

assessments if the patient conditions changes was 93.4%. The completion of updating the risk assessment following a fall is also consistently high at 91%.

- **Trial the Bedside Mobility Assessment Tool (BMAT) to increase early mobilisation in patients and increase the number of patients sat out at mealtimes to prevent deconditioning associated with increased falls.**

Early and safe mobilisation is essential to reducing hospital-associated deconditioning, preventing complications, and supporting timely discharge. Current Moving and Handling (M&H) assessments completed weekly by nursing staff do not always reflect real-time patient mobility, leading to missed opportunities for early mobilisation, increased falls risk, avoidable pressure ulcers, and inconsistent communication across the multidisciplinary team.

Hospital-associated deconditioning is a well-recognised issue in UK healthcare, particularly highlighted through Professor Brian Dolan's #EndPJparalysis movement. NHS England reports that many frail older adults spend up to 83% of their inpatient stay in bed, walking only a few steps a day, and this lack of mobility leads to rapid deconditioning characterised by loss of fitness, muscle tone, and independence. Deconditioning can begin within 24–48 hours of admission and can delay recovery and lead to a prolonged length of stay, emphasising the need for structured approaches to maintain mobility in hospital.

To address these issues, the Bedside Mobility Assessment Tool (BMAT) was piloted on two medical wards at SaTH (Ward 26 RSH and Ward 11 PRH). BMAT offers a quick, standardised way for nursing staff to assess a patient's functional mobility and match them with the correct level of assistance or equipment.

Prior to the six-week pilot, staff received face to face targeted training, and the Quality team completed weekly audits during the pilot to monitor uptake and practice. The pilot demonstrated improved clarity around mobility status and increased awareness of patient ability and there was more evidence of an increased number of patients sitting out.

Key aspect of BMAT:

Purpose: To identify a patient's highest achievable mobility level and match it with the safest handling approach or equipment.

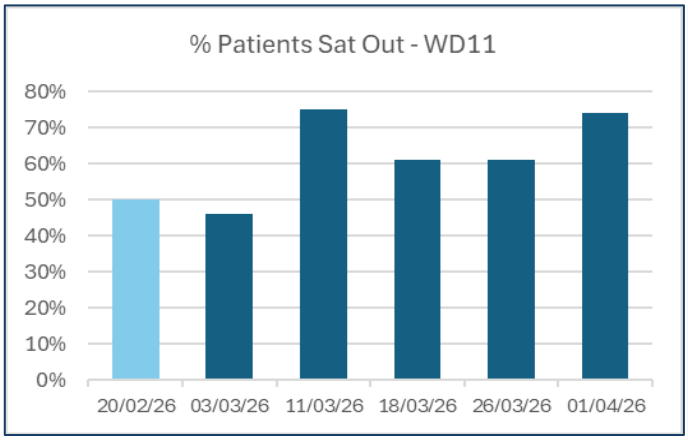
How it Works: BMAT consists of four progressive tasks (Sit & Shake, Stretch & Point, Stand, Walk), enabling staff to determine the patient's functional level quickly.

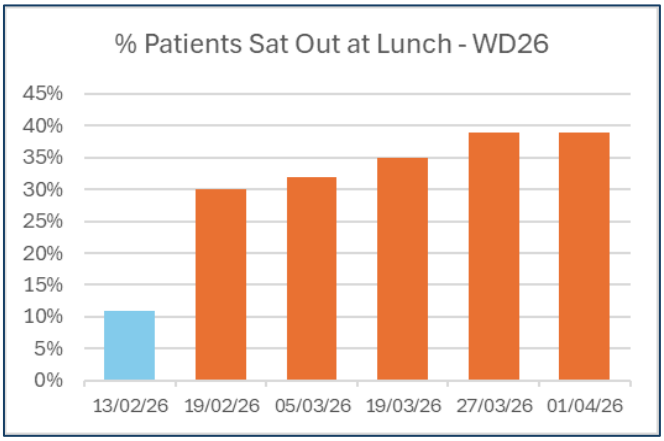
Benefits: Promotes early mobilisation, reduces immobility-related harm, improves communication between staff, ensures appropriate use of equipment and supports safer nursing practice.

Overall, BMAT shows potential to strengthen early mobilisation practices and enhance patient safety, meaning there is the potential for a reduction in falls associated with patients being nursed in bed as they will be mobilised and sat out sooner.

For successful implementation Trust-wide, a comprehensive training programme, strengthened ward leadership oversight, integration of BMAT indicators into existing documentation systems (Combined BMAT & M&H assessment and bedside indicator), and regular audit mechanisms are recommended.

During the trial there was an increase in the number of patients sat out at mealtimes. Ward 11 demonstrated a 25% improvement in week 3 and week 4. Ward 26 demonstrated a 27% improvement over the duration of the 6 week pilot period.





- **Improve compliance with Lying and Standing blood pressure recording**

The primary risk of not completing a lying and standing blood pressure is underestimating a patient's risk of falls as it could identify postural hypotension, or orthostatic hypotension. In Quarter 3 and 4 of 2025/2026 the Quality Team undertook supportive actions in the clinical areas to ensure that all health care workers undertaking lying and standing blood pressure had the knowledge on how to complete, how to record and what to do if there is a significant deficit in the lying and standing blood pressure undertaken on a patient. The Quality matron and team started to raise awareness through face-to-face education on all wards throughout the Trust. Pocket size awareness cards were also being handed to healthcare workers when the education was given to provide an aide memoire for nursing staff.

Alongside this a daily report of compliance with recording of the lying and standing blood pressure for patients has been re-instated in Quarter 4. This dashboard shows all patients on the ward that require a lying and standing blood pressure, and whether it has been completed as well as highlighting a systolic drop, enabling the ward manager to swiftly follow these assessments up with the nursing staff caring for the patient.

The actions being undertaken by the Quality team described above alongside more focused discussion at the monthly nursing quality meetings, which have been re-structured to reintroduce the matron's exception reporting and actions for metrics off-track are aimed at improving compliance with these assessments.

- **Increase awareness of falls prevention.**

Raising patient awareness focuses on the prevention of falls particularly among older adult and by highlighting risk factors and providing patient education this may prevent patients falling. Patient education such as understanding the environment whilst in hospital is essential to keeping our patients safe. When a patient arrives on the ward a risk assessment is completed within 6 hours, this ensures the patient is aware of their surroundings, highlight where their call bell is located and provide verbal and written education on how the patient can prevent themselves falling whilst in hospital. Some areas within the hospital have started laminating the falls prevention leaflet on an A4 version which is easier for the patients to read and locate. Other wards are now adopting this. Compliance on the delivery of patient education on falls awareness is captured during the Matrons reviews.

Falls training for the adult inpatient wards is completed every two years and covers all aspects of falls risk assessment on admission, ongoing assessments during the patients stay in hospital and post falls care. The aim in 2025/2026 was for falls training compliance for staff on the adult inpatient wards to be above 90% by the end of March 2026, however at the end of March training was 88.6% against this target.

Other Falls Improvement Work undertaken in 2025/2026.

Patient Vision Checks

The National Audit of Inpatient Falls (NAIF) looks at patient vision checks as part of the national audit and recommends Trusts ask about spectacle use and complete an assessment of distance and near vision. An action in the Falls Management plan is to *'ensure patient can correctly identify a pen or key from the end of the bed'.* An audit took place in September 2025 to understand more about how and if the vision check was being completed. The audit of the nursing teams demonstrated that 45.73% completed the 'pen test', 38.46% did not know about the test or how to complete it. Education was shared with divisions around this part of the assessment via the falls steering group and education was delivered by the Quality team to raise awareness.

Zimmer Frames

In November 2025 an audit of patients requiring Zimmer Frames to mobilise was completed. The results showed most wards were sharing zimmer frames between patients and behind the bed boards were not always up to date with current mobility status. Very few patients had their own walking aid from home and in some cases there were additional zimmer frames in storage not being utilised.

Trust Summary	Yes	No
Ask RN – are Zimmer Frame shared between patients	73%	27%
For all patients who use a Zimmer Frame has the bed board been updated?	54%	46%
Do any patients have their own walking aid from home with them?	23%	77%
Additional Zimmer Frame found in store cupboards	50%	50%

Following assessment by the Physiotherapist all patients who require a zimmer frame, will now have one in place for their own use. This will ensure that the correct height of frame is in place, meaning they will not have to stretch or stoop when using the frame which may contribute to the risk of a fall. Having their own frame will also ensure that there are no IPC risks with the sharing of frames and enable the patient to mobilise freely where appropriate.

Falls awareness week

As part of the National Falls Awareness Week, which took place in September 2025 staff were invited to complete a knowledge quiz. This raised awareness of resourses available including hospital anti-slip socks and yellow falls wrist bands.

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

Omitted doses of time-critical medication remains a formally agreed PSIRF priority for the Trust, reflecting both the frequency of incidents and the potential for avoidable patient harm. Time-critical medications, including insulin, anti-epileptics, anticoagulants and Parkinson's medication, carry a disproportionate risk of clinical deterioration when delayed or missed. Within the Trust, prescribing and medication administration remained paper-based throughout the period covered by this report, limiting routine visibility of omitted dose data and requiring manual drug chart review to measure the scale of the problem locally.

In 2024/25, early scoping work was undertaken through initial audits on a small number of wards and the development of a structured observation tool using a human factors and ergonomics approach. That work identified preliminary themes and informed the scope of further analysis undertaken in 2025/26.

What has been done

During 2025/26, further scoping and analysis was undertaken specifically to gain a deeper understanding of the factors contributing to omitted doses at ward level and to develop targeted improvement actions. Led by the Trust Medication Safety Officer (MSO) and Patient Safety Specialists (PSS), this work comprised three complementary data streams designed to build a rounded picture of the problem:

- **Drug chart audit:** A retrospective audit of 1,200 prescriptions across fourteen in-patient wards at both the Royal Shrewsbury Hospital (RSH) and the Princess Royal Hospital (PRH), capturing 9,331 scheduled doses over a four-week period. The audit measured omission rates, reasons for omission, documentation compliance and prescribing standards.
- **Structured observations:** Medication administration round observations were completed across nine wards at both hospital sites using a structured observation tool informed by systems-based methodology. Observations covered pre-administration preparation, the ward environment and available tools, interruptions and competing demands, medication supply and stock management, and variation in administration practice against Trust policy and professional standards.
- **Staff interviews:** Semi-structured interviews were conducted with seven registered nurses across the surgical assessment, acute medical, orthopaedic, elderly care, general medical, respiratory and specialist renal settings. Interviews explored nursing perspectives on contributing factors, system conditions and adaptive practices associated with omitted doses.

Together, these three approaches provided both quantitative measurement of the scale of the problem and qualitative understanding of the system conditions that influence medication administration in everyday practice. This represents the first Trust-wide analysis focused on omitted doses and the conditions that contribute to them.

Key findings:

Findings across all three data streams were largely convergent, indicating that omitted doses result from interacting system pressures rather than individual non-compliance. The most significant findings with direct implications for improvement are summarised below.

Omission prevalence and variation. The Trust-wide omission rate was 11% across 9,331 scheduled doses. Ward-level rates ranged from 4% to 27%, with both acute medical admissions wards exceeding 20%, compared with specialist wards reporting below 10%. This variation reflects differences in patient turnover, acuity and the stability of ward-level processes rather than individual performance.

Medication unavailability. Stock unavailability was the most frequently documented reason for omission, accounting for almost half (46.7%) of all coded omissions. This was reinforced across observations and interviews, where staff described considerable time spent sourcing routine medications from neighbouring wards or pharmacy. On eight of nine observed wards, patient-specific medications dispensed by pharmacy were found undistributed in ward iBins, meaning medication dispensed specifically for the patient was unavailable at the point of need.

Pre-administration preparation. Structured pre-round preparation was absent on eight of nine observed wards. Only one ward demonstrated standardised processes, including systematic iBin distribution, drug trolley management, drug chart review and locally agreed task separation from mealtimes. This ward

recorded the lowest omission rate across the Trust and provides an organisational benchmark for wider improvement.

Documentation and escalation of omitted doses. Fewer than 10% of coded omissions had a corresponding entry in the dedicated drug chart omissions section, despite this being a mandated requirement under the Trust Medicines Code. Post-round review and escalation was observed on only two of nine wards. Without completed documentation, omissions remain invisible to prescribers, pharmacy and oncoming nurses, limiting the ability to act and reducing the safety-net this system is designed to provide.

Interruptions and competing demands. Concurrent mealtime service and medication administration was observed on six of nine wards, creating routine interruptions and competing priorities. Clinical ward rounds, treatment room congestion and variable drug trolley provision further disrupted administration workflow. The red “Do Not Disturb” tabard was adopted on only two wards, with staff interviews indicating barriers including perceived ineffectiveness, cost and inconsistent organisational support.

Self-administration of medication. Of the 142 audited patients, 26 were identified as self-administering at least some of their medications. None had a documented assessment or consent form in place, despite this being a mandatory Trust requirement. Several nursing staff were unaware the Trust policy existed. Self-administration is well evidenced as a method for reducing omitted doses, particularly for patients with complex dosage regimes such as Parkinson’s and insulin.

Adaptive practice. Staff had developed a range of workarounds to manage omissions, including drug chart review at handover, night-team completion of morning rounds, and improvised drug trolley substitutions. These adaptations demonstrate resourcefulness and a commitment to safe practice but are built on individual initiative rather than organisational design and lack standardisation.

Planned next steps

Staff focus groups are planned to share findings from the audit, observations and interviews directly with operational staff and to discuss recommendations for improvement. The focus groups are designed to ensure that those closest to medication administration i.e. nurses, ward managers and pharmacy teams, are actively involved in shaping the improvement response. This reflects a deliberate approach: operational staff are key to the design, implementation and sustainability of improvements. Solutions developed without the involvement and ownership of frontline teams are unlikely to be practical, contextually appropriate or sustained.

Following the focus groups, improvement actions will be co-designed with frontline staff and tested on an initial group of wards using structured improvement methodology. This will include establishing baseline measurements and re-measurement to evaluate the impact of changes. Five areas have been identified for focused improvement: standardising pre-round preparation, protecting medication administration rounds

through workflow design, increasing omission visibility and post-round escalation, improving medication availability at the point of administration, and strengthening self-administration processes within routine practice.

In parallel, Emergency Department-specific improvement work linked to the Royal College of Emergency Medicine's Time Critical Medication Improvement Programme continues, led by ED clinicians with support from the Quality Governance Team and the MSO. A gap analysis against the Health Services Safety Investigations Body national report on time-critical medicines in Emergency Departments has been completed, and audit data has been collected and analysed. This data is now starting to shape improvement opportunities within the ED setting. Incoming pharmacy colleagues supporting the Emergency Department will be engaged in this work as both subject matter experts and key enablers of improvement.

No-harm and low-harm Datix reports relating to omitted doses continue to be monitored and are used to inform the ongoing understanding of system-level issues. Any report believed to flag new learning is raised for further review at the Review, Action and Learning from Incidents Group (RALIG). Improvement work will also be integrated into the Trust's ePMA development and implementation plans, recognising that while ePMA will significantly improve omission visibility, digital solutions alone will not resolve the system conditions identified through this work.

Summary

Findings across all three data streams confirm that omitted doses within the Trust are shaped by interacting system conditions including medication supply, pre-round preparation, environmental design, competing demands and documentation practices rather than individual behaviour alone. A systems-based, staff-inclusive approach to improvement is essential. The audit, observations and interviews were undertaken to understand how work is actually done at ward level, and the planned focus groups and co-designed improvement cycles will ensure that changes are grounded in the realities of clinical practice. The Trust remains committed to addressing omitted doses of time-critical medication as a PSIRF priority, working with operational staff to deliver practical, sustainable improvement alongside the transition to ePMA.

4. Improve reporting and missed radiology results

During 2025/26 the following improvement work took place in relation to this PSIRF quality priority:

The Trust has been undertaking work to introduce an electronic system called ICE which will improve both the requesting of radiology tests and how the results are distributed to our clinical teams. This system will allow tracking of results to ensure they have been received and read by our clinicians so ongoing decisions can be made around patient treatment.

The system was due to be operational in March 2026. There has been a delay until May 2026 to ensure the system and processes around it are ready to be operational.

We are confident that the ICE system will reduce the risk of radiology results being missed and leading to harm. While we will not take this forward as a priority in 2026/2027 we will continue to monitor safety by reviewing any incident reports that are submitted so we can be sure our systems are working as intended and reducing the risk of any missed radiology results.

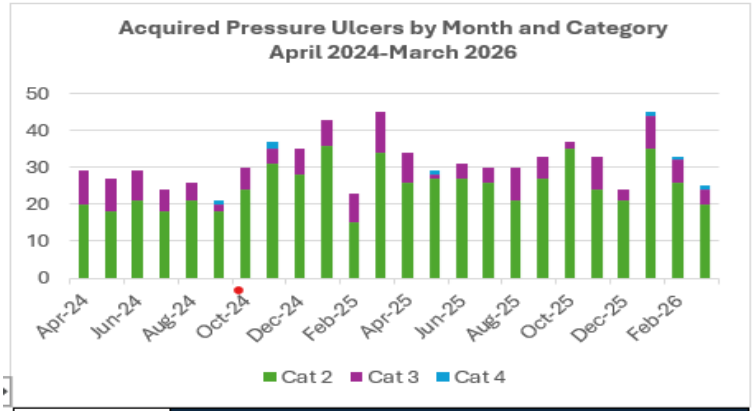
PRIORITY 2: Reduce Hospital Acquired Pressure Ulcers

What we said we would do

- Implement revised governance processes for the monitoring and evaluation of learning from pressure ulcers, increasing the 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

What we have achieved

During 2025/26 one of our main objectives was to reduce the number of hospitals acquired pressure ulcers (HAPU). Overall, there has been a rise in HAPU in 2025/26 compared to 2024/25 with a total of 384 reported compared to 369 in 2024/25, however we did see a reduction in category 3 pressure ulcers which cause more significant harm to patients.



	Category			
	Cat 2	Cat 3	Cat 4	Total
2024/2025	284	82	3	369
2025/2026	315	65	4	384

There was:

- A rise in the number of Category 2 pressure ulcers, 10.9% increase.
- There was a reduction in the number of Category 3 pressure ulcers by 20.7% (these are deeper tissue injuries).
- Although the numbers of Category 4 pressure ulcers are small these are the ones representing those that result in more harm to patients

- **Implement revised governance processes for the monitoring and evaluation of learning from pressure ulcers, increasing the accountability at ward level**

The documentation pertaining to patients with acquired pressure ulcers is reviewed in line with the aSSKINg care bundle to ascertain the areas of learning identified. These findings are then reviewed by the Tissue Viability Team and cross referenced with the known areas of learning as identified from previous reviews and the pressure ulcer review meeting, to ensure that no new learning needs have been identified.

From April 2025 the process for reviewing all hospital acquired pressure ulcers was changed and a monthly Pressure Ulcer Review Meeting (PURM) was re-instated chaired by the Lead Nurse for Tissue Viability. Ward managers and matrons are invited to share the findings from the reviews of any acquired pressure ulcers. During this review meeting all documentation is reviewed including daily skin inspection checks, repositioning checks, core care plans and wound assessment chart. Any actions for improvement are agreed, and learning is discussed and then shared with the teams.

In March 2026, further changes were made to the review meetings specifically for Category 3 and 4 pressure ulcers. These are now discussed at individual face-to-face meetings with the Deputy Chief Nurse, Tissue Viability Nurse (TVN), the ward manager and the matron. Following the review meeting, a weekly visit by the TVN to the ward/clinical area is put in place to support the agreed improvement actions and provide specialist advice. A 6-week ward review is undertaken with the TVN, ward manager and matron visiting the ward/unit and this is followed by the 6- weeks follow up evaluation meeting with the Deputy Chief Nurse to review findings and progress against the agreed actions and the overarching tissue viability action plan.

- **Ensure all patients have a Purpose T Skin Assessment completed on admission and regular review**

PURPOSE-T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) is an evidence-based clinical tool designed to assess adults for pressure ulcer risk. It guides decisions on both primary prevention for at-risk patients and secondary management for those with existing or previous injuries, improving care standards. It was introduced into the Trust in October 2024 and replaced the previous Waterlow risk assessment.

The table below shows the average percentage over the last 12 months for the questions asked during the audits.

Has the patient had a Pressure Ulcer Risk Assessment completed within 6 hours of admission, or transfer to the ward?	Is the Pressure Ulcer Risk Assessment completed in the Skin Assessment, Pressure Ulcer Prevention and Wound Care Booklet?	Has the Pressure Ulcer Risk Assessment been updated weekly?	Has the Pressure Ulcer Prevention Care Plan been completed?	as a skin assessment / body map been updated within 6 hours of arrival to the	Is the frequency appropriate for the patients needs and has repositioning been performed in line with the frequency stated	Has the daily inspection skin chart log been completed daily ?	Is the patient on the appropriate mattress for their identified risk status	Are the patient heels offloaded?
95.7	96.7	92.5	81.8	94.4	95.1	84.7	98.5	81.4

These results and plans to improve are discussed during the monthly Quality metrics meetings with the divisional nursing teams. Throughout 2025/26 compliance with risk assessment completion has shown areas of consistent compliance e.g. completion of risk assessments on admission to the ward, as well as areas for ongoing improvement including completion of care plans, daily skin inspections, frequency of patient repositioning and the offloading of patient heels to relief pressure. These remain key areas of focus for improvement.

- **Ensure timely provision of pressure relieving equipment and mattresses- Hybrid Pressure relieving Mattresses**

The Trust is committed to providing the best possible pressure preventing equipment to add another layer, alongside patient repositioning to keep our patients safe.

In 2025/26 a business case was accepted to replace our existing hospital foam mattress and replace them with a hybrid mattress. The hybrid mattress acts as a static foam mattress when in non-pumped mode and becomes a pressure relieving alternating mattress when in pumped mode. This will improve patient care by ensuring patients are on the correct mattress therapy and in a timely manner.

PRIORITY 3: Achieve best compliance with nutritional assessments and nutritional care planning

What we said we would do

- Ensure all patients have a MUST assessment completed on admission and regular review
- Deliver training around the updated MUST tool, weigh process, and referral process to dietetics
- Update fluid balance policy and support improvements in completion in practice

What we have achieved

- **Ensure all patients have a MUST assessment completed on admission and regular review.**

During 2025/26 the Trust has been committed to ensuring that all patients admitted to a ward have a Malnutrition Universal Screening Tool (MUST) completed.

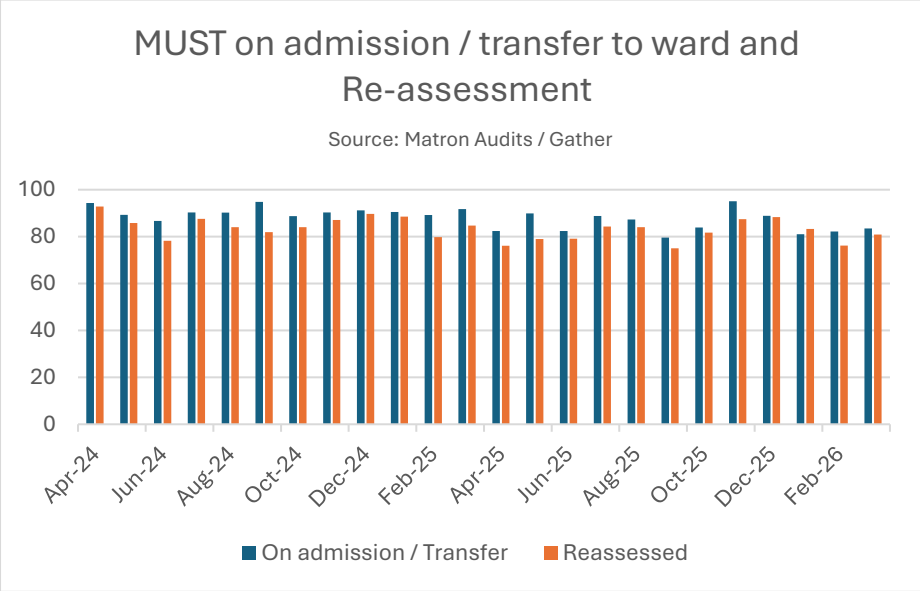
MUST is a nationally recognised tool. It is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop care plans.

Step 1 Measure height and weight to get a BMI score
Step 2 Note the percentage unplanned weight loss and score
Step 3 Establish acute disease effect and score

Step 4 Add score from step 1,2, and 3 together to obtain overall risk of malnutrition

Step 5 Use management guidelines and/or local policy to develop care plan

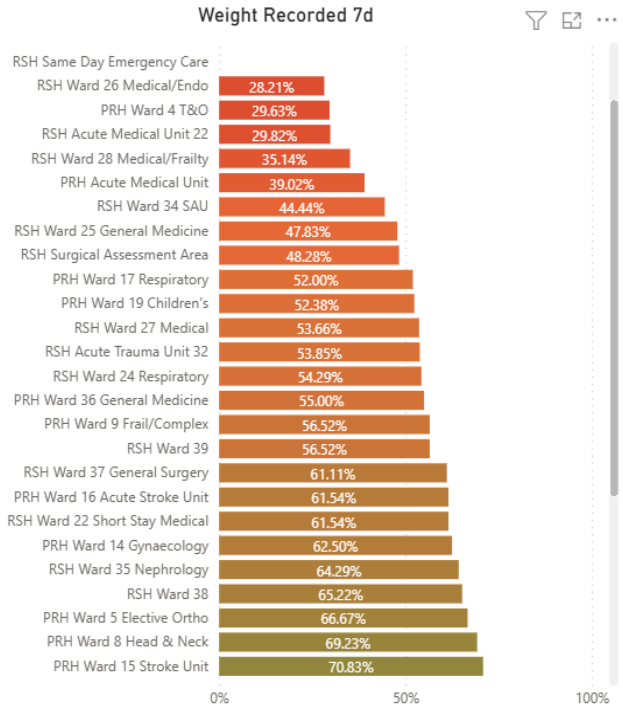
MUST compliance is captured through the monthly Matrons Nursing Quality assurance audits. Several questions around MUST are completed which gives us an overall Nutrition score. Throughout 2025/2026 the MUST assessment has been audited as part of the monthly matron quality audits. Feedback to the nursing teams in relation to completion and quality of these assessments is given at the time of the audits and at monthly quality review meetings.

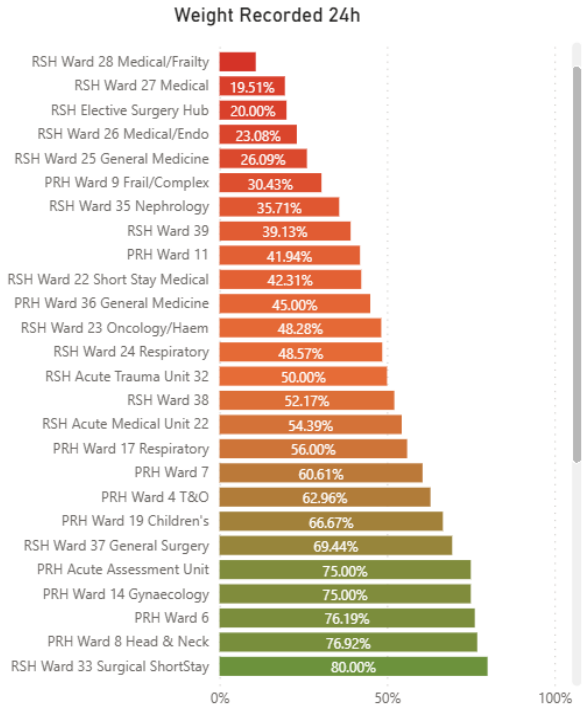


The MUST audits show that the completion of the MUST assessment on admission is higher than the completion of subsequent assessments.

Both remain below the target of 90% of all patients having an assessment completed.

A persistent omission in relation to the MUST assessment completion is ensuring that patients are weighed as part of this assessment, which is an important aspect of this assessment. This has been discussed at the quality metrics meetings, and the ward managers and matrons are reviewing the assessments at ward level daily to support teams with the improvements required and to ensure that all patients who can be weighed are weighed on admission and regularly during their hospital stay thus ensuring the appropriate level of nutritional support is in place.





Source BI840 ward manager dashboard / VitalPAC reporting as at 5/5/2026

During 2025/26 a digital platform for the MUST has been designed and will be trialled in the first quarter of 2026/27. This will allow visibility of completion of the MUST and highlight any omissions in a more timely manner ensuring safe care.

- **Deliver training around the updated MUST tool, weigh process, referral process to dietetics.**

Training and support in relation to MUST assessment on admission, weekly and when a patient's condition changes are provided in a variety of arenas. This is provided by the Quality team and includes:

- As part of the Exemplar ward accreditation programme, the review team specifically review with the nursing team patient nutritional assessments and care planning. This is done with the senior nursing team as well as with the nurses caring for the patients reviewed ensuring real-time feedback and learning can be provided based on direct observations of patient care.
- Training is provided to newly qualified and newly appointed registered nurses and nursing associates.
- MUST training is included in the annual Quality Team study days.
- Specific focused support has been provided on wards 11 and 17 with the HCAs to raise awareness.
- All new HCA attend the Healthcare Academy when training is delivered on nutrition and hydration to help raise awareness with HCAs.

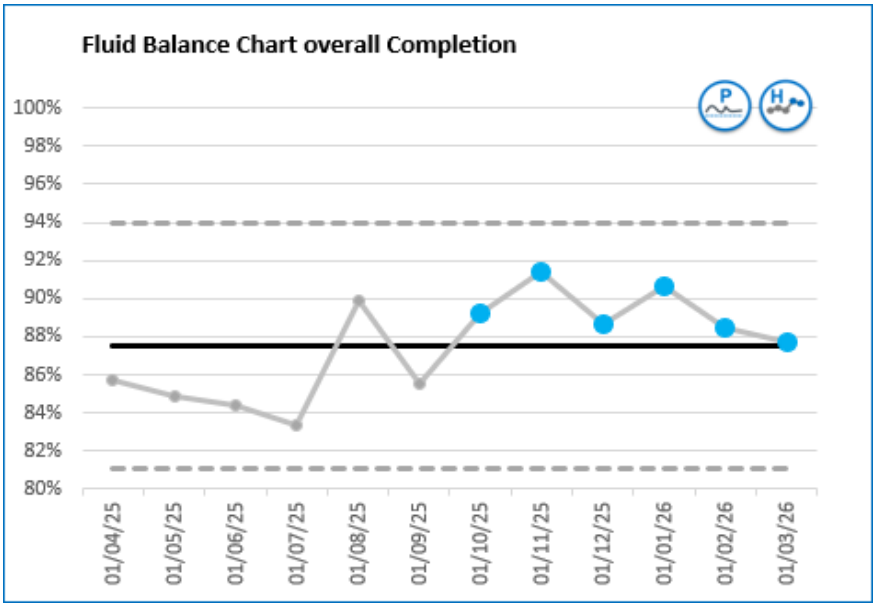
Face to face training on completion of the risk assessment has been delivered to areas where compliance has been low with a focus on the weighing element for those patients who may have to remain in bed due to

their condition. Updates have also taken place at ward level on how to refer to dietetics when a MUST management plan has indicated escalation.

Training for Nutrition is also undertaken and is captured through the learning management system. We have seen increased compliance this year, with compliance of 95.56% in 2025/2026 compared to 93.95% in 2024/2025.

- **Update fluid balance policy and support improvements in completion in practice.**

The Fluid Balance Policy is currently being revised with input from our Divisional senior nursing teams. Once approved the new policy will be re-launched with educational support at ward level from our matrons and Quality Team.



Through Nursing Quality assurance audits the completion of fluid balance charts is recorded and monitored.

Ensuring accurate completion of these charts has continued to be supported and challenged at both ward level and via monthly quality meetings. We have seen improvements in completion throughout Q3 and Q4 with performance being above 88% but still just below the 90% target.

PRIORITY 4: Improve the experience of our elective care pathways: reducing our radiology waiting times and reducing radiology reporting delays

What we said we would do

- 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 session
- Onboarding a second outsourcing reporting provider, to address gaps in our current outsourcing provider and provide resilience during busy periods

What we have achieved

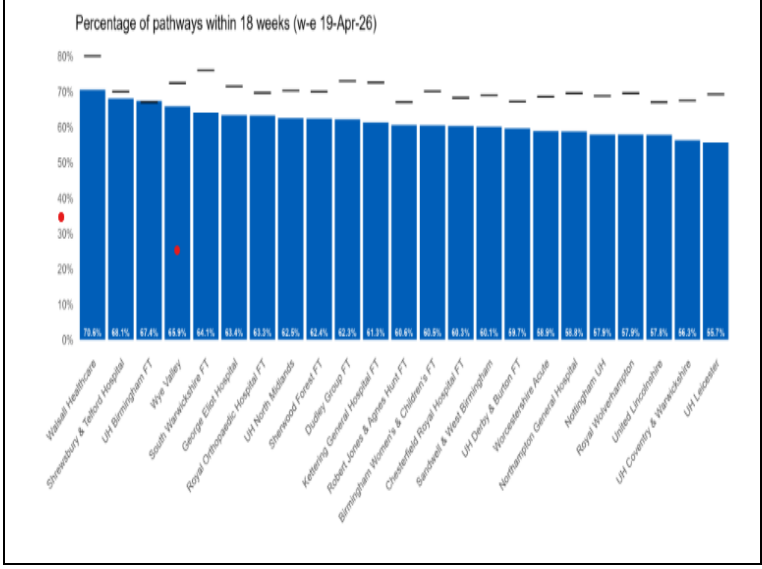
We have completed the following actions in 2025/2026:

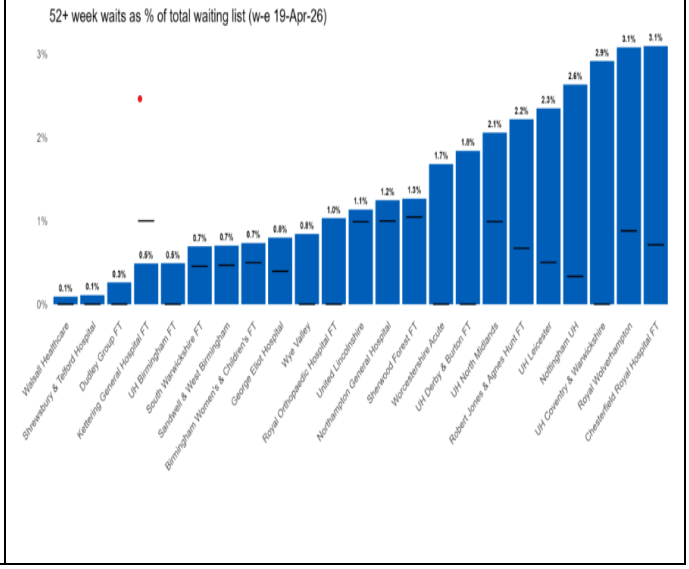
Action	Update
Review of scanning templates in all modalities to maximise outpatient scanning capacity.	This has been completed
Expand use of MRI acceleration software to reduce scanning times where appropriate.	This has been completed
Temporary insourcing/outsourcing support for MRI and NOUS while sustainable plan is developed.	We are still using the temporary solutions, but are less reliant on them as we have increased our workforce.
Further roll out of Home Reporting workstations for Radiologists to reduce interruptions to reporting sessions.	Due to PACS replacement being delayed, to align with WMIN joint PACS/RIS systems, we are unable to obtain further home reporting workstation hardware as part of the PACS contract. Due to be replaced end 2027.
Onboarding a second outsourcing reporting provider, to address gaps in our current outsourcing provider, and provide resilience during busy periods.	This has been completed

Improvements in our Elective Care Pathway

The 18-week performance standard is an NHS England target requiring that patients on non-urgent (elective) waiting lists start consultant led treatment within 18 weeks of referral. Over the last year the Trust has moved from the bottom decile for 18-week performance to being on the border of the upper quartile nationally (based on February 2026 data). Likewise for 52-week performance, aimed at reducing long waits for patients, the Trust has moved from the bottom decile a year ago, to being in the top performing decile nationally.

We are the most improved Trust in the country over the last year for both 18-week and 52-week performance. None of this would have been possible without the significant improvements in access to diagnostics.

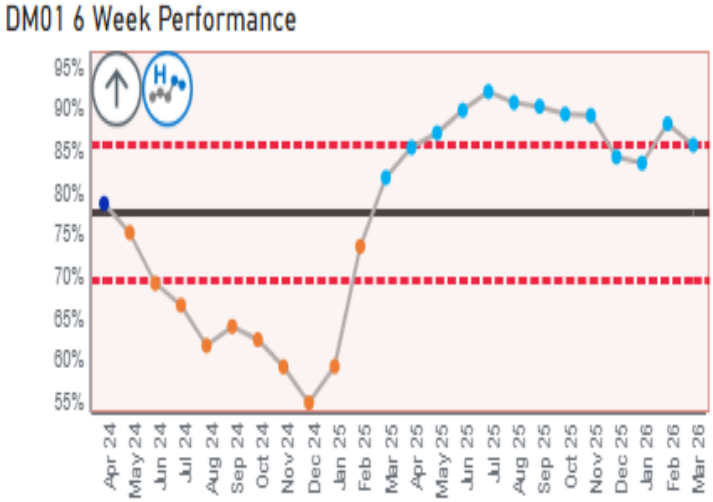




The Trust continues its improvement journey and our ambition to deliver the very best for our patients over the year ahead. We aim to push further to perform beyond what we have committed to NHS England to

deliver in 2026/2027, including how we can eradicate waits of over 40 weeks, and how quickly we can get to the 92% constitutional standard 18-week performance for our Children & Young People.

Waits for Diagnostic Tests.



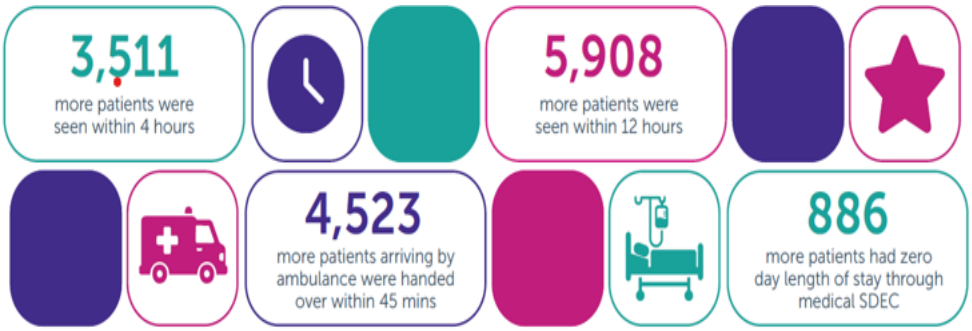
The performance, which is a percentage of all patients having their tests within the 6-week target is shown and the improvements achieved over 2025/2026.

The Trust has moved from being in the bottom decile a year ago, to being consistently in the top half nationally and in the Top 5 most improved in the country over the last year.

PRIORITY 5: Improve the experience of our emergency care pathway:

- Improving time to triage/initial assessment
- Improve the timeliness of handover for patients arriving by ambulances
- Reducing the number of patients who spend more than 4 hours and more than 12 hours in our departments
- Improve the number of patients reporting a positive experience of care in our ED

Improving the experience of our emergency care pathway has been a key focus of our quality improvement work in 2025/2026, with our multi-disciplinary workstreams within the Emergency Departments, Medicine and Emergency Care Division, and Trust-wide working collaboratively delivering actions to improve the patient experience and outcomes of accessing our emergency services. Some of the outcomes of these improvement workstreams include:



What we said we would do

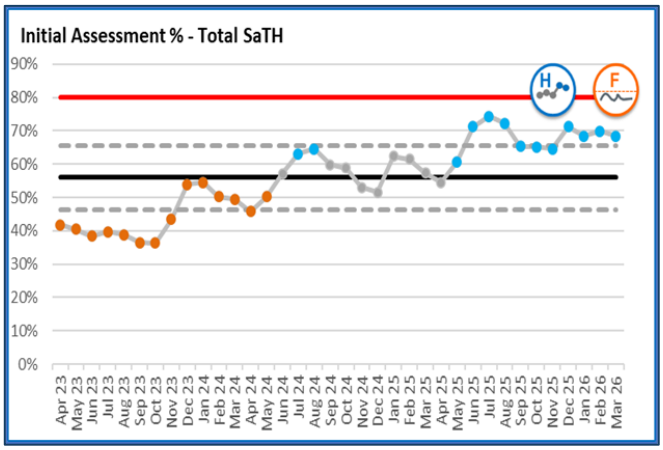
- Ensure 80% of patients receive Initial Assessment within 15 minutes of arrival to our Emergency Departments
- Continue to develop and embed our ambulance handover assessment model (Offload to Assess)
- Increase streaming of patients to our SDEC services to increase the proportion of non-elective admissions managed as 0 day length of stay
- Implement the provision of additional funded bed capacity at both hospital sites in Q3 2025/2026
- Improve the number of patients reporting a positive experience of care in our Emergency Departments through a thematic review of complaints and development an overarching action plan, and a new patient experience team led monthly patient experience survey
- Achieve greater than 90% compliance for Quality Audits in ED

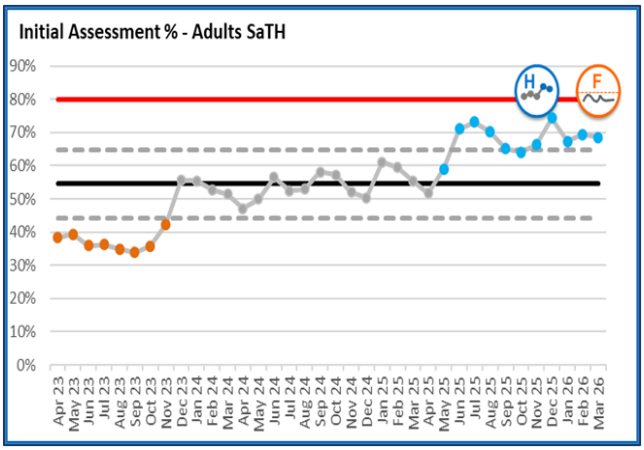
What we have achieved

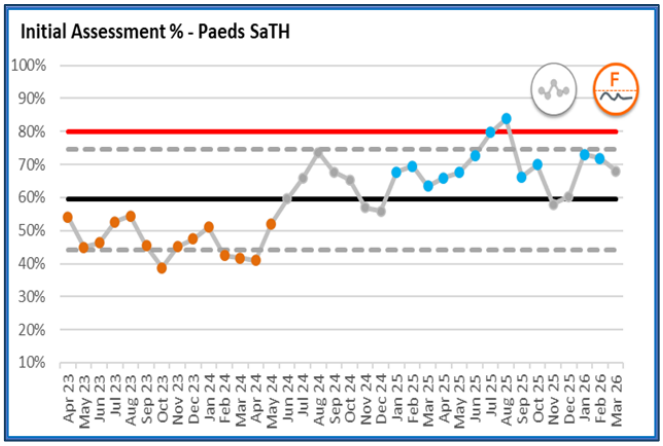
- **Ensure 80% of patients receive an Initial Assessment within 15 minutes of arrival to our Emergency Departments**

We are demonstrating statistically significant improvement in the percentage of patients receiving an Initial Assessment (IA) within 15mins of arrival to our Emergency Department (EDs). The CQC Section 31 condition in relation to Paediatric Triage within 15 minutes of arrival to the Emergency Departments was removed by the CQC in December 2025 following a successful application by the Trust. However, focused work continues with paediatrics at PRH to further improve these triage times for our paediatric patients.

The next steps in relation to further improving the initial assessment of all patients attending our Emergency Departments include the capturing of streaming decisions to further demonstrate that all patients are seen by senior nurse on arrival to ED prior to formal IA.





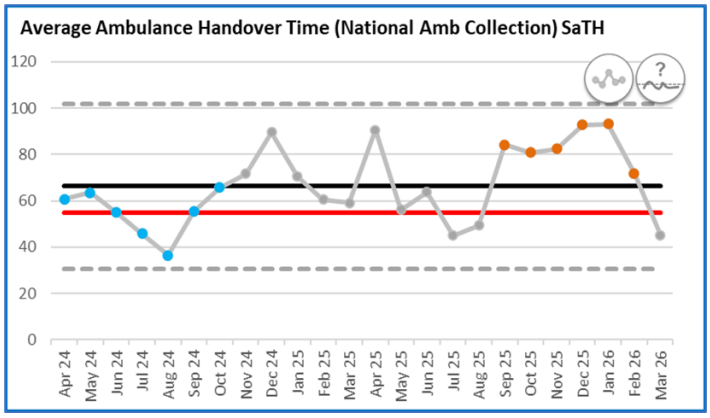


	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26 (MTD)
Initial Assessment % - **Total** SaTH	54.6%	60.7%	71.3%	74.3%	72.3%	65.3%	65.2%	64.6%	71.3%	68.4%	69.9%	68.4%	73.7%
Initial Assessment % - **Adults** SaTH	51.7%	59.0%	71.0%	73.2%	70.2%	65.1%	64.1%	66.3%	74.3%	67.4%	69.4%	68.5%	73.2%
Initial Assessment % - **Paeds** SaTH	66.0%	67.6%	72.8%	79.7%	83.9%	66.2%	69.9%	57.9%	60.4%	73.0%	71.9%	68.0%	76.7%
SaTH Improvement Target - 80%													

- **Continue to develop and embed our ambulance handover assessment model (Offload to Assess)**

Offload to Assess (OTA) is a well embedded process in both of our Emergency Departments. In the event that we are unable to offload ambulances all patients go through the OTA process. Harm reviews triangulate and provide assurance that this process is well embedded.

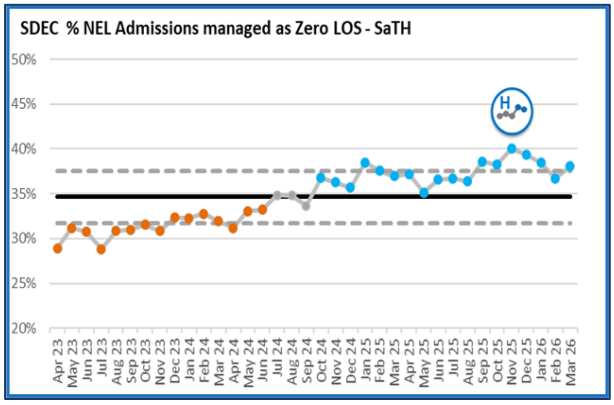
Our average ambulance handover time has demonstrated significant improvement and in March 2026 the average handover was 45.2 minutes, 10 minutes under an operational plan of 55 mins.

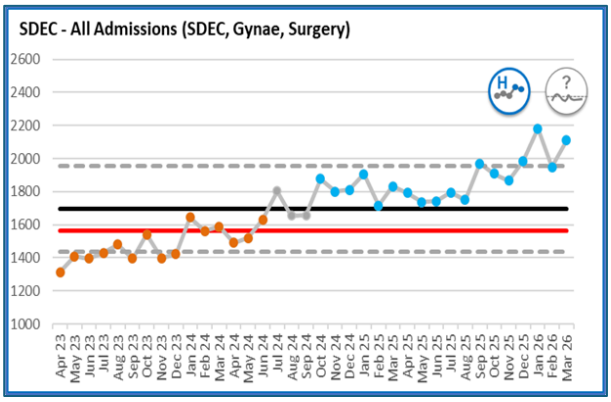


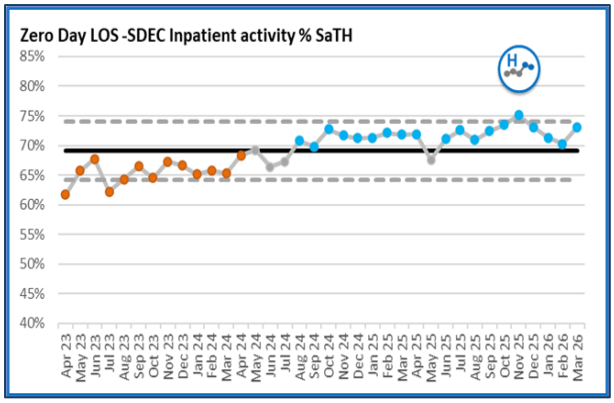
	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Average Ambulance Handover Time (National Amb Collection) SaTH	90.52	56.07	63.82	44.98	49.44	84.20	80.75	82.52	92.73	93.14	71.95	45.20
Average Ambulance Handover Time (National Amb Collection) PRH	85.18	55.42	59.72	45.94	41.17	79.66	78.99	82.37	97.23	97.86	64.89	41.38
Average Ambulance Handover Time (National Amb Collection) RSH	96.68	56.81	68.65	43.85	59.00	89.52	82.71	82.69	87.50	88.24	79.66	49.82
Operational Plan 2025 - 55mins												

- **Increase the streaming of patients to our SDEC services to increase the proportion of non-elective admissions managed as 0 day length of stay**

Ongoing work has continued in 2025/2026 to increase the number of patients who are streamed to our Same Day Emergency Care (SDEC) for our medical patients. We are showing statistically significant improvement in the percentage of Non-Elective admissions managed through our SDEC and who have a zero-day Length of Stay (SDEC).



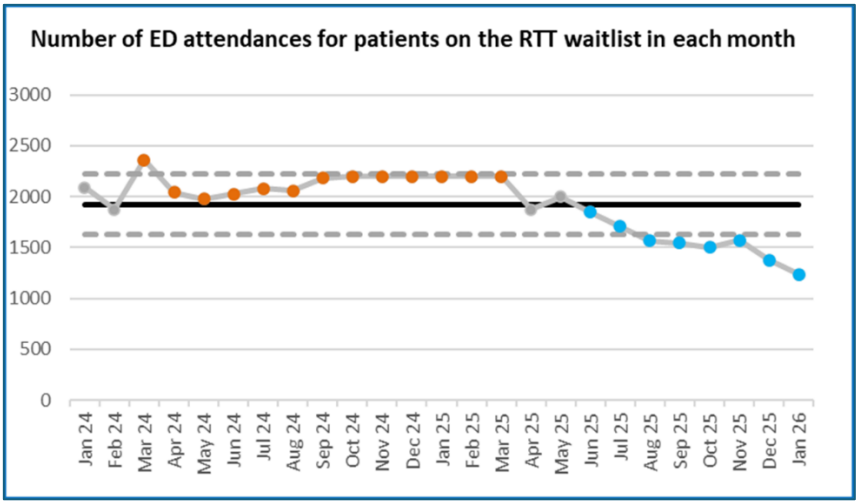




Work has also been ongoing in 2025/2026 to increase the number of patients managed through our other emergency admission portals including the Gynaecology Assessment and Treatment Unit (GATU) and our Surgical Assessment Unit aimed at reducing the time our gynaecology and surgical patients spend in the Emergency Departments.

	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Zero Day LOS-SDEC Inpatient activity % SaTH	71.9%	67.6%	71.1%	72.6%	70.9%	72.4%	73.5%	75.1%	73.1%	71.3%	70.3%	73.1%
Zero Day LOS-SDEC Inpatient activity % - Medicine SaTH	80.5%	75.0%	76.7%	79.7%	79.1%	78.6%	77.9%	79.7%	79.5%	75.9%	76.5%	79.5%
SDEC % NEL Admissions managed as Zero LOS-SaTH	37.2%	35.1%	36.6%	36.6%	36.3%	38.6%	38.2%	40.0%	39.4%	38.4%	36.7%	38.0%
SDEC - All Admissions (SDEC, Gynae, Surgery)	1793	1738	1743	1794	1750	1969	1909	1866	1985	2181	1948	2109
SDEC Admissions (All Specialities) - Operational Plan25/26	1553	1586	1552	1587	1582	1581	1603	1581	1586	1593	1487	1566

The number of patients presenting to the Emergency Departments on an active elective RTT waiting list has reduced by over 40% in the last year and shows special cause improvement.



- **Implement the provision of additional funded bed capacity at both hospital sites in Q3 25/26**

In 2025/2026 the Trust has worked to increase its bed and trolley spaces across the two hospital sites. In December 2025, 56 new inpatient beds opened at the Royal Shrewsbury Hospital (modular wards) increasing the bed capacity for both surgical and medical patients. This has helped reduce the amount of time patients have to wait to be admitted to the appropriate ward from the Emergency Departments for their care.

Previous Space	Previous Capacity	New Space	New Capacity	Capacity Change	Planned Commencement date
W25G	18 beds	W38 (modular)	28 beds	+ 10 beds	Opened 8 December 2025
W25CR	20 beds	W39 (modular)	28 beds	+ 8 beds	Opened 8 December 2025
General Med	0	W25	20 beds	+ 20 beds	Opened 22 December 2025
Winter Flex	0	W25	18 beds	+ 18 beds	Opened 29 December 2025
TOTAL	**38 beds**		**94 beds**	**+ 56 beds**	

Alongside this the Discharge Lounge capacity was increased in December 2025, and the opening hours were extended from January 2026.

Previous Space	Previous Capacity	New Space	New Capacity	Capacity Change	Planned Commencement date
Discharge Lounge (W31)	6 beds 10 chairs	W18	8 Beds 15 Chairs	+ 2 beds + 5 chairs	Opened 1 December 2025

At the Princess Royal Hospital new acute assessment spaces opened through from December 2025 to February 2026 meaning patients could move from the EDs to more appropriate spaces and environments to continue their care.

Previous Space	Previous Capacity	New Space	New Capacity	Capacity Change	Planned commencement date
Medical Escalation (Med Esc)	17 inpatient beds	Ward 36	26 inpatient beds	+9 inpatient beds	Move to W36 completed October 2025 Additional 5 beds - w/c 5 January 2026 with the 6th bed on 20 January 2026
AAU	4 assessment spaces	Current Med Esc	17 assessment spaces	+13 assessment spaces	Opened 15 Dec 2025
AMU	17 assessment unit beds	AMU + Apley Ward	25 assessment unit beds	+8 assessment unit beds	Opened 13 February 2026
Acute Med SDEC	10 chairs 3 trolleys assessment spaces	SDEC + AMA	10 chairs 7 trolleys	+ 4 assessment spaces	Opened 15 December 2025
Frailty SDEC	0	DTA Unit	3 trolleys 3 chairs	+6 assessment spaces	Opened 17 December 2025

ED DTA Unit	5 ED cubicles	DTA Unit	0	-5 ED DTA cubicles	Completed 15 December 2025
TOTAL	**17 inpatient beds 17 assessment spaces 17 assessment unit beds**		**26 inpatient beds 40 assessment spaces 25 assessment unit beds**	**+9 inpatient beds +23 assessment spaces +8 assessment unit beds -5 ED DTA cubicles**	

- **Improve the number of patients reporting a positive experience of care in our EDs, through a thematic review of complaints and development of an overarching action plan, and a new patient experience team led monthly patient experience survey**

In 2025 a thematic review of complaints in the Emergency Departments was undertaken by the Head of Complaints and PALS. The key themes and main issues raised under these are shown:

Clinical Treatment • Failure to give definitive diagnosis • Incorrect diagnosis • Missed fractures • Inadequate pain management	**Communication** • Failure to listen to patient • Patient not kept updated • Family not able to get through to department • Family not told when patient transferred / discharged
Patient Care • Lack of assistance with mobilisation • Not offered food and drink	**Waiting times** • Patients left in chairs for hours • Patients not updated about waiting times • Overall waiting times in ED
Values & Behaviours • Staff rude to patients • Staff ignoring patients • Inappropriate / unprofessional questioning	

Patient experience audits have been undertaken by the Patient Experience Team monthly across both Emergency Departments throughout 2025/2026 to measure patients experience of care, whilst areas for improvement continue to be areas of focus, the percentage of people reporting that they are happy with their care has increased to 96.43%.

Alongside this patient experience audit, patient feedback and engagement has been sought through:

- The re-introduction of SMS text service for Friends and Family Test (FFT)T to increase patient feedback
- Inclusion of patient representatives at the Urgent and Emergency Care Transformation and Assurance Committee
- Development of workstreams within the speciality Urgent and Emergency Care Patient Experience Group (PEG). This includes 3 workstreams:

- Communication
- Patient Wellbeing and Comfort
- Patient Involvement in Decision Making

The Friends and Family Test (FFT) is captured from people accessing services to capture feedback on their experience of care. During 2024/2025 the percentage of patients reporting a good or very good experience of care was 68.13%. A range of improvements have been made within the Emergency Departments during 2025/2026 and by March 2026 the percentage of patients reporting a good or very good experience of care increased to 71.37%.

The Urgent and Emergency Care (UEC) Patient Experience Group continues to meet and has increased the number of patient partners involved in the group. There are presently three areas of focus, each with a workstream focusing upon communication, comfort and wellbeing, and involvement in decision making.

We have significantly reduced the use of temporary escalation space in both EDs improving privacy and dignity for our patients.

- Eliminated the use of the Main Corridor at PRH to care for ED patients (July 2023)
- Eliminated the use of the X-Ray Corridor at RSH to care for ED patients (March 2025)
- Eliminated the use of the AMA seated area at RSH to care for Acute Medical patients (November 2025)
- Eliminated the routine practice of corridor care for Acute Medical patients awaiting a space on SDEC/AMU at PRH (December 2025)
- Ceased the use of the portacabin at PRH (formerly known as Ambulance Receival Area and Decision To Admit unit) for 24/7 overnight care (December 2025)

- **Achieve greater than 90% compliance for Quality Audits in ED**

In order to support the UEC Transformation Plan and to maintain improvements in key areas, a suite of identified metrics was agreed upon. Over the previous 18 months the metrics, audit questions / schedule and reporting have been developed to ensure that the number of patients captured via the audit process is a reasonable representation of the presenting patients in both Emergency Departments.

These metrics include previously identified areas audited and reported as part of the improvements made following the last CQC inspection, following the Dispatches program and through the various oversight mechanisms and visits undertaken.

Quality data is collected via the completion of 30 audits conducted per week by the respective matron and Band 7 Emergency Department Nursing team. These audits also act as an opportunity for restorative action and education being put in place in real time. The previous schedule of 10 audits per month did not provide assurance hence the increase in the sample size. Quality audit outcomes are triangulated with safety

outcomes and training data at the monthly Nursing Quality Audit meetings chaired by the Deputy Chief Nurse where actions are agreed and monitored. The daily presence of the Matrons in the department undertaking the Quality Assurance audits has been instrumental in providing the required level of assurance in the quality and safety of the departments. Due to the levels of assurance this has now been transitioned to business as usual.

Metric	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26	Total	Target	Progress
NMQ									
ED - Documentation	94.5 (222)	93.9 (204)	94.8 (164)	94.3 (151)	95 (135)	93 (160)	94.2	80 - 90	
ED - Skin integrity	89.4 (222)	91.5 (204)	91.3 (164)	87.5 (151)	87.7 (135)	92.7 (160)	90.1	80 - 90	
ED - Nutrition	96.7 (222)	96.3 (204)	98.7 (164)	100 (151)	96.7 (135)	97.8 (160)	97.6	80 - 90	
ED - Safety, Privacy & Dignity	96.1 (233)	94.9 (216)	96.3 (173)	94.8 (160)	92.8 (141)	96.5 (166)	95.4	80 - 90	
ED - Patient Experience	94.7 (271)	93.5 (263)	89.1 (206)	91.8 (190)	90 (172)	92.8 (188)	92.2	80 - 90	
ED - Comfort Care Round	96.5 (204)	96.6 (180)	95.2 (152)	91.2 (129)	86.2 (122)	92.9 (146)	93.7	80 - 90	
ED - Fluid Balance	89.9 (222)	93.5 (204)	93.5 (164)	94 (151)	90 (135)	91.5 (160)	92.1	80 - 90	

PRIORITY 6: Implement System-wide working to improve the discharge planning processes and our patients experience of involvement in their discharge plans

What we said we would do

- Set up joint Discharge Improvement Group chaired by Chief Nurse SATH/Shropshire Community Trust to drive forward improvements
- Increase the number of patients discharged pre midday and 5pm and reduce the number of patients discharged after 10pm
- Improve the discharge processes including: increase number of planned discharges in discharge lounge by 08.45am

What we have achieved

- **Establish a System Wide Discharge Improvement Group**

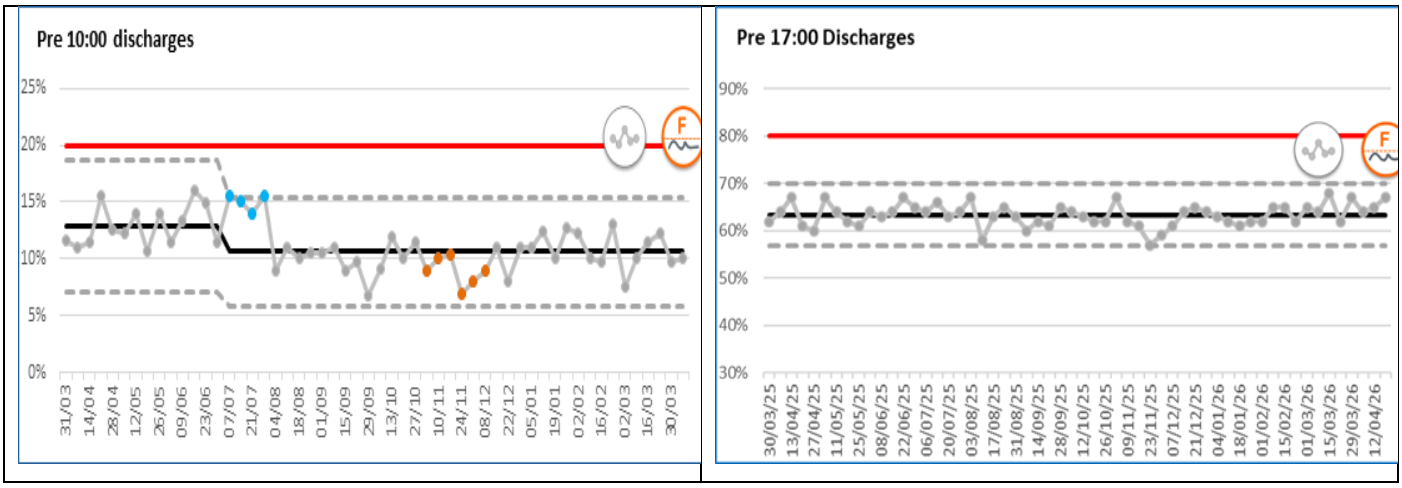
A System-wide Discharge Improvement Group is now in place chaired by the Chief Nurse SATH/Shropshire Community Trust. The Group meets monthly.

The Improvement project consists of 5 workstreams and reports through to Quality Operational Committee, and Quality and Safety Assurance Committee.

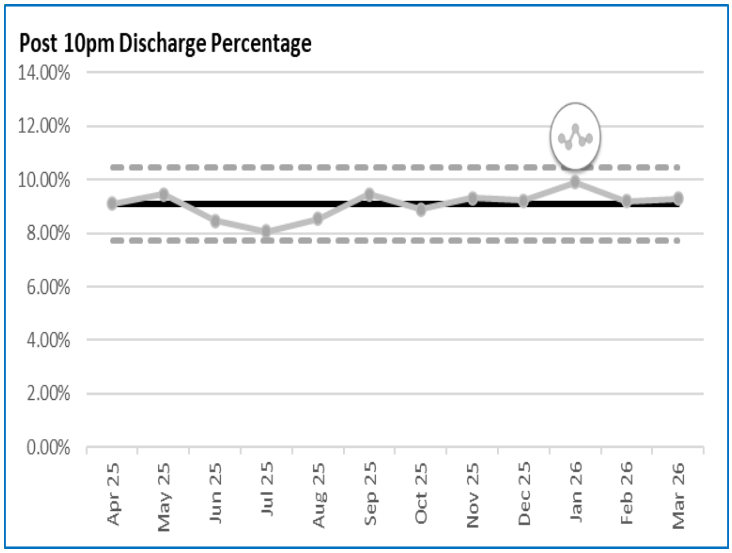
- **Transport workstream** – aim for a reduction in % of patients discharged through patient transport, reduction in aborted journeys and a reduction in patient waiting time for transport
- **TTO (To Take Out) Medication /Pharmacy workstream** – aim for 75% of discharges from clinical areas with a pharmacy service to be supplied on the day of discharge, 60% of patients to be reviewed by pharmacy within the first 24 hours of admission
- **Therapies workstream, Therapy Discharge to Assess Pathway (D2A)** – aim for reduction in average length of stay by 1 day, 5% increase in patients discharged on pathway 0 (these are patients ready for a simple discharge, back to their own home with no new or additional health or social care support needed)
- **Handover and communication workstream** – aim for reduction in emergency readmissions, reduction in number of incidents by 10% relating to incomplete or no community referrals
- **Patient experience and expectation workstream** – increase patient satisfaction feedback, decrease % of negative feedback received relating to discharge, reduction in top 3 complaint themes surrounding discharge
- **Discharge lounge workstream** – aim for reduction in time spent in the discharge lounge, increase in patients discharged via discharge lounge, increase in number of patients moved to discharge lounge by 8.45

- **Increasing the number of patients discharged pre midday and 5pm and reduce the number of patients discharged after 10pm**

Throughout 2025/2026 the Trust has continued to see variation in pre 10.00am discharges, with this remaining a key areas for focus and improvement metric for 2026/2027.



We have started to see an improvement in pre 5pm discharges and this continues to be a focus during 2026/2027.



During 2025/2026 the number of patients discharged late into the evening remains higher than we would want as a Trust. Whilst for some simple discharges this may be appropriate, for frail patients and those who have cognitive impairment, discharging after 10pm is not appropriate.

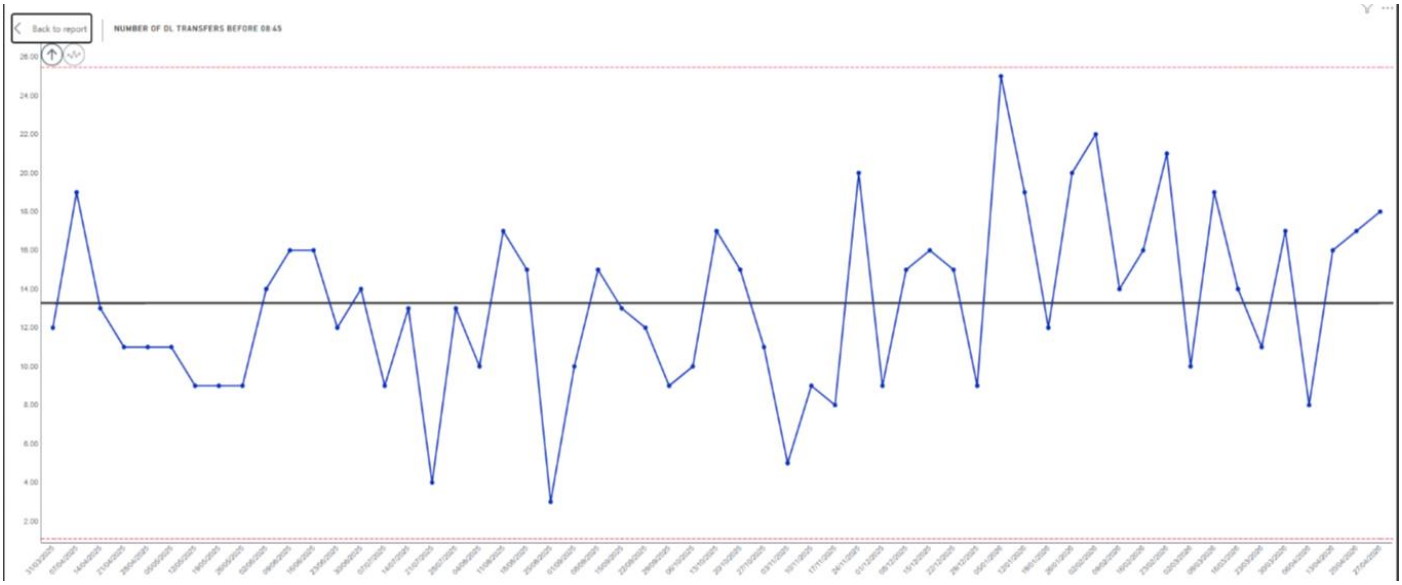
In 2026/2027, reducing the number of patients inappropriately discharged late into the evening will be included in the Discharge Group workstreams.

Improving Discharge Processes

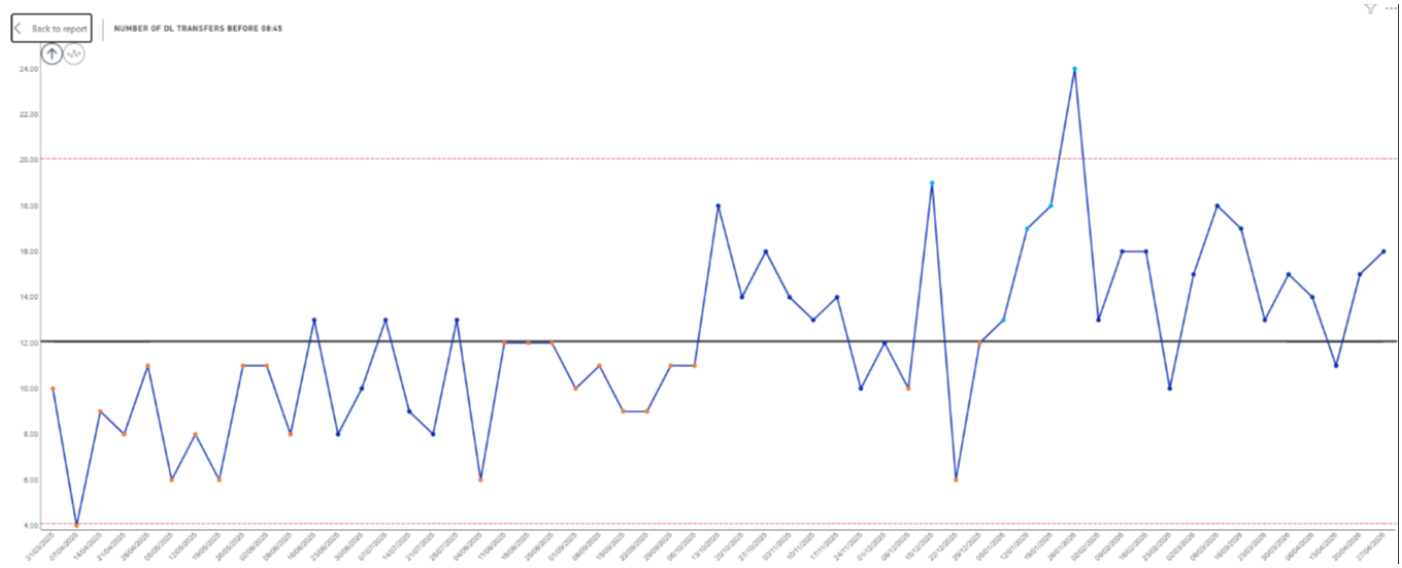
Ensuring that all patients are discharged in a timely and safe manner remains a focus for the Trust. The ward managers and clinical site team have worked throughout the year on ensuring that patients who are for discharge are transferred to the discharge lounge early in the morning on the day of their planned discharge where they can be cared for until they leave the hospital. This also ensures that our beds are freed up earlier in the day for patients waiting to be admitted in our Emergency Departments. The Discharge Lounge capacity was also increased in December 2025, and the opening hours were extended from January 2026.

There has been an increase in the number of patients transferred to the Discharge Lounge by 08.45, throughout this year, particularly in Quarter 3 and 4. In 2025/2026 the average number of patients transferred to the discharge lounge before 08.45 each week was 14 patients, and an average of 42 patients per week were in the discharge lounges by 10am (total across both sites). This is compared to an average of 7 patient a week in the discharge lounge by 08.45, and an average of 35 patients a week in the discharge lounge by 10am in 2024/2025.

Royal Shrewsbury Hospital – Patients in Discharge Lounge by 08.45.



Princess Royal Hospital – Patients in Discharge Lounge by 08.45



In summary, there remains ongoing improvements work required in 2026/2027 to improve the experience of patients discharged from our hospitals, to ensure that patients and families/loved ones are involved in the decisions around discharge plans and that these discharges take place in a safe and timely manner. This improvement work will be delivered through the 5 workstreams of the System-wide Discharge Improvement Group attended by key stakeholders across our local health economy.

PRIORITY 7: Improve Foot care for people with Diabetes (PWD) who are admitted to the Trust

What we said we would do

We aimed to improve foot care for people with diabetes

- Improve inpatient foot assessment:
  - Ensure that compulsory foot assessment for people with diabetes (PWD) is embedded on all wards
  - Ensure that all relevant clinical staff have completed the diabetes foot education on LMS to achieve >90%
  - Monthly audit of Foot assessments as part of the Matron Quality Audits
  - To re-audit against NICE (NG19) in 2025 to review improvements and highlight findings to all matrons and nursing staff
  - Assessment of all PWD with foot wounds by Podiatry team
- Wound conference for staff June 2025 to introduce '*Lift the sheet check the feet'* campaign

What we have achieved

- **Improving in-patient foot assessments and preventing harm.**

In 2025/2026 we have made substantial progress in ensuring all inpatients with diabetes receive timely and appropriate foot assessments.

These improvements have been as a result of:

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

The Achilles Heel Tool is now part of nursing admission documentation. It prompts timely assessment within 4 hours of admission to the adult inpatient wards for people with diabetes (PWD) and referral of diabetic patients with heel wounds to the Diabetic Foot Team.

The audit repeated in 2025/2026 has enabled a review of the improvements made since the audit was undertaken in 2024/2025. The results show that more people with diabetes (PWD) are receiving a foot assessment on admission. There has been an increase in the percentage of patients correctly referred to the Multi-disciplinary Foot Team for PWD and a significant increase in the percentage of people with diabetes assessed as high risk receiving heel pressure relief.

Audit Results 2025/2026 and Comparison to 2024/2025	2024/2025	2025/2026
Percentage of people with diabetes (PWD) receiving a compulsory foot assessment on admission	10%	60%
Correct referrals to MDFT for PWD and foot ulceration	42%	67%
High- risk PWD receiving heel pressure relief	13%	53%

Staff training has continued to be progressed during 2025/2026 across all inpatient ward areas. In relation to staff training the following has been achieved:

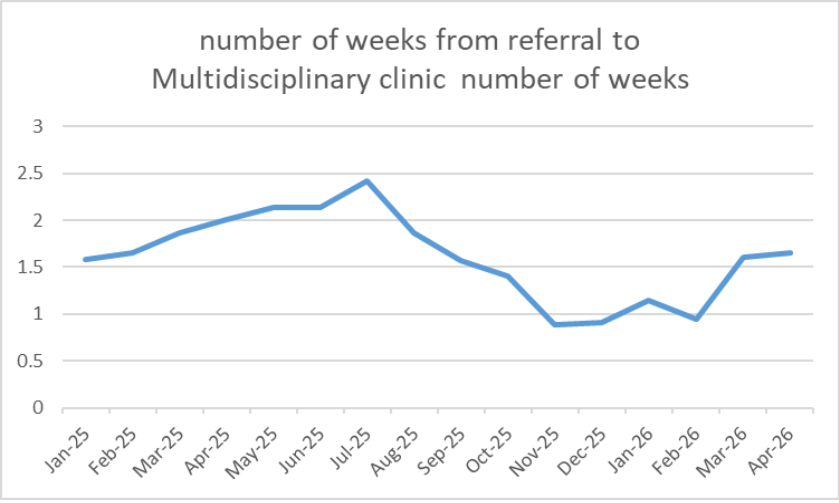
- A single mandatory diabetic foot training module is now in place.
- Trust-wide completion is now at 92.09%
- Medicine & Emergency: 91.58% (exceeding the 90% target)

Both mandatory training and completion of the Achilles Foot Tool within 4 hours of admission are currently being incorporated into the Ward Quality Dashboards for reporting and continuous monitoring. These metrics will also be reviewed during the monthly Nursing Quality Metrics Confirm and Challenge meetings to ensure sustained progress and achievement of the desired improvements. The Achilles Foot Tool assessment document will move online in 2026/2027 which will simplify the audits and highlighting knowledge gaps. Diabetes education sessions will be updated to support this.

- **Rapid access to the Multidisciplinary Foot Team.**

In 2025/26 the team have continued to significantly reduce the length of time diabetic patients 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 202/23 the average waiting time was 4 weeks

In 2023/24 the average wait time was 2.68 weeks

At the start of 2024/25 the average wait was 2.37 weeks

There have been significant improvement in 2025/2026 with the average wait time less than 2 weeks

The National Diabetic Foot Audit (NDFA) recommends expert assessment of new diabetes foot ulcers are seen within 14 days. The NDFA target is 70% of people receive first expert assessment within 14 days. We are exceeding this target with 80% of PWD seen in under 14 days. These improvements in assessment to referral time have been achieved despite a significant increase in clinical need.

We have evidence of rising clinical activity:

- 2022: 2,832 contacts
- 2024: 4,584 contacts
- 2025: 4,650 contacts

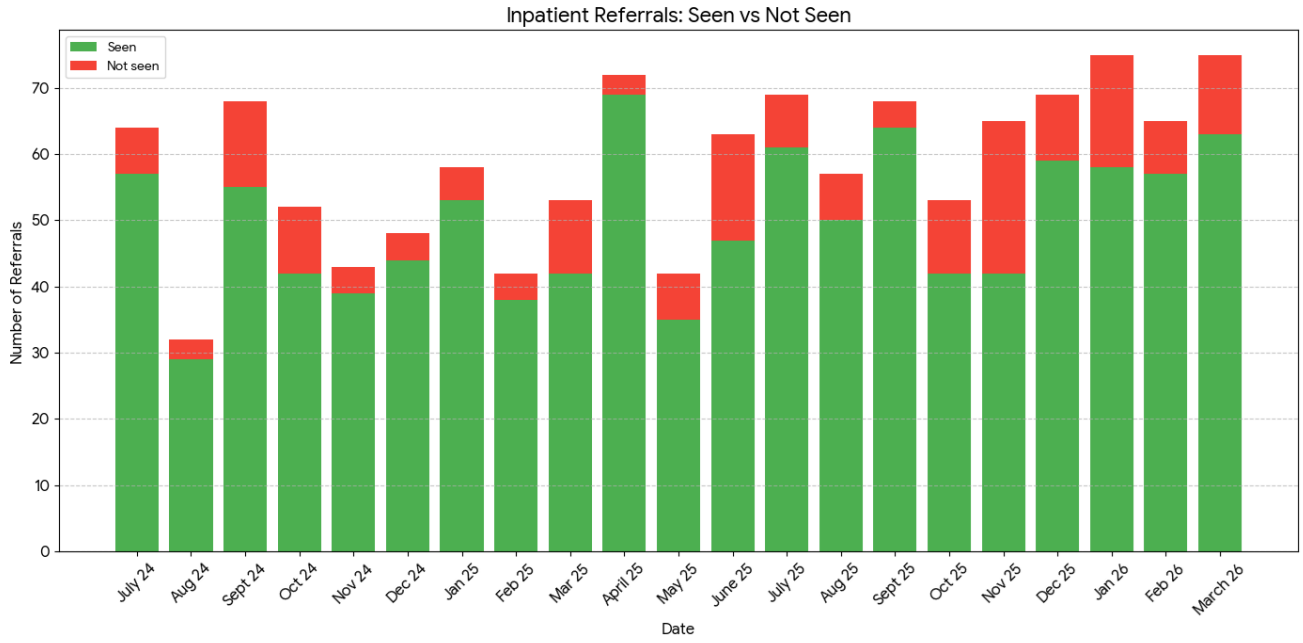
A new hot clinic now provides next-day access for urgent diabetic foot concerns from the Emergency Departments and Urgent Care Centres meaning next day access is available to any patient presenting with a diabetes foot complaint who does not require admission.

Bringing Podiatry in-house to SaTH, has improved governance, quality, cost effectiveness, and service flexibility.

- **Inpatient Foot Reviews and Outpatient Parental Antimicrobial Therapy (OPAT) Pathway.**

The **Achilles Heel Tool** is now part of nursing admission documentation; it prompts timely referral of diabetic patients with heel wounds to the Diabetic Foot Team.

Inpatient referrals:



Throughout 2025/2026 there has been a steady increase of referrals to the inpatient podiatry, with peak referrals received January and March 2026. Despite higher volume, the service remains committed to face to face access.

Inpatient referrals:

Date (6mth period)	Number of referrals	Seen face to face	Discharged without face to face review
July 2024	308	267 (87%)	41 (13%)
Jan 2025	316	274 (87%)	42 (13%)
July 2025	359	315 (88%)	44 (12%)

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.

Referrals to OPAT for diabetes foot complications

	2024/2025	2025/2026
Referrals directly from DFC	22	13
Osteomyelitis referrals	25	22
Diabetic foot infection referrals	10	2

- **Wound conference for staff June 2025 to introduce '*Lift the sheet check the feet*' campaign**

The Wound Conference took place in June 2025 and was attended by 187 staff from across the Trust. Feedback provided from the conference by attendees showed that the majority of the feedback was excellent, with participants finding the sessions very informative, useful and relevant. 77% of participants reported their practice would change as a result of the training received as part of the conference. The delegates took the learning back into their clinical areas so improvements could be embedded in practice.

In summary, significant progress has been made across all areas of diabetic foot care, with faster access to specialist teams, improved inpatient assessment, enhanced staff training, and strengthened pathways supporting early discharge. Continued digital development and education updates planned for 2026/2027 will further embed these improvements.

PRIORITY 8: Reduce the risk of mortality in patients presenting to the Trust who are acutely unwell

What we said we would do

- Ensure VTE assessments are completed and comply with national standards
- Understand and put in place interventions to address the increased Emergency Department mortality seen the mortality figures

- Implement Martha's Rule

What we have achieved

- **Ensure VTE assessments completed and comply with national standards**

The preventions of venous thromboembolism (VTE) in hospitalised patients is a clinical priority for the NHS. VTE is one of the most common complications of hospital care, can lead to unpleasant and potentially life-threatening conditions but is easy to prevent by undertaking a risk assessment and administering appropriate prophylaxis. The NHS standard for VTE risk assessment requires that 95% of all adults admitted to hospital are assessed for the risk of developing a VTE and have appropriate prophylaxis prescribed.

The process of VTE assessment currently relies on a separate IT system which from a human factors point of view means it does not easily fit into current workflow. Compliance has improved over the year 2025/2026, although has remained below the 95% national target. The quarterly performance figures are shown below:

- Q1 performance was 75.37%
- Q2 performance was 77.92%
- Q3 performance was 75.82%
- Q4 performance was 81.63%

Education with medical staff occurs at every induction and divisions have regular sessions through the year to highlight the importance. The monitoring has been added to the ward metrics to ensure a more multidisciplinary approach to managing this risk across the profession to improve patient care. The process will be embedded in the Electronic Prescribing and Medicines Administration (ePMA) systems within the Trust to improve compliance on this important task.

- **Understand and put in place interventions to address the increased Emergency Department (ED) mortality seen the mortality figures**

The Shrewsbury and Telford Hospital Trust has consistently been an outlier in terms of ED mortality. An in-depth piece of work in 2024 with Integrated Care Board (ICB) involvement did not demonstrate significant areas of intervention, however we continue to see the same outlier status.

A multidisciplinary working group was commissioned and continues to work chaired by a Deputy Medical Director. The group has regular input from the Emergency Department Leadership Team, Medical Division, Patient Safety Team, and Learning from Deaths Group, with input from others as required e.g. the Deteriorating Patient leads and RESPECT lead. The focus of the group is to provide ongoing assessment and identification of areas of improvement as we accept there will not be one single area of improvement that will improve the care of patients and reduce mortality.

Detailed analysis of the deaths in the department, combined with data from the Patient Safety Groups have identified areas of improvement focus such as timely antibiotic administration if there is delay in ambulance offload, time spent in ED before transfer to the appropriate ward, closer monitoring of high-risk sepsis patients and appropriate advance planning for palliative patients.

- **Implement Martha's Rule**

Much of the last year has been spent preparing the Critical Care Outreach Team for the implementation of Martha's Rule. A dedicated project manager is now in place (commenced March 2026). The project consists of two complementary components and will link closely with the NHS 'It's OK to Ask' campaign. The two components are the 'Call for Concern' and the 'Patient Wellness Questionnaire'.

The Call for Concern is planned for implementation by the end of June 2026 and will initially include all adult wards and paediatrics. There is ongoing national work to look at models for the Emergency Departments and Maternity services. We will roll out to these areas as models become clear. The roll out will be timed with the "It's OK to Ask" campaign as communications will be combined to ensure clarity for patients and families on the best pathway to use and to take advantage of the two funding streams for efficiency.

The Patient Wellness Questionnaire is already in use in three wards with learning from the implementation here being used to guide further roll-out. All divisions are engaged and the education package for patients and staff is being finalised. The roll-out will be completed by September 2026. The process is paper based at present; an electronic system is being worked on and will be finalised once the learning from implementation has been analysed.

PRIORITY 9: Improve the experience of patients and their loved ones who have a learning disability and/or autism

What we said we would do

- 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 for LeDeR and Clive Treacey
- Continue the LD/Autism Patient Experience Group and act upon the issues raised

What we have achieved

- **Undertake the Learning Disabilities Improvement Standards Self Improvement tool and create an action plan based on the findings.**

In June 2018 NHS Improvement published the learning disability improvement standards for all NHS Trusts. These are supplemented by a framework of improvement measures or actions that NHS Trusts are expected to take to make sure they can meet the standards and deliver the outcomes that people with a learning disability and their families can expect.

The tool focuses on the actions that are needed by acute NHS Trusts to address concerns about the premature deaths of people with a learning disability using the Learning Disability Standards. The aim of the standards is to reduce unacceptable variations in the quality and outcomes that people experience, by driving improvements in the planning and coordination of support to people with a learning disability and ensuring that their rights are fully respected and protected.

The improvement tool was designed to be completed in two separate workshops, one for NHS Trust managers and one for frontline staff. Questions for managers focus on critical service structures, whilst questions for staff explore the processes by which people are supported. An independent facilitator helps participants explore questions concerning each of the metrics. Consensus performance ratings from pre-set menus are entered into the improvement tool, in real time. This information serves as a starting point for reflection on performance and improvement action planning.

Two workshops took place in May 2025; one attended by staff providing direct patient care and one by Trust managers.

Learning Disability Standard 1: Respecting and Protecting People's Rights.

"Trusts must have measures in place to promote anti discriminatory practice in relation to people with a learning disability".

- Managers felt that there were systems in place to allow senior managers to hear the experiences and views of people with a learning disability, the staff were not aware of these and didn't think any measures existed.
- There was a similar difference in frontline staff seeing and reflecting on data regarding the clinical effectiveness of the support offered to patients with a learning disability. This highlighted the need for further data collection and improved communication with staff delivering care.
- Managers were confident that there was a robust Mental Capacity Act Policy in place that was audited and supported staff when making decisions about capacity and best interest.
- Staff had good knowledge of the policy but highlighted that some may not know how to refer to an Independent Mental Capacity Advocate.

- Staff highlighted a need to improve the communication between departments to be explicit that a patient has a learning disability and they required reasonable adjustments.
- Managers noted that there was a requirement to improve the auditing of the care provided to patients with a learning disability and how reasonable adjustments are recorded and communicated to identify areas of good practice and those that need improvement.

"Trusts must demonstrate that reasonable adjustments are made to care pathways, to allow people with a learning disability to achieve highly personalised care, and equality of outcomes".

- Whilst there was some knowledge and documentation of patients' specific needs that there was some inconsistency and a need to raise awareness about reasonable adjustments and accessible information.
- Environmental adaptions to meet the needs of patients with disabilities were difficult to achieve
- Not all staff felt they were familiar with the use of adapted pain assessment approaches and tools. Meaning they were not always used. Further work in this area is therefore required.

"*Trusts must demonstrate that they vigilantly monitor any restrictions or deprivations of liberty associated with the delivery of care and treatment".*

- Both staff and managers agreed that there was a robust Deprivation of Liberty Policy that was well embedded in practice and compliance demonstrated by audit.
- Staff highlighted that they did not get to see the audit reports regarding deprivation and restrictions of liberty however were aware that if there were areas requiring improvement that they would be informed by their manager.

"Trusts must have processes to investigate and learn lessons if people with learning disabilities die whilst using their services".

- managers were confident in the processes in place to notify LeDeR and share information as required to support the reviews. Staff had some knowledge regarding LeDeR however there were opportunities identified to further share the learning from reviews of the deaths of patients with learning disabilities at a team level.
- Managers also recognised that governance processes could be strengthened further to ensure that there was greater understanding and actions generated to reduce potentially avoidable deaths within the Trust.

Learning Disability Standard 2: Including and Engaging People and their Families.

"Trusts must ensure people with a learning disability, their families and carers, are all empowered to be partners in the care they receive and must demonstrate processes that ensure they work and engage with people receiving care, their families and carers".

- Both managers and staff agreed that there was a well embedded policy and process related to serious incidents and that patients with a learning disability and their families/carers would be given apologies and information in the most appropriate format and supported with reasonable adjustments to help them understand what had happened.
- Staff were not aware that meeting records could be provided in accessible formats but that is something they would not be required to organise or discuss with patients and their families/ carers. The Quality Governance, Patient Experience or Complaints teams would be involved and have that knowledge to support.

"*Trusts must demonstrate that they learn from complaints, investigations and mortality reviews, and that they engage with and involve families and carers throughout these processes".*

- Staff felt that processes related to safeguarding were well known and working well.
- Managers answered that all questions related to this measure are currently being achieved at the Trust.

"*NHS Trusts should have the skills and capacity to meet the needs of people with a learning disability, by providing safe and sustainable staffing, with effective leadership at all levels.*

- Staff responses to this measure identified that further knowledge and skills were required by some to enable them to be confident in meeting the needs of patients with learning disabilities.
- Managers identified that while the specialist liaison nurse service is commissioned from the Midlands Partnership University NHS Foundation Trust (MPFT), the Trust could work in collaboration with the Integrated Care Board (ICB) and MPFT to ensure the current service model is sufficient to provide effective services for patients.

"*Staff must be trained and routinely refreshed, in the delivery of care and support to people with learning disabilities who use their services".*

- The responses provided by both staff and managers showed that there was a gap currently in the learning disability and autism training available to provide staff with the specialist knowledge they required. This would be addressed through implementation of Oliver McGowan training and targeted learning disability awareness training.

"Trusts must have workforce plans which include provision to manage and mitigate the impact of the growing, cross- system shortage of qualified practitioners with a professional specialism in learning disabilities".

- Both staff and managers agreed that there were clearly identified people in lead roles who were able to provide specialist advice and improve service delivery.

The summary of findings identified eighteen measures that were currently being achieved, four measures not fully achieved but which would be in the next 6 months. Another eight measures were not fully achieved but would be in the next 12 months and one was not fully achieved and unlikely to in the next 12 months.

An action plan to address these findings was developed in collaboration with the Specialist Learning Disability Liaison Nurses. This was initially shared with the LD and Autism Patient Experience Group for their review and input and then at the Joint Safeguarding, Mental Health and LD/ Autism Operational Group. It was agreed that a new Learning Disability and Autism Improvement Group would be formed with the aim to implement at pace the improvement plan and other actions arising from LeDeR, previous serious incidents and the LD and Autism Patient Experience Group. The Improvement Group commenced in October 2025 and consists of internal stakeholders from all clinical divisions, along with external stakeholders such as LD specialist nurses, Voluntary, Community and Social Enterprise (VCSE) representatives and service users. The output of the group is being shared at the Patient Experience meeting and Safeguarding Assurance Committee to demonstrate progress against the improvement action plan.

- **Implement the reasonable adjustments digital flag on EPR.**

Under the Equality Act 2010, organisations have a legal duty to make changes in their approach or provision, called reasonable adjustments, to ensure that services are as accessible to people with disabilities as they are for everyone else. This duty aims to address the recognition that people with disabilities may have equal access to care and services, but without specific adjustments being made, that access may not be equitable.

NHS England has built the Reasonable Adjustment Digital Flag in the NHS Spine to enable health and care professionals to record, share and view details of Reasonable Adjustments across the NHS, wherever the person is treated. The flag indicates that Reasonable Adjustments are required for an individual and optionally includes details of their significant impairments, underlying conditions and key adjustments that should be considered.

The flag aims to enable:

- Clear identification of all patients for whom Reasonable Adjustments may be required.
- Identification of patients with impairments including learning disability or autism (and all other relevant key impairments).

- Identification and sharing of key adjustments that will help a care episode go well or happen at all.
- Ubiquitous, consistent visibility and structure of the information, wherever a patient is treated in health and care.
- Identification and maintenance of the information recorded and shared through the Reasonable Adjustment Digital Flag in conjunction with the wishes of patients and carers, leading to tailored, personalised care.

There is a requirement for all organisations to have implemented the Reasonable Adjustment Digital Flag by September 2026. NHS England moved the implementation date for the Reasonable Adjustment Digital Flag from December 2025 to 30 September 2026 to align with a new Information Standards Notice (ISN) issued on 19 December 2025, which made the flag mandatory rather than advisory. This change introduced new legal, technical, and consent-model requirements and the extended timeline reflects the additional time providers and system suppliers need to meet these strengthened obligations and achieve full national compliance.

The Trust has completed a gap analysis against the new Information Standards Notice and is working with our system supplier to ensure technical readiness alongside strengthening staff awareness and training so teams understand how to record, review, and act on reasonable adjustments consistently. The Trust is engaging with our system partners and national programmes to ensure alignment, share learning, and confirm that our implementation approach meets the new mandatory requirements.

- **Achieve compliance with LD training for clinical staff.**

The Health and Care Act 2022 introduced a statutory requirement that CQC registered providers must ensure their staff receive learning disability and autism training appropriate to their role. The Oliver McGowan Mandatory Training is the standardised training that was developed for this purpose and is the preferred and recommended training for health and social care.

There are two tiers of training:

- **Tier 1** This 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** This 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 2025/26 staff at SaTH have undertaken the Oliver McGowan e-learning training which is mandated by the Trust and 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. NHSE provided three years of funding for Shropshire, Telford and Wrekin

(STW) to implement the Oliver McGowan Training which came to an end in March 2025. The way this funding was distributed across the system created organisational challenges and as a result SaTH was only able to offer training to staff during the 2024/25 financial year. This limited the number of colleagues who could be trained and had an impact on overall compliance rates. In recognition of this the ICB allocated the small amount of remaining NHSE funding to SaTH enabling additional training sessions to run between November 2025 and March 2026. A total of 330 Tier 1 places and 180 Tier 2 places were offered and fully utilised resulting in a modest improvement in compliance. A wider plan has been developed by the Trust for 2026/27 to deliver 3,000 training places prioritising patient-facing colleagues. This programme will include 92 Tier 2 sessions and 16 Tier 1 sessions with the aim of increasing compliance for both Tiers to 60% by March 2027. A business plan outlining the long-term, sustainable approach to ongoing training delivery will be developed during 2026/27.

Additionally, during 2025/26 the Learning Disability Awareness sessions delivered by the Acute Liaison Nurses Learning were available and while they are not mandatory, clinical services were encouraged to prioritise attendance for staff to improve the quality of care provided to patients with learning disabilities.

- **Embed the Hospital Passport process.**

A Learning Disability Patient Passport is a three paged assessment that has been designed to support patients with a learning disability when attending hospital as an inpatient or an outpatient. The Patient Passport includes information that staff must, and should know, as well as the patient's likes and dislikes. The patient with a learning disability should come to hospital with a Patient Passport but if they do not have one then staff should offer the patient (and carer) a Patient Passport and should offer to help the patient (and carer) to complete it. The use of these patient passports had not been consistent, and a previous knowledge base "Ask 5" audit undertaken on the adult inpatient wards identified a significant lack of awareness as to what a passport was and how to use it.

One of the key areas associated with improving staff knowledge related to the need for a refreshed LD policy. Subsequently the Care of Adults with a Learning Disability Policy has been fully reviewed and updated during 2025/26. It now places greater focus on tackling health inequalities, addressing diagnostic overshadowing, and ensuring consistent use of Patient Passports and accessible communication tools across all clinical settings. Expectations around documentation have been strengthened and the role of the Acute Learning Disability Liaison Nurses has also been clarified. Input was sought and received from relevant clinical and corporate teams including Learning Disability Liaison Nurses. Auditable standards have been included during the review of the policy, including those related to the use of patient passports, and it is being added to the 26/27 forward audit plan. This will enable assessment of compliance which has not been possible previously.

The standardised and consistent use of patient passports has been a key action of the LD and Autism Improvement Group with ownership for individual ward/ departmental actions taken by the divisional clinical members. LD and Autism resource folders have been introduced with the contents including printed copies

of the patient passports and completion guidance for staff with easy read versions for patients. Clinical walkarounds took place in Quarter 4 and further ones are planned in Quarter 1 of 2026/2027 to further raise staff awareness of the updated policy, resource folders, reasonable adjustments and patient passports.

- **Implement the actions from LeDeR and Clive Treacey.**

Learning from Lives and Deaths (LeDeR) is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received.

It does this by:

- Delivering local service improvement, learning from LeDeR reviews about good quality care and areas requiring improvement.
- Driving local service improvements based on themes emerging from LeDeR reviews at a regional and national level.
- Influencing national service improvements via actions that respond to themes commonly arising from analysis of LeDeR reviews.

The Trust had been participating in the LeDeR Steering Group and Governance panel but due to a gap in a dedicated Trust lead during 2024/25 there had been some delay in actioning the learning from reviews. Collaborative work with the Lead and Deputy for the STW LeDeR programme was undertaken in 2025/2026 to gain clarity around outstanding actions and provide a comprehensive update of how previous learning has been embedded. New processes for sharing the learning and examples of good practice from the reviews were developed and implemented. These included sharing the NHSSTW LeDeR quarterly reports at the Joint Safeguarding/Mental Health and LDA Operational Group and sharing individual LeDeR reviews where there is learning or good practice relevant to Trust.

Additionally, a change in process of Structured Judgement Reviews (SJR's) for patients with a Learning Disability or Autism who have died was enacted with specialist learning disability input now provided to identify learning and support the external LeDeR process. To allow greater oversight and more timely responses of any learning from the deaths of adults with Learning Disability and/ or Autism a quarterly thematic summary of completed SJR's is now being shared at the LD and Autism Patient Experience Group and the Joint Safeguarding/Mental Health and LDA Operational Group to disseminate the learning points.

A national Safeguarding Adults Review into the death of Clive Treacey highlighted the need for stronger coordination, clearer accountability, and more proactive identification and support for people with learning disabilities and autistic people. There is an STW action plan, and the Trust fully reviewed and updated our position during 2025/26 including strengthening how we record and act on reasonable adjustments and improving communication between clinical teams and specialist learning disability services.

- **Continue the LD/Autism Patient Experience Group and act upon the issues raised.**

The LD/Autism Patient Experience Group is now chaired by the Lead for Health Inequalities and EDI and has met monthly throughout 2025/26. The group is well attended by 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 the Trust decision making processes and driving improvements. The Group reports into the Patient and Carer Experience (PaCE) Panel chaired by the Interim Chief Nurse.

During 2025/26 several improvements have been guided by the patient/ carer perspectives of the group. A key area identified was the improvement of the experience of patients with LD and Autism during an emergency admission. In addition to people being unwell, scared and vulnerable they are also often unprepared so do not have items with them to aid with the sensory overload of the hospital environment. Many other Trusts have introduced 'Care Bags' which contain sensory/distraction tools along with easy read patient information literature. The group agreed that the introduction of Care Bags would be very beneficial to improve patient experience and charitable funding was requested and confirmed to purchase 100 branded care bags containing ear defenders, chew bracelet, stress ball, fidget toy, colouring book and colouring pencils, eye mask and 8-page A5 easy read patient information booklet. The design of the bag and patient information booklet were decided by the Group, and the bags will be launched during Learning Disability Awareness week in June 2026.

An easy read pledge poster has been co- produced to be displayed within both the Shrewsbury and Telford Hospital NHS Trust and Shropshire Community Trust. The poster is based on one within the Royal College of Emergency Medicine Learning Disabilities Toolkit and states the commitment to provide reasonable adjustments to those with LD, autism and communication difficulties. The poster will be displayed on boards and digital screens within wards and departments and also on the LD section of the intranet and internet.

Standardised LD and Autism resource folders have been developed for clinical departments with the contents discussed and decided at the Patient Experience Group.

From May 2026 the group will be held jointly with Shropshire Community Trust (SCHT) and additional members have been identified to allow for a wider scope of improvement work including community pathways.

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 2025/26 the Shrewsbury and Telford Hospital NHS Trust provided a wide spectrum of acute services to NHS and Non-NHS patients through our contracts with Integrated Care Boards, NHS England and other commissioning organisations, including Welsh organisations to the value of £727.942 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 the 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 (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 Care Quality Commission has not taken enforcement action against the Trust in 2025/26 and the Trust has not been subject to any special reviews or investigations by the Care Quality Commission during 2025/26.

The Trust has continued its improvement journey, with two conditions previously imposed by the CQC remaining on its Provider Licence at the start of 2025/26. Following a successful application to the CQC, one of these conditions was removed in December 2025 and ongoing improvement actions have continued

throughout the year to progress the removal of the remaining condition which relates to the initial assessment of all patients within 15 minutes of arrival in our Emergency Departments.

The CQCs most recent inspection of the Trust took place on 3rd and 4th March 2026. The unannounced CQC inspection was a winter pressure service review. The focus of this inspection was on our Urgent and Emergency Care Pathways, with our Emergency Department and Medical Wards at both the RSH and PRH being included. The inspection report is expected to be published in Quarter 1 of 2026/27.

A CQC inspection of Clinical Diagnostic Services including MRI, CT, Nuclear Medicine and Ultrasound was also undertaken on the 1st May 2026.

The current ratings for the 2 hospital sites, based on the 2024/25 inspection by the CQC are shown:

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

Our overall rating for the Trust remains unchanged at the time of production of the Quality Account.

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

Throughout 2025/26 there have been improvements and innovation in many services, which has led to improvements in the quality and timeliness of care provided to our patients. These improvements have been recognised by a number of external visits and independent reports. However, the Trust recognises that there are still areas for improvement in some services and these remain a priority for the Trust. We are awaiting

the CQC's most recent inspection report, feedback from this will be incorporated into our Trust-wide improvement plans.

PARTICIPATION IN CLINICAL AUDIT AND CONFIDENTIAL ENQUIRIES

The Trust uses clinical audit to provide assurance that appropriate care is being delivered in line with local and national guidance, and to drive improvements in patient care.

During 2025/26, 99 national clinical audits and 9 national confidential enquiries were prioritised by the Healthcare Quality Improvement Partnership (HQIP) for Trust's to participate in (where applicable). During the reporting period, SaTH participated in 89% (63/71) of the national clinical audits and all (9/9) 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. Audits included in the National Clinical Audit and Patient Outcomes Programme (NCAPOP) are mandatory audits covering key conditions, indicated with a tick in the fifth column of table 1. Examples of key findings and actions taken to improve patient care following participation in national audits are listed in Table 3.

Table 1: National Clinical Audits 2025/2026.

Table 1 – National Clinical Audits 2025/26					
Title		***Eligible***	***Participating***	***NCAPOP***	***Submission rate (%) / Comment***
British Association of Urological Surgeons (BAUS)	Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	✓	×	×	Urology department not invited to participate
	British audit Of the investigatiOn and referral of woMen with rEcurrent uRinary trAct infectioN using recent Guidance (BOOMERANG)	✓	×	×	Did not participate due to capacity issues
Breast and Cosmetic Implant Registry		×	×	×	Specialist Centre
British spine Registry		×	×	×	Specialist Centre
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	✓	✓	✓	2/6 cases submitted
	Stabilisation of the critically ill child	✓	✓	✓	Currently in progress

Table 1 – National Clinical Audits 2025/26					
Title		***Eligible***	***Participating***	***NCAPOP***	***Submission rate (%) / Comment***
	Juvenile Idiopathic Arthritis	✓	✓	✓	7/7 cases submitted
Cleft Registry and Audit Network (CRANE)		×	×	×	Specialist Centre
Emergency Medicine QIPs:	Adolescent Mental Health	✓	✓	×	Currently in progress
	Care of Older People	✓	✓	×	Currently in progress
	Time critical medications	✓	✓	×	Currently in progress
	Mental Health – Self harm	✓	✓	×	All eligible cases
Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies in Children and Young People		✓	✓	✓	All eligible cases
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database	✓	✓	✓	All eligible cases to date
	Inpatient Falls	✓	✓	✓	All eligible cases
	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	✓	✓	✓	No eligible cases
	Pleural procedures	✓	✓	✓	Currently in progress
	Acute illness in people with a learning disability	✓	✓	✓	4/4 cases submitted
	Rib fractures	✓	✓	✓	Currently in progress
	Blood Sodium Study	✓	✓	✓	3/9 cases submitted
	Rehabilitation following critical illness	✓	✓	✓	12/12 cases submitted
Mental Health Clinical Outcome Review Programme	Real-time data collection of probable suicide deaths by mental health in-patients and patients who	×	×	✓	Specialist Centre

Table 1 – National Clinical Audits 2025/26					
Title		**Eligible**	**Participating**	**NCAPOP**	**Submission rate (%) / Comment**
	died within 14 days of discharge				
	Suicide (& homicide) by people under mental health care	×	×	✓	Specialist Centre
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	✓	✓	×	All eligible cases
	Diabetes Prevention Programme (DPP) Audit	×	×	×	Primary Care
	National Diabetes Footcare Audit (NDFA)	✓	✓	×	All eligible cases
	National Diabetes Inpatient Safety Audit (NDISA)	✓	✓	×	Data submitted from November 2025 onwards
	National Pregnancy in Diabetes Audit (NPID)	✓	✓	×	All eligible cases
	Transition (Adolescents and Young Adults) and Young Type 2 Audit	×	×	×	Primary Care
	Gestational Diabetes Audit	✓	✓	×	All eligible cases
National Audit of Cardiac Rehabilitation		×	×	×	Specialist Centre
National Audit of Cardiovascular disease in primary care (CVD Prevent)		×	×	✓	Primary Care
National Audit of Care at the End of Life (NACEL)		✓	✓	✓	Required sample submitted
National Audit of Dementia		✓	✓	✓	Currently in-progress
National Audit of Eating Disorders (NAED)		×	×	✓	Specialist Centre
National Bariatric Surgery Registry		✓	✓	×	All eligible cases
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

Table 1 – National Clinical Audits 2025/26					
Title		**Eligible**	**Participating**	**NCAPOP**	**Submission rate (%) / Comment**
	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	×	×	×	Specialist Centre
	Congenital Heart Disease (CHD)	×	×	×	Specialist Centre
	National Heart Failure Audit (NHFA)	✓	✓	×	All eligible cases
	National Audit of Cardiac Rhythm Management (CRM)	✓	✓	×	All eligible cases
	Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	×	All eligible cases
	National Audit of Percutaneous Coronary Interventions (PCI)	×	×	×	Specialist Centre
	UK Transcatheter Aortic Valve Implantation (TAVI) Registry	×	×	×	Specialist Centre
	Left Atrial Appendage Occlusion (LAAO) Registry	×	×	×	Specialist Centre
	Patent Foramen Ovale Closure (PFOC) Registry	×	×	×	Specialist Centre
	National Audit of Mitral Valve Leaflet Repairs (MVLR)	×	×	×	Specialist Centre
National child mortality database		✓	✓	✓	All eligible cases
National Clinical Audit of Psychosis (NCAP)		×	×	✓	Specialist Centre
National Comparative Audit of Blood Transfusion programme	2025 Major haemorrhage Audit	✓	✓	×	All eligible cases
National Early Inflammatory Arthritis Audit (NEIAA)		×	×	✓	Specialist Centre
National Emergency Laparotomy audit (NELA)	Laparotomy	✓	✓	✓	All eligible cases
	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 eligible cases
National Neonatal Audit Programme (NNAP)		✓	✓	✓	All eligible cases
National Obesity Audit		✓	✓	✓	All eligible cases

Table 1 – National Clinical Audits 2025/26					
Title		**Eligible**	**Participating**	**NCAPOP**	**Submission rate (%) / Comment**
National Ophthalmology Database (NOD)	Age-related Macular Degeneration Audit	✓	×	×	Did not participate due to capacity issues
	Cataract Audit	✓	✓	×	All eligible cases
National Paediatric Diabetes Audit (NPDA)		✓	✓	✓	All eligible cases
Perinatal Mortality Review Tool (MBRRACE)		✓	✓	×	All eligible cases
National audit of Pulmonary Hypertension		×	×	×	Specialist Centre
National Respiratory Audit Programme (NRAP)	Adult Asthma Secondary Care	✓	✓	✓	Currently in progress
	Children and young people asthma secondary care	✓	✓	✓	All eligible cases
	Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	✓	✓	✓	Currently in progress
	Pulmonary rehabilitation	×	×	✓	Specialist Centre
National Vascular Registry		✓	✓	✓	Currently in progress
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry		×	×	×	Specialist Centre
Paediatric intensive care (PICaNet)		×	×	✓	Specialist Centre
Perioperative Quality Improvement Programme		✓	×	×	Did not participate due to capacity issues
Prescribing Observatory for Mental Health (POMH-UK)	Improving the quality of valproate prescribing in adult mental health services	×	×	×	Specialist Centre
	Use of clozapine	×	×	×	Specialist Centre
	Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	×	×	×	Specialist Centre
Sentinel Stroke National Audit Programme (SSNAP)		✓	✓	✓	All eligible cases
UK Cystic Fibrosis Registry	Cystic fibrosis – Adults	×	×	×	Specialist Centre
	Cystic Fibrosis - Children	×	×	×	Specialist Centre
UK Interstitial Lung Disease (ILD) Registry		✓	×	×	Did not participate due to capacity issues
UK Parkinson's Audit		✓	✓	×	Currently in progress
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 2025/2026

Table 2 – National Confidential Enquiries (NCEPOD) 2025-26 (9)				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
Child Health Clinical outcome Review Programme	Emergency surgery in children and young people	✓	✓	2/6 cases submitted
	Stabilisation of the critically ill child	✓	✓	Currently in progress
	Juvenile idiopathic arthritis	✓	✓	7/7 cases submitted
Medical and Surgical Clinical outcome Review Programme	Acute limb ischaemia	✓	✓	No eligible cases
	Pleural procedures	✓	✓	Currently in progress
	Acute illness in people with a learning disability	✓	✓	4/4 cases submitted
	Rib fractures	✓	✓	Currently in progress
	Blood Sodium Study	✓	✓	3/9 cases submitted
	Rehabilitation following critical illness	✓	✓	12/12 cases submitted

**Based on information available at the time of publication.*

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 key outcomes and actions taken following National Audits	
Title	***Outcome/actions***
Intensive Care and National Audit Research Centre (ICNARC) audit (RSH & PRH 6154/5)	• Ongoing national intensive care unit (ICU) audit comparing key quality indicators and risk-adjusted mortality against similar units provided assurance in these areas for both hospital sites. All quality indicators rated as green and risk adjusted mortality was in the expected range.
National Ovarian Cancer Audit (NOCA) 21-23 (6415)	• To improve ovarian cancer survival outcomes in line with national standards. Diagnostic, referral, and multi-disciplinary team (MDT) timelines reviewed in accordance with NICE CG122.
Blood Sodium – National Confidential Enquiry into Peri-operative Deaths (NCEPOD) (5929)	• SaTH is compliant with the national recommendations made by the study.
Sentinel Stroke National Audit Programme (SSNAP) - 2024/25 (6220)	• To ensure patients are admitted to the stroke ward within 4 hours ring-fencing of stroke beds is now being monitored in line with the 'Protecting Beds for Emergency Admission of Stroke Patients to the Stroke Unit' standard operating procedure (SOP).

Table 3 - Examples of key outcomes and actions taken following National Audits	
Title	***Outcome/actions***
	• Now following the SHOP model (framework for improving patient flow) to facilitate improved Stroke Unit flow.
National Audit of Inpatient Falls (NAIF) 2024 (6330)	• Nationally, 43% of patients had five or more elements of the multifactorial assessment completed, compared with 37% in 2022. Just over half (54%) of patients had a documented post-fall check indicating that the patient had sustained an injury.
National Lung Cancer Audit (NLCA) 2023 (6424)	• Over the last 12 months a lung cancer screening programme has been commissioned for Shropshire, Telford and Wrekin. Our screening programme started in the middle of January, with the first low dose CT scan taking place on the 21st January 2026.
National Emergency Laparotomy Audit (NELA) – Year 10 (6622)	• The data shows a reduction in mortality and length of stay.
National Cardiac Arrest Audit (NCAA) 2023-24 (6545)	• Both PRH and RSH in-hospital cardiac arrest are in line with other similar hospitals. • Differences in survival to discharge between hospital sites (PRH 24.4%, RSH 12.9%) being reviewed and focus on appropriate ReSPECT planning.
National Ophthalmology Database Cataract Audit 23/24 (6455)	• Outcomes were comparable to national standards.
National Audit for Care at the End of Life (NACEL) 2024 (5659)	• Improvements since previous audit following delivery of action plan, including recognition and communication of expected death and patients expected to die having an individualised plan of care.
Juvenile Idiopathic Arthritis (NCEPOD) (5624)	• Nationally, the study showed major non-compliance with access to therapies / psychology. An action plan has been developed to address this locally.
Time critical Medicines (TCM's) – Royal College of Emergency Medicine (RCEM) (5651)	• Dedicated Pharmacists are now based in ED's at both sites from November 2025, providing support by identifying and escalating patients on TCM's and ensuring these are recorded on the Careflow computer system.

**Based on information available at the time of publication.*

Table 4: Trust Local Audits

SaTH also undertakes a Trust-wide programme of local audits against local and national guidance. During 2025/2026, action plans were returned for 260 completed local audits. A sample of key findings and recommendations from these audits are summarised in Table 4.

TABLE 4 – Trust Local Audits 2025-26		
CLINICAL SUPPORT SERVICES – ONCOLOGY & HAEMATOLOGY		
No	**Audit Title**	**Key actions/improvements following audit**
6386	3rd and on treatment checks	• The audit showed 78% compliance • There was no increase in non-conformities noted, decision made to bring all sites in line and do 1 mid-point check for any treatments over 5#s. Concession written, staff informed.

TABLE 4 – Trust Local Audits 2025-26		
6292	4D lung planning	• No issues of concern noted. Some minor documentation changes implemented.
6566	Anal Cone Beam CT scan (CBCT) consistency	• No significant issues – A reminder in the newsletter to ensure correct imaging form attached to request.
6328	Bladder filling Colorectal audit	• Trial of new bladder filling process showed that reduced bladder size was easier for patients to achieve and for radiographers to compare to original CT scan.
5948	Brain tumours (primary) and brain metastases in adults – National Institute for Health and Care Excellence (NICE) NG99 & QS203	• Re-audit following delivery of audit action plan showed improvement in compliance from 75% to 98%.
6396	CT checks Form	• All documents were scanned correctly, site, laterality and pregnancy checks were completed in 100% of cases.
5807	Haematological cancers: improving outcomes - NICE NG47 & QS150	• The audit showed that we are mainly compliant with the protocols that are currently in place. • We do not currently have a Specialist Integrated Haematological Malignancy Diagnostic Service (SIHMDS), so samples are sent to Birmingham.
6569	Oesophagus consistency	• All 40 images patients were treated accurately and correctly.
6281	Patient feedback 2024	• The audit showed consistent performance
6283	Prostate image match consistency	• Good compliance with standards for prostate soft tissue matching and high levels of inter-observer reliability for prostate imaging.
6286	Quality performance analysis	• No concerns were identified.
CLINICAL SUPPORT SERVICES – PATHOLOGY		
No	**Audit Title**	**Key actions/improvements following audit**
6301	B3 and B4 breast core re-audit 2024	• Reporting times of B3 and B4 core breast biopsies falls short of the standards of 80% within 7 days (68% SaTH) and 90% within 10 days (87% SaTH). Positive predictive rate for B4 biopsies is 100%, with 99% of cases double reported compared to standard of 95%. The reporting pro-forma has been updated to improve reporting of epithelial atypia.
6403	Cellular pathology Lymphoma audit 2025	• The audit demonstrates that the involvement of SATH in the referral pathway contributes a notable delay, with an average increase of five days in turnaround time. • Changes have now been made to direct referral to address this.
6300	Cervical pathology proforma audit 2025	• Audit showed good use of pro-forma with compliance in 100% of lletz biopsies and 98.9% of cervical biopsies. Further updates made to documentation to attain 100% for cervical biopsies.
6375	Vulval specimens (re-audit)	• Re-audit showed good increase in compliance with standards following implementation of actions after previous cycle of audit.
CLINICAL SUPPORT SERVICES – RADIOLOGY		
No	**Audit Title**	**Key actions/improvements following audit**
6402	CT colonography 2025	• The polyp identification rate (PIR) remains constant and above the target standard at 16%. The positive predictive value (PPV) reduced slightly but remains at the threshold of aspirational standard (90%).
6004	CXR confirmation of nasogastric (NG) tube placement (re-audit)	• Re-audit showed improvement to 100% compliance in documentation of NG tube in situ in the gastric bubble following implementation of actions.

TABLE 4 – Trust Local Audits 2025-26		
6246	Radiology Department Preparedness and knowledge on the management of mild to severe contrast medium reactions (re-audit)	• Re-audit showed a marked improvement in compliance from 2.27% to 26%, but still below optimal standards. Targeted education delivered to address problem areas.
CORPORATE – TRUST WIDE		
No	**Audit Title**	**Key actions/improvements following audit**
5969	Bereavement feedback questionnaire 2024-2025	• The monitoring and actions relating to the bereavement feedback are now more structured and are presented and monitored via the Palliative and end of life care (PEoLC) steering group monthly meetings.
6088	Specialist Palliative Care advice sought out of hours (OOH) by SaTH clinicians from the Severn Hospice advice line 2024 (Q2)	• Advice line is being utilised by SaTH staff, mostly by palliative care Clinical Nurse Specialists (CNS) on weekend cover but evidence of other contacts as well. • Evidence of improved patient care as a result of contacts including improved/ earlier symptom control.
5902	Symptom control audit 2024	• Training package delivered using SIM, re-audit to be carried out in 1 year to assess impact.
SURGERY, ANAESTHETICS & CANCER – THEATRES, ANAESTHETICS & CRITICAL CARE		
No		**Key actions/improvements following audit**
5957	Anaesthetic Involvement in Major Obstetric Haemorrhage > 1.0 litres - re-audit	• Results satisfactory, no recommendations required.
6522	Anaesthetic management – cardio-pulmonary resuscitation (CPR) in pregnancy 2026	• During this period, there were no obstetric patients receiving CPR.
5891	Anaesthetic management of pregnant women with raised body mass index (BMI)	• Audit showed high levels of referral and assessment of high-risk women with risks well documented.
6211	Peripartum Hyponatraemia (re-audit) 2025	• Hyponatremia patients were managed successfully without any maternal or fetal complications.
5889	Post-dural puncture headache (re-audit)	• Demonstrated low incidence of post dural puncture headache (PDPH) of 0.2% when compared to published figures.
6159	Reviewing anaesthetic practice - enhanced recovery from arthroplasties	• Remifentanil leaflet was approved and has been updated with patient friendly language. This is now available on the intranet, Badgernet & Padlet.
6521	Suxamethonium apnoea in pregnancy (re-audit) 2026	• During this period, there were no obstetric patients found with Suxamethonium Apnoea.
SURGERY, ANAESTHETICS & CANCER – HEAD & NECK AND OPHTHALMOLOGY		
No	**Audit Title**	**Key actions/improvements following audit**
6340	“Virtual” oral surgery assessment clinic for orthodontic patients	• Letters not always standardised – ensure that standard template Is used • To aid communication an multi-disciplinary team (MDT) referral request proforma has been created. • Demonstration that virtual pathway is clinically safe to use.
6659	Adult Clinical Key Performance Indicator (KPI) Annual Analysis: August - October 2025/6	• Good overall clinical compliance • Good start of implementing Client Oriented Scale of Improvement (COSI) outcome questionnaire.
6658	Adult Facilities Key Performance Indicator (KPI) Annual Analysis: September - October 2025	• Reassuring quality of adult audiology facilities and equipment checks • Subsequent re-audit showed improvement in all areas reviewed.
6378	Allied Health Professional (AHP) intravitreal injection service	• Large volume of patients being treated by AHP’s with below average incidence of adverse effects.

TABLE 4 – Trust Local Audits 2025-26		
6054	Casenote & Stamp Max Fax 2024 (Jun-24 pts)	• Significant improvement in discharge summaries, which was a recommendation from the previous audit cycle.
6235	Clinical Aftercare Key Performance Indicator (KPI) Annual Analysis: October 2024 - January 2025	• To improve compliance, individualised results were shared with staff members. • All aftercare staff to have clinical competency observations completed within 2-year cyclical process.
6334	Improving quality of haematology referrals for dental assessment prior to Bisphosphonate therapy	• A standard referral template was introduced to improve inadequate documentation of medical history and current medication.
6015	Oral surgery written consent form for record-keeping	• Only 39% of consent forms were completed prior to the day of surgery. Consent forms updated to include operative risks.
6169	Paediatric clinical quality report for Auditory Brainstem Response (ABR) testing 2024/25	• Monthly timetabled ABR meeting introduced following last year's audit to monitor internal and external peer review. Since introduction. 100% of both internal and external reviews have been completed.
6252	Retinopathy of prematurity screening audit -Sep 2024 to Feb 2025	• Audit showed excellent compliance with national guidance. Information leaflet now being used for parents.
6178	Total Thyroidectomy	• A new standard operating procedure (SOP) has been implemented, and a re-audit is being undertaken.
6170	Verification of Real Ear Measurements in Paediatric Audiology rehabilitation appointments 2024-25	• The audit showed 98% compliance with guidance.
SURGERY, ANAESTHETICS & CANCER – TRAUMA & ORTHOPAEDIC		
No	**Audit Title**	**Key actions/improvements following audit**
6223	Assessing Compliance of Postoperative Weight-Bearing Instructions with British Orthopaedic Association (BOA) Standards and Identifying Interventions to Improve Adherence to Standards	• Non-compliance with British Orthopaedic Association (BOA) standards for post-operative weight-bearing instructions. Operation forms have been updated to reflect new guidance.
6362	Best Practice Tariff for Neck of Femur Fractures (NOF #) (Re-audit)	• BPT achievement (January to May 2025) was 41%. Causes for failure to achieve a higher rate of compliance identified. "Golden patient" and Sunday trauma list for #NOF being explored.
6398	Distal Radius Management at PRH (re-audit)	• Re-audit following actions to reduce unnecessary x-ray requests showed reduction of inappropriate x-ray requests from 47 % to 18 % and an improvement in documentation of reasons for repeat the radiographs from 24 % to 76 %.
6196	Mental Capacity Assessments for Surgical Intervention	• The audit highlighted areas of improvement; notably patient information (including date and time of assessment) and reason for lack of capacity and best interest checklist.
6115	Nutrition screening and optimisation in orthopaedic patients in Royal Shrewsbury Hospital	• Ward manager has reminded nursing staff the importance of prescribing nutritional support for those at medium and high risk of malnutrition.
6507	Pre-theatre checks on the ward	• The audit highlighted that the assessment needs to be done at the time of clerking by the on-call team. Actions implemented to improve this and re-audit planned to assess impact of these.
SURGERY, ANAESTHETICS & CANCER – SURGERY		
No	**Audit Title**	**Key actions/improvements following audit**

TABLE 4 – Trust Local Audits 2025-26		
5927	Endoscopy Unit Patient Satisfaction Questionnaire (20) - re-audit	• Re-audit showed improved patient satisfaction and reduced waiting times. Education delivered on co-morbidities and titration of sedation.
6460	Laparoscopic cholecystectomy operation notes - re-audit	• Re-audit following interventions including implementation of revised operation pro-forma and Surgeon education showed significant improvement in 12/15 parameters measured by Get it Right First Time (GIRFT) and Royal College of Surgeons (RCS).
6461	Prescribing Analgesia Audit	• Trust guidelines for pain management updated.
MEDICINE & EMERGENCY CARE – EMERGENCY CARE		
No	**Audit Title**	**Key actions/improvements following audit**
6070	Head injury: assessment and early management - NG232	• Re-audit showed significant improvement in compliance with ordering head CT imaging in line with NICE guidance.
6447	Improving the care of the patients having sepsis - re-audit	• Improvement in patients receiving antibiotics within 1 hour from 10.3% to 33.3%, recommendations agreed to further improve this.
6308	Management of Suspected subarachnoid haemorrhage (SAH) in emergency department NG228	• Poor documentation of time of onset and time to peak intensity, which is crucial for diagnostic accuracy of CT. Areas of good practice include timely discussion with specialist centre for CT positives, and CT performed in all patients with suspected SAH. • SAH to be included in junior doctors' teaching and development of guideline for management of SAH in Emergency Department (ED).
MEDICINE & EMERGENCY CARE – MEDICINE		
No	**Audit Title**	**Key actions/improvements following audit**
5898	Discharge summary audit for newly diagnosed Type 1 Diabetes (T1DM)	• Findings showed inconsistent adherence to safe discharge criteria, and improvements needed in ensuring all newly diagnosed T1DM patients receive appropriate education and referrals before discharge. All patients were seen by the Diabetes Nurse Specialist and diabetes discharge bundle introduced to improve compliance.
6201	Evaluating Oxygen Prescribing on Ward 27	• To ensure oxygen is documented and prescribed correctly, a poster was produced and displayed and teaching sessions delivered.
6049	Improving culture negative peritonitis rate 2024	• Re-audit showed an improvement in culture negative peritonitis rate following amendments to peritonitis protocol and participation in ongoing regional quality improvement (QI) project.
6189	Offering Ultra Violet B (UVB) phototherapy to patients with plaque/guttate psoriasis who have been uncontrolled with topical therapy - NICE CG153/QS40	• 2 out of 3 standards demonstrated 100% compliance with guidance. The documentation has been updated to allow assessment of the third standard which has previously been captured verbally.
6150	Peak Flow (PEFR) Measurement Practices in Patients Admitted with Asthma Exacerbation to the Acute Floor in October 2024	• Non-compliance with PEFR measurement. Work with Matrons has been undertaken to distribute peak flow charts and support use where needed.
6199	QI Project to improve the management of patients with or at risk of Acute Kidney Injury (AKI)	• Poor compliance with patient information, search terms for leaflet updated on the intranet, and AKI working group set up.
6311	QI project on patients being discharged on Lansoprazole indefinitely following stroke (re-audit)	• Duration of proton pump inhibitors (PPI) required was rarely stipulated. Education delivered. Subsequent re-audit showed some improvement, with further education underway.

TABLE 4 – Trust Local Audits 2025-26		
6469	Urine culture for urinary tract infection (re-audit) NG109 + NG111	• Re-audit following implementation of recommendations showed improvement in urine cultures being performed for suspected urinary tract infections from 46% to 70%.
WOMEN & CHILDREN'S – GYNAECOLOGY		
No	**Audit Title**	**Key actions/improvements following audit**
6152	Colposcopy patient satisfaction survey 2025	• Improved levels of patient satisfaction since last survey. Overall results now excellent
6203	Recognition and management of Ovarian Cancer - NICE CG122 & QS18	• Strong compliance with NICE guidelines in management of ovarian cancer in SATH.
5607	Urinary incontinence in women - NICE QS77 (re-audit)	• Good overall compliance with NICE Quality Standard QS77. • Appointment of additional Urogynaecologist in progress to address waiting times.
WOMEN & CHILDREN'S – NEONATOLOGY		
No	**Audit Title**	**Key actions/improvements following audit**
6099	Care of the neonates requiring inhaled Nitric oxide treatment	• Nitric Oxide use complied with guidelines in 100% of cases, with no complications and was mainly commenced in-hours.
6202	Donor Milk usage within SaTH	• SOP has been developed to guide neonatal staff ordering donor human milk (DHM) from regional milk banks. Increasing practice of using DHM in appropriate clinical situations has enabled more usage and less wastage of ordered DHM.
5959	Golden Hour audit	• Re-audit showed improvement in compliance with standards following recommendations implemented after previous audit.
WOMEN & CHILDREN'S – MATERNITY & OBSTETRICS		
No	**Audit Title**	**Key actions/improvements following audit**
6158	Antenatal Fetal Monitoring	• Of the 16 standards audited, 13 (81%) achieved >=90% compliance. • Spot checks and further education introduced to improve compliance with completion of chronic hypoxia checklist. • Work underway with triage core staff to understand barriers to compliance with use of Pinnards and sonicaids.
5966	Management of surrogacy in Maternity services 2025 (Within the Clinical Guideline for Maternity Services Safeguarding)	• Compliance was <50% for 11 of 30 standards audited. No relevant cases were identified for 14 standards. Guideline reviewed and updated and due to the infrequency and complexity of surrogacy, a checklist is being developed for use throughout maternity care.
6350	Perinatal Pelvic Health Service (PPHS) Referral Pathway for Antenatal women to Physiotherapy Outpatients Department	• To improve compliance, a newsletter has been issued highlighting the importance of following the SOP's for both antenatal and postnatal pelvic health assessments on BadgerNet.
6384	Pertussis vaccine in pregnancy	• Pertussis vaccine routinely discussed and offered. • Identified vaccinators are accurately recording vaccinations/declined on maternity information system (MIS). • If women are not attending clinic/scan department at 28 weeks they are being offered vaccines later in the pregnancy, ensuring larger volume of the maternity population are now receiving the vaccine.
6228	Saving Babies Lives (SBL) Continuous Electronic Fetal Monitoring in Labour – Quarter 2 2025-26	• An increase in compliance of greater than 5% was achieved in 9 standards audited.

TABLE 4 – Trust Local Audits 2025-26		
6019	Urinalysis in pregnancy and screening for asymptomatic bacteriuria (including antibiotic treatment)	• Audit showed insufficient compliance with 3 standards. Memo sent to staff to highlight areas of non-compliance. Timescale for reviewing results to be agreed, and SOP updated accordingly.
WOMEN & CHILDREN'S – PAEDIATRICS		
No	**Audit Title**	**Key actions/improvements following audit**
5937	Heart murmur in neonates and infants	• The audit shows that most children referred for murmurs had structurally normal or physiologic heart murmurs, with only a small minority diagnosed with haemodynamically stable congenital heart disease. However, incomplete referral details and the absence of risk-based prioritisation meant waiting times were similar for both benign and congenital heart disease cases. Referral documentation and structured triage being reviewed and updated to prioritise higher-risk children for earlier cardiology review.
6247	Initial diagnosis of type 1 diabetes mellitus in patients presenting in diabetic ketoacidosis (DKA) and subsequent management	• Following reduction in insulin dosing in new DKA guideline from January 2024 – compliance to new dose was excellent – with subsequent reduction in insulin associated hypokalaemia – this reflected the regional audit outcome. • Systems introduced to improve timely reviews and monitoring, including ongoing education. Importance of this highlighted at audit meeting. There is also a step-by-step flow sheet for DKA management in the guideline and is now encompassed in the new diabetes bundle booklet, to support timely reviews and monitoring.
6208	Paediatric cervical lymphadenopathy (re-audit)	• Re-audit demonstrated that the introduction of local guidelines has positively impacted the management of paediatric cervical lymphadenopathy, supporting more appropriate clinical decision-making and more efficient use of resources.

Compliance with Audit Standards

All completed audits are given an overall compliance rating. During 2025/2026 there were 21 completed audits with an overall rating of "significant non-compliance" (overall compliance with standards audited of less than 50%). Key recommendations and actions for these audits are detailed in Table 5.

Table 5 – audits demonstrating significant non-compliance with standards audited

Table 5 – Audits demonstrating significant non-compliance with standards audited		
CLINICAL SUPPORT – RADIOLOGY		
No	**Audit Title**	**Recommendations - actions**
6246	Radiology Department Preparedness and knowledge on the management of mild to severe contrast medium reactions (re-audit)	• Re-audit showed a marked improvement in compliance from 2.27% to 26%, but still below optimal standards. Targeted education delivered to address problem areas.

Table 5 – Audits demonstrating significant non-compliance with standards audited		
6430	Computed tomography Aortograms (CTA) for the diagnosis of Thoracic Aortic Dissection (TAD) in the emergency department (ED) and the use of Aortic Dissection Detection Risk Score (ADD-RS)	• Audit highlighted poor compliance with structured risk assessment (ADD-RS) and incomplete application of D-dimer and imaging pathways in suspected TAD. 24/7 access to CTA was available. Consideration of use of ADD-RS in documentations and CTA request forms, targeted D-dimer testing and CT pathway clarification.
SURGERY - HEAD, NECK AND OPHTHALMOLOGY		
No	**Audit Title**	**Recommendations - actions**
6015	Oral surgery written consent form for record-keeping	• Only 39% of consent forms were completed prior to the day of surgery. Consent forms to be updated to include operative risks.
6178	Total Thyroidectomy	• A new standard operating procedure (SOP) has been implemented, and a re-audit is being undertaken to assess effectiveness.
6334	Improving quality of haematology referrals for dental assessment prior to Bisphosphonate therapy	• A standard referral template was introduced to improve inadequate documentation of medical history and current medication.
SURGERY – MUSCULOSKELETAL (MSK)		
No	**Audit Title**	**Recommendations - actions**
6115	Nutrition screening and optimisation in orthopaedic patients in Royal Shrewsbury Hospital	• Ward manager has reminded nursing staff the importance of prescribing nutritional support for those at medium and high risk of malnutrition.
6223	Assessing Compliance of Postoperative Weight-Bearing Instructions with British Orthopaedic Association (BOA) Standards and Identifying Interventions to Improve Adherence to Standards	• Results showed low compliance with BOA standards for post-operative weight-bearing instructions. Operation forms have been updated to reflect new guidance.
6362	Best Practice Tariff (BPT) for Neck of Femur Fractures (NOF#) (Re-audit)	• BPT achievement (January to May 2025) was 41%. Causes for failure to achieve a higher rate of compliance identified. “Golden patient” and Sunday trauma lists for #NOF to be explored.
SURGERY – GENERAL SURGERY		
No	**Audit Title**	**Recommendations - actions**
6249	Unnecessary pre-op blood tests abscess patients	• Deviation from national guidance on pre-operative investigations and documentation of justification for these. Further education was delivered to address this.
6461	Prescribing Analgesia Audit	• Trust guidelines for pain management updated.
SURGERY – ONCOLOGY		
No	**Audit Title**	**Recommendations - actions**
6326	Consent process for specified locum doctors	• Concession in place for doctors not to be required to sign for each patient is still required and will continue.
MEDICINE – EMERGENCY MEDICINE		
No	**Audit Title**	**Recommendations - actions**
6308	Management of Suspected subarachnoid haemorrhage (SAH) in emergency department NG228	• Poor documentation of time of onset and time to peak intensity, which is crucial for diagnosis accuracy of CT. • Areas of good practice include timely discussion with specialist centre for CT positives, and CT performed in all patients with suspected SAH. • SAH to be included in junior doctors’ teaching and development of guideline for management of SAH in ED.

Table 5 – Audits demonstrating significant non-compliance with standards audited		
6411	Reduction of time to access computer log-on in the RSH ED	• To address the concerns identified in the audit, a business plan has been submitted to change the configuration. This is currently awaiting approval.
6447	Improving the care of the patients with sepsis (re-audit)	• Improvement in patients receiving antibiotics within 1 hour increased from 10.3% to 33.3%, recommendations agreed to further improve this.
MEDICINE		
No	**Audit Title**	**Recommendations - actions**
5898	Discharge summary audit for newly diagnosed Type 1 Diabetes (T1DM)	• Findings showed inconsistent adherence to safe discharge criteria, and improvements needed in ensuring all newly diagnosed T1DM patients receive appropriate education and referrals before discharge. All patients were seen by the Diabetes Nurse Specialist and diabetes discharge bundle introduced to improve compliance.
6150	Peak expiratory flow rate (PEFR) Measurement Practices in Patients Admitted with Asthma Exacerbation to the Acute Floor in October 2024	• Non-compliance with PEFR measurement. Work with Matrons has been undertaken to distribute peak flow charts and support use where needed.
6199	QI Project to improve the management of patients with or at risk of Acute Kidney Injury (AKI)	• Poor compliance with patient information, search terms for leaflet updated on the intranet, and AKI working group set up
6201	Evaluating Oxygen Prescribing on Ward 27	• To ensure oxygen is documented and prescribed correctly, a poster designed and teaching sessions delivered.
6469	Urine culture for urinary tract infection (re-audit) NG109 + NG111	• Re-audit showed improvement in urine cultures being performed for suspected urinary tract infections following implementation of recommendations from 46% to 70%.
WOMEN & CHILDREN'S		
No	**Audit Title**	**Recommendations - actions**
6240	Gynaecology Assessment and Treatment Unit (GATU) scan slots audit and quality improvement project (QIP)	• The audit highlighted the need for a SOP for referral to GATU scan slots, which is being developed.
5966	Management of surrogacy in Maternity services 2025 (Within the Clinical Guideline for Maternity Services Safeguarding)	• Compliance was <50% for 11 of 30 standards audited. No relevant cases were identified for 14 standards. Guideline to be reviewed and updated and due to the infrequency and complexity of surrogacy, a checklist is being developed for use throughout maternity care.

NICE GUIDANCE COMPLIANCE

The Trust aims to ensure maximum use of NICE Guidance by achieving a target of 98% completion of templates within target timescales by the use of a dynamic tracker to monitor progress, further staff training and regular progress updates at clinical governance meetings.

Percentage of guidance published during the year completed within target timescales:

	2022-23	2023-24	2024-25	2025-26
Clinical Guidelines (NG)	80% (12/15)	60% (3/5)	80% (4/5)	100% (6/6)

Quality Standards (QS)	100% (2/2)	100% (2/2)	None published this year	100% (4/4)
Interventional Procedural Guidelines (IPG)	97% (32/33)	100% (29/29)	100% (18/18)	100% (9/9)
Total	92% (45/49)	95% (34/36)	96% (22/23)	100% (19/19)

The appointment of dedicated NICE Facilitators, use of an updated dynamic tracker to monitor progress, further staff training and regular progress updates at clinical governance meetings has led to an increase in completion within target timescales from 60% in 2023/2024 to 100% in 2025/2026. This is a particularly encouraging achievement due to the increasing length and complexity of NICE guidance in recent years.

The Trust aims to ensure local guidelines are based on NICE guidance by achieving a target of 99% overall completion of templates and education and support programme delivered by two NICE Facilitators

Overall percentage of ALL published NICE guidance completed:

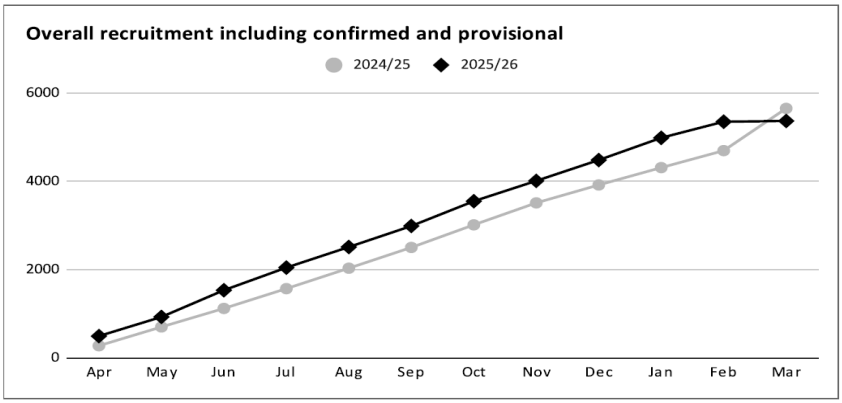
	2022/2023	2023/2024	2024/2025	2025/2026
Clinical Guidelines (NG)	99.7% (297/298)	100% (297/297)	99.5% (300/303)	100% (306/306)
Quality Standards (QS)	100% (198/198)	100% (200/200)	100% (200/200)	100% (199/199)
Interventional Procedural Guidelines (IPG)	99.9% (576/577)	100% (598/598)	100% (613/613)	100% (618/618)
Total	99.9% (1071/1073)	100% (1095/1095)	99.8% (1113/1116)	100% 1123/1123

The target for overall completion of templates has continued to be exceeded. Two dedicated NICE/Clinical Guideline facilitators have continued to review and monitor compliance with NICE guidance, ensuring that this is used to inform development of local guidelines. The Head of Clinical Audit meets regularly with the Associate Medical Director who supports with progressing completion of templates and updating clinical guidelines. Our local audit programme has been used to evidence compliance with NICE guidance through completion of local case note audits.

RESEARCH AND INNOVATION

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

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 specialty areas this year, which is comparable to last year, reflecting SaTHs commitment to continue the ongoing success of the R&I Department this year in its portfolio research.

This also does not include 2800 patients recruited through the TRIOMIC colorectal cancer study as well over the last 18 months, introducing a new device for diagnosis in the future and changing the whole pathway of the colorectal cancer service.

A further portfolio research study is coming to an end, the OBS-UK focused on improving the post-natal bleeding pathway with a quality improvement bundle, which has now been adopted by NHS England due to the success of the study.

2) To develop SATH staff in order to design, deliver and implement R&I in practice

- The Annual R&I event held on 16th May 2025 shared good practice and engaged with over 50 clinicians across the Trust. This externally sponsored event allowed SaTH to showcase how quality is at the heart of the research that we delivered and an event in the afternoon allowed staff to think about the research impact within their area and the different services available to support research.
- 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 specialties. It has launched the Self-assessment of Organisational Readiness (SORT) tool to review the current research culture at SaTH and create an improvement plan around how we continue to grow R&I
- R&I has continued to present at the consultants/GP ICB wide welcome, and the nurse preceptorship programme
- R&I have actively supported a number of high-profile grant application and funding opportunities, including securing strategic funding for the next year to focus on equality, diversity and inclusion within research

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

- R&I has a standing agenda item on the last session of the Improvement Practitioner course to support staff across the Trust to consider whether their quality improvement project could be turned into a research project.
- A flow chart has been refreshed to support staff to access support for projects from across the different teams including R&I, Improvement, Audit, PMO and the library.
- R&I continues to work closely with the library services and the 'Research Across SaTH Group' to begin to develop critical appraisal groups to support clinicians to think critically about their services and improvements that could be implemented.
- R&I continues to collect feedback from research participants and receives positive praise for the service that we provide and we continue to look at areas for improvement, including running a patient thank you afternoon tea event this year to highlight the impact of taking part in research and also thank the Telford Male Voice choir for sponsoring our charity this year.

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

- R&I contributed heavily to the successful University status application and continue to work closely with Keele to further strengthen the links between the two organisations through collaborative strategies around research development
- As we move towards a Group Model with Shropshire Community Trust, R&I have highlighted the opportunities for effective research delivery that this collaboration presents and continue to work with the recently launched Commercial Research Delivery Centre Central and North Midlands to increase the number of commercial studies being developed and delivered within the Midlands
- R&I continue to support the 'Moving to 'Excellence' initiative by delivering high quality research and increasing access to research across the Trust, and have also supported the recent focus on Cancer service improvements where R&I has become a central theme

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

- The links to Keele and commercial companies are highlighted above and R&I continues to work with a variety of commercial partners, including Pfizer, where we are currently delivering a maternity vaccine study, Beatrix. The Trust is the highest recruiters internationally at present due to the team's engagement with potentially participants and commitment to improving care within maternity services.
- Our relationship with 'Origin Science' (a UK medical Technology Company) remains strong and there are further opportunities to grow this partnership into the women's health part of the company in the next few years and deliver innovative research in the future.

Next Steps:

The R&I Department are currently developing a new five year strategy and objectives to fit with our University Hospital status ambition to grow homegrown research and the opportunities for growth through the Group Model.

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 2024/25, independently audited by our 3rd Part Auditor is (MIAA) achieved non-compliance '***Approaching Standards'***. This was widely anticipated NHS wide, in light of the September 2024 DSPT change to adopt the National Cyber Security Centre's Cyber Assessment Framework (CAF) as its basis for cyber security and IG assurance. IG & Cyber are jointly working on an action plan in consultation with MIAA to aim toward compliance.

The Trust is due to submit its 25/26 submission in June 2025.

LEARNING FROM DEATHS

The Learning from Deaths team provide assurance on the quality of care provided to patients whom have died in our Trust. Learning from these care episodes is shared across the Trust and used to inform workstreams such as those under the Patient Safety Incident Framework (PSIRF) agenda.

To maintain oversight, the team conduct a regular review meeting of all Trust Deaths. The level of scrutiny afforded is based on concerns raised by the bereaved, the medical examiners service, or staff involved in patient care. The Learning from Deaths team coordinate the level or response & learning required, including local learning back to divisional teams, Structured Judgement Review or Patient Safety Enquiry.

Deaths of children are reviewed using the Child Death Overview Panel (CDOP) processes and, where appropriate, the Perinatal Mortality Review Tool (PMRT).

Learning from Excellence is captured utilising the Trust LFE platform.

SUMMARY OF MORTALITY ACROSS THE TRUST

In 2025/2026, the Trust recorded 1980 adult and child deaths through the Medical Examiner Service. 1641 (82.9%) deaths occurred in the inpatient setting. 339 (17.1%) deaths occurred in the Emergency Department (ED). This figure includes patients referred to allied teams but due to transfer delays subsequently died within the Emergency Department. 207 of the Emergency Department deaths (61%) were under the care of an allied team. 132 of the Emergency Department deaths (39%) were under the care of an Emergency Department consultant.

In Divisional terms 78.9% of deaths occurred under the Medicine and Emergency Care Division, 15.8% under the Surgery Division, 4.8% under Clinical Support Services and 0.4% under the Women and Children's Division.

The distribution of deaths across the Trust in terms of inpatient/ED split and Divisional data is broadly in line with 2024/2025.

A mandated Structured Judgement Review (SJR) is undertaken for all patients who have died in the Trust with a confirmed Learning disability, Autism or Serious Mental Illness (SMI). During 2025-2026, 13 patients have died with a confirmed learning disability or autism and 13 patients have died with a serious mental illness.

In accordance with national guidance (National Guidance on Learning from Deaths, NHS 2017) all Trust deaths involving patients with a confirmed learning disability or autism are reported externally under the

program 'Learning from Lives – People with Learning Disability and Autistic People' (LeDeR).

There have been 9 deaths reported through PSIRF processes 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 acute kidney injury and fluid balance
- Management of nil by mouth status and SALT reviews
- Management of waiting lists, and tracking of patients
- Emergency management post seizure
- Management of the deteriorating patient
- Communication between clinical teams and with families

Some of the key improvement targets and actions 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.*

The above requirement has been met. A dashboard has been implemented to review all deaths that occur within 30 days of attending the Emergency Department. The dashboard incorporates data from April 2023 onward and can scrutinise against delayed Emergency Department transfer and by admitting allied team. The dashboard is being used to prospectively influence ongoing improvement workstreams at Trust level. To maintain oversight monthly review meetings are being held between Clinical Leads for the acute sector and the Deputy Medical Director. All deaths within the ED are reviewed at local level and mortality figures are presented at Clinical Governance & ED Morbidity & Mortality meetings.

- *Review thematic analysis of identified learning from the Mortality Triangulation Group (MTG) and Structured Judgement Reviews (SJR) processes to promote consistency internally and within the wider PSIRF agenda, and to inform quality improvement initiatives within the organisation.*

The 2025/2026 period has seen considerable change within Learning from Deaths towards a local model of thematic analysis. The aim has been to capture local learning in a manner which is standardised, yet responsive to real world events pertinent to Trust quality of care. This process has utilised a pre-existing NHSE framework [Structured Judgment Review platform], but with significant local and prospective refinement. This work has been incorporated into weekly operations culminating in a Thematic Analysis Grid that is now maintained as an active & dynamic tool for assessing quality of care. The Thematic Analysis Grid has been utilised throughout 2025/2026 with improved maturity of data capture & utilisation throughout this timeframe. The process aligns with the wider PSIRF agenda and is being collated into an evolving Trust Integrated Learning report. Incorporation of the Thematic Analysis Grid into the SJR process is a key objective for the 2026/2027 period.

- *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.*

In the 2025/2026 period, regular monthly meetings between the Leaning from Deaths (LFD) team and corporate SJR reviewers have been establish. These provide an opportunity for training and support alongside a forum to discuss the future direction of travel of the LFD agenda. It provides a regular opportunity for the SJR reviewers to feedback any of their concerns directly and to contribute to the evolution of our Thematic Analysis Grid.

- *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.*

In the 2025/26 period the Trust has implemented a Learning from Excellence platform. The Learning from Deaths team utilise this platform to ensure that positive practice is acknowledged. The platform ensures the positive examples of patient care are shared with recipients by an automated process as well as contribute to Trust wide learning from examples of excellent care.

Some of the key improvement targets and actions to be taken for 2026/2027 include:

- *Development of a local SJR Platform:* For the last four years the Trust has procured access to a Structured Judgment Reviews tool, hosted by Aqua on behalf of NHSE. This platform was unilaterally withdrawn mid-contract, and after only a short period of notice on the 27th March 2026. The team have worked hard to accommodate an in-house solution to maintain Structured Judgement Review. The local SJR tool is in its infancy, and throughout 2026/27 will be evolved to ensure that the LFD team have a robust, dynamic and contemporaneous process for continuing this work.

- *Thematic Analysis of SJR output at source:* In 2026/27 the Trust plans to incorporate our locally evolved 'Thematic Analysis Grid' into our new, locally hosted SJR tool. This capitalises on the improved data capture we've seen through weekly operational meetings and sets the scene for a common approach to quality of care across all work streams under the Learning from Deaths agenda.

MEDICAL EXAMINER SERVICE

As part of its statutory responsibilities, the Medical Examiner (ME) Service reviews 100% of deaths occurring across both hospital sites that are not reportable to the coroner. The service aims to review and release Medical Certificates of Cause of Death (MCCDs) within three calendar days, supporting timely registration for bereaved families. Performance against this standard is monitored quarterly by the National Medical Examiner (NHSE) and reported to the Trust Board. In addition, monthly monitoring is undertaken via the ME performance dashboard, presented at the Learning from Deaths meeting.

For deaths that are initially referred directly to the coroner but are subsequently not taken forward for investigation, the ME Service conducts a full review and authorises the MCCD. This ensures that every death within the Trust is formally scrutinised either by a Medical Examiner or by the coroner.

During 2025/26, the Medical Examiner Service undertook reviews of 1,976 hospital deaths, representing 99% of all deaths occurring in the Trust during this period.

A core function of the ME Service is to ensure that the voices of bereaved families are heard. The service supports relatives in understanding the circumstances surrounding the death of their loved one and provides an opportunity for them to raise concerns or ask questions. The ME Service, hosted by SaTH, maintains this commitment at the centre of its daily operations. In 2025/26, the service supported 1,949 bereaved relatives, 98% of the overall number of cases that were reviewed.

Medical Examiner Service Quality Improvement Actions 2025/26:

Throughout 2025/26, the Medical Examiner Service continued to strengthen the quality and timeliness of reviews. The service maintained its multidisciplinary engagement, working closely with governance teams to provide feedback arising from ME reviews and contributing to system-wide learning. The ME performance dashboard was further developed to improve visibility of key metrics, enabling earlier identification of delays and supporting operational decision-making. The service also strengthened pathways for referral of concerns, supporting improved escalation into existing patient safety processes and also developed processes to ensure learning from excellence is also highlighted and shared. Together, these actions have contributed to maintaining a robust scrutiny process and ensuring continual improvement in the experience of bereaved families and the quality of care provided by the Trust.

ENCOURAGING STAFF TO SPEAK UP

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

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

FTSU concerns raised by Quarter and Year (2020 to 2026)

	Q1	Q2	Q3	Q4	Total	Increase/ Decrease	National Increase
2025/26	79	51	57	51	**238**	↑9%	Not yet available
2024/25	67	48	56	47	**218**	↑0.5%	↑18.6%
2023/24	47	52	68	50	**217**	↓23%	↑27.6%

2022/23	71	73	79	59	**282**	↓23%	↑25%
2021/22	100	113	90	66	**369**	↑21%	0%
2020/21	41	82	103	78	**304**	↑110%	↑26%

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

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

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
- Ensuring that the changes to exception reporting introduced in February 2026 are implemented smoothly and without detriment to resident doctors
- Working in collaboration with the Medical Peoples Services and the Medical Directorate Team
- Education of 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 2025 to 31 March 2026, 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 2025/26	Peer Comparator 2025/26	2024/25	2023/24	2022/23	2021/22
Awaiting data	Awaiting data	No data	96.26	97.65	97.65
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 2025/26 it has not been possible to provide updated 12-month rolling SHMI data for the period for 2025/26 for the Shrewsbury and Telford NHS Trust due to the ongoing challenges with the Data Warehouse.

PERCENTAGE DEATHS CODED AT EITHER DIAGNOSIS OR SPECILAITY LEVEL

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 2026/26	National Average 2025/26	Highest Score 2025/26	Lowest Score 2025/26	SaTH 2024/25	SaTH 2023/24	SaTH 2022/23
Awaiting data	Awaiting data	Awaiting data	Awaiting data	No data	31%	28.54%
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						

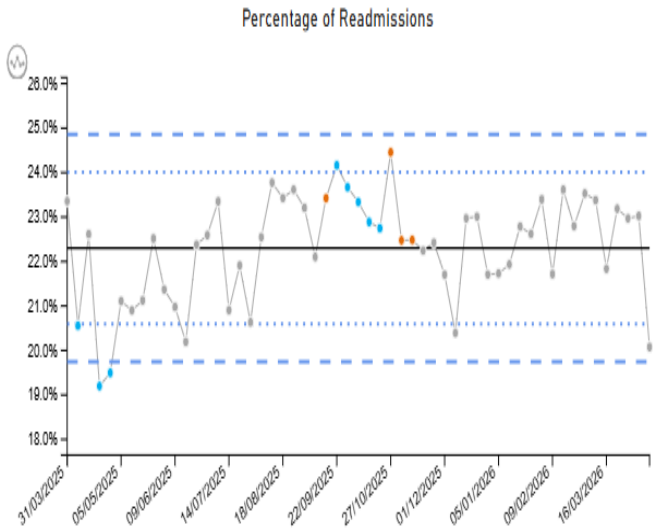
To note, at the time of the publication of the Quality Account for 2025/26 it has not been possible to provide updated 12-month data for this core quality indicator for the period for 2025/26 for the Shrewsbury and Telford NHS Trust due to the ongoing challenges with the Data Warehouse.

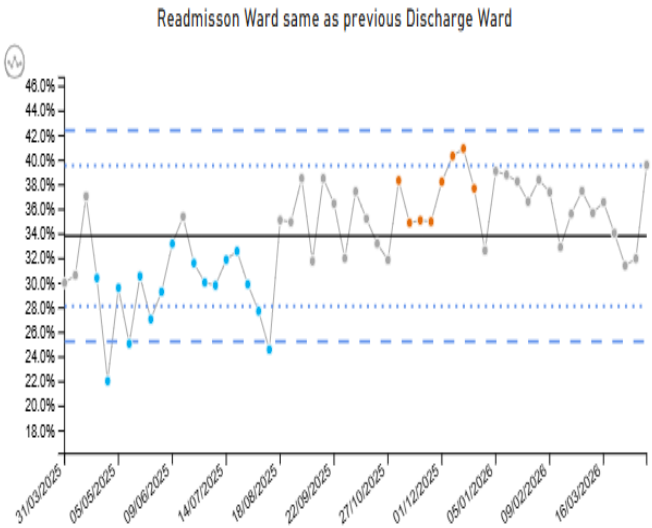
THE PERCENTAGE OF PATIENTS RE-ADMITTED TO HOSPITLA WITHIN 28 DAYS OF DISCHARGE.

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.

Due to the ongoing challenges with the Data Warehouse the Trust is unable to produce the data in the format for previous years however the data below is produced from emergency readmissions data for 2025/2026.

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 2026/27.





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 2025	**National Average 2025**	**Best performing Trust 2025**	**Worst performing Trust 2025**	**SaTH 2024**	**SaTH 2023**	**SaTH 2022**	**SaTH 2021**
45.49%	60.83%	88.41%	34.73%	45.75%	44.98%	39.2%	43.5%
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.							

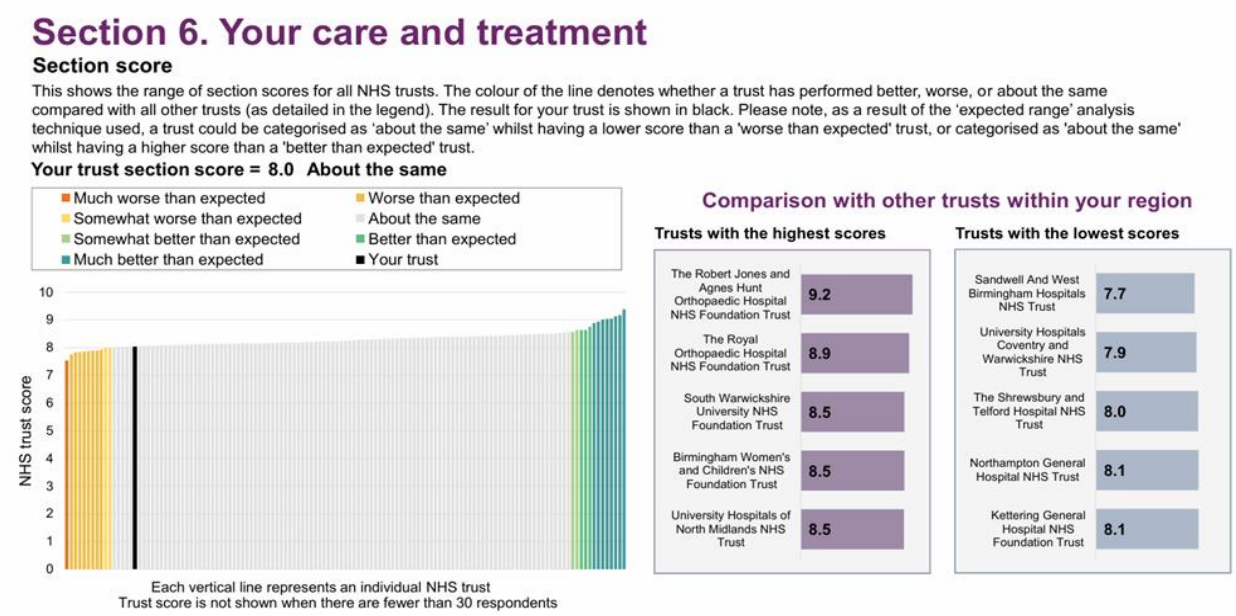
The percentage of staff who would recommend the Trust as a provider of care to their friend or family has dipped slightly for 2025. The Trust remains below the national average which declined in 2025. The decrease follows the national trajectory, as average, best and worst scores have all declined in 2025.

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

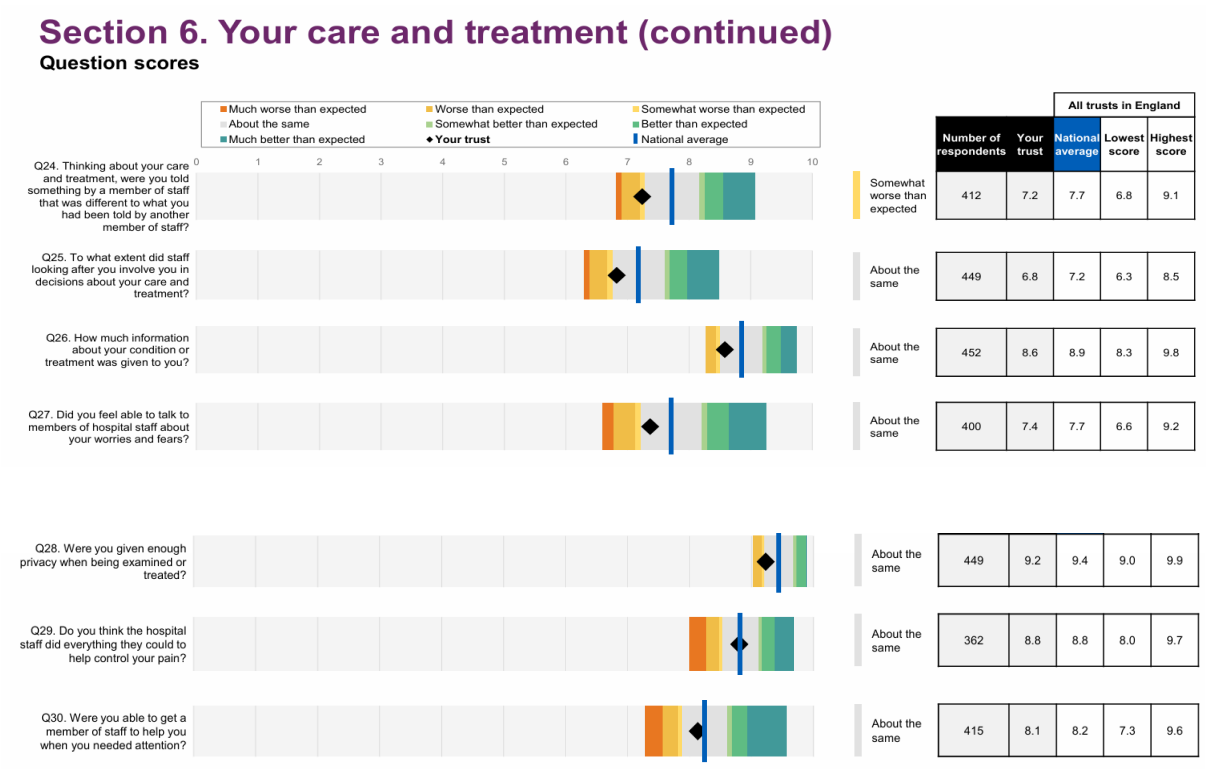
THE TRUST RESPONSIVENESS TO THE INPATIENTS' PERSONAL NEEDS.

The results for the National Inpatient Survey (2024) Adult Inpatient Survey which were published in 2025 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 8.0, 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.

PATIENTS ADMITTED TO HOSPITAL WHO WERE RISK ASSESSED FOR VENOUS THROMOEMBOLISM (VTE)

The Trust performance for VTE has been consistently under the 95% target for the financial year of 2025/2026. VTE assessment completion was 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. Trust performance in relation to VTE has been reported as part of the Quality Priory 8 for 2025/26 earlier in this Quality Account.

PATIENT SAFETY INCIDENTS AND THE PERCENTAGE REPORTED THAT RESULT IN SEVERE HARM OR DEATH.

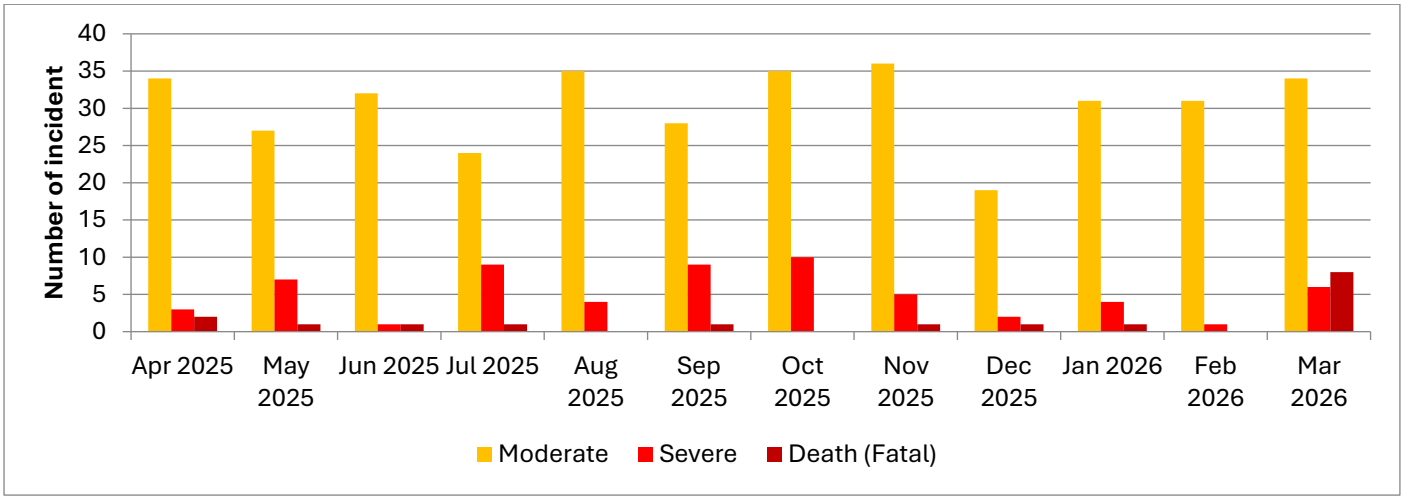
A Patient Safety Incident is an unintended or unexpected incident which could have or did lead to harm for patients receiving NHS care. In previous years data produced by the National Reporting and Learning System (NRLS) was used to provide comparison nationally, however the National Reporting database changed in September 2023 to Learning from Patient Safety Events (LFPSE), validated comparator data is not reliably available for 2025/26.

The number and the rate of Patient Safety Incidents reported within the Trust in 2025/2026, and the number and percentage of Patient Safety Incidents that resulted in severe harm or death, are identified below:

Domain					
	SATH 2025/2065	SATH 2024/2054	SATH 2023/24	SATH 2022/23	SATH 2021/22
Number of Patient Safety Incidents	23,397	18,684	18,212	20,456	18,000
Rate of Patient Safety incidents per 1,000 bed days	74.42	61.50	61.35	70.35	74.75
Severe harm or death	80	90	52	79	56
Percentage of Patient Safety Incidents which resulted in severe harm or death	0.34%	0.48%	0.29%	0.39%	0.31%

Rate of Severe/death incidents per 1,000 bed days	0.25	0.30	0.18	0.27	0.23

The Shrewsbury and Telford Hospital NHS Trust continues to be a high reporter of incidents which may represent a positive reporting culture. It is 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 2025/2026. Data for March2026 was still under review at the time of writing the Quality Account and is subject to change once the review has taken place.



RATES OF CLOSTRIDIOIDES DIFFICULE

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 2025/26 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 2025/26	SaTH 2024/25	SaTH 2023/24	SaTH 2022/23
	45.7	36.9	34.5	20.1
Data Source – Based on SaTH held data				

To note the rate per 100,000 bed days is based on estimated bed days not actual. The actual bed days in 2025/2026 will have increased due to additional plus bed spaces on wards being in continuous use and the opening of 56 additional beds at the Royal Shrewsbury Hospital site in December 2025 and additional medical beds at the Princess Royal Hospital.

Every case of C Diff is scrutinised and an 'After Action Review' with the Infection Control Team and Microbiology is undertaken to determine whether the case was linked with an issue in the quality of care provided to patients. Common themes remain similar to previous years include, antibiotics usage, timely obtaining of stool samples and isolation of the patient. This year we have more closely tracked those infections that appear to have been caused by inappropriately prescribed antibiotics, and at the time of writing the Quality Account this equated to approximately a third of cases that had been reviewed to date. The Trust has responded to the NHSE Antimicrobials Call to Action (November 2025) and presented the Trusts priority actions to the Trust Board in March 2026.

The Trust trajectory for C. difficile cases in 2025/2026 was no more than 98 cases. There was a total number of cases of 132. National data for the year 2025/2026 is not yet available for benchmarking.

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 C. difficile Improvement Plan, this plan strengthens ownership of actions at ward/Divisional level, and we will be continuing to implement these actions through 2026/2027. This is monitored via our Infection Prevention and Control Operational Group which meets monthly.

2.4 LOOKING FORWARD: OUR PRIORITIES FOR QUALITY IMPROVEMENT 2026/2027

The aim of the quality priorities for 2026/2027 is to continue to focus on embedding quality as the core principle underpinning how we deliver services and the improvements we make, ensuring that the care provided is safe, effective, person-centred, timely and equitable

- ***SAFE*** *- The care we provide avoids preventable harm*
- ***EFFECTIVE*** *- The care we provide is based on the best evidence base*
- ***PERSON CENTRED*** *- The care we provide is respectful and responsive to the individual patient needs and values, ensuring that these are embedded into clinical decisions about care*
- ***TIMELY*** *- The care we provide reduces waits and delays in receiving care and any associated harm as a result of any delays in care*
- ***EQUITABLE*** *- The care we provide ensures that all patients are treated fairly, giving equal opportunity to access and to receiving the highest quality of care.*

The proposed quality priorities for 2026/2027 have been developed following a review of the last year's priorities and the progress made in relation to achieving these as well as a review of our quality and safety data, regulatory compliance workstreams and in collaboration with a variety of stakeholders via two engagement sessions attended by a number of Divisional representatives, Deputy Medical Director, Corporate Nursing, Clinical Governance Team and Patient Representatives.

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 quality priorities for 2026/2027.

In 2025/2026 the Trust undertook a review of the Quality Strategy and commenced the development of a new Quality and Safety Strategy. We are awaiting the publication of NHS England National Quality Strategy due in early 2026/2027 before finalising this and will be working towards creating a Group Quality and Safety Strategy during 2026/2027.

The quality priorities for 2026/2027 are outlined below.

Quality Domain	Priorities	Aims
Improving the Care of the Deteriorating Patient	**Priority 1:** *Implement and embed Martha's Rule across the Trust*	This includes: • Daily patient wellness checks • Rapid independent Reviews • Staff empowerment
	Priority 2: *Focus on the prevention of patient deterioration by improve the recognition, escalation, and response to the deteriorating patient.*	This includes: • Increase the number of patients appropriately screened and treated for sepsis (including antibiotics within 60 mins) • Increase the frequency of observations recorded on time. • Increase the number of patients who are escalated and treated in line with our Trust guidelines
Ensure Patients Receive the Right Care, in the Right Place, at the Right Time	**Priority 3:** *Deliver safe, responsive and timely emergency care through improving the experience of our Emergency Pathway.*	This includes: • Improvement in the percentage of patients seen within 4 hours in the Emergency Departments • Reducing the number of patients waiting in the Emergency Department >12 hours • Improve Ambulance response times-handover within 45 minutes • Eliminate all corridor care in our Emergency Department • Increase the number of patients who report a positive

		experience of care in our Emergency Departments
	Priority 4: *Improve the experience of our cancer and elective pathways*	This includes: • Improve the number of cancer patients who are diagnosed within 28 days through the Faster Diagnosis Standard • Maintain the performance on the 31 day decision to treat standard • Maintain the focus on performance to reduce the number of patients waiting over 62 days for their cancer treatment • To comply with the standards to reduce long waiting times • Maintain the throughput through our Community Diagnostic Centres • Continue to deliver the 85% theatre utilisation • Transform the delivery of Outpatient services to improve productivity and patient experience
	Priority 5: *Ensure that all patients experience a safe and timely discharge and deliver the discharge priorities outlined in the System wide Discharge Improvement Group.*	• Increase the timeliness of discharges across the Trust including before midday and 5pm • Work with partners to speed up discharge from hospital and reduce the number of patients with no criteria to reside • Ensure that patients and families are involved in decisions about their discharge plans.
Fundamentals in Care – Reduce Avoidable Harm	**Priority 6:** *Reduce the harm caused to patients from falls whilst in hospital*	This includes: • All patients to have risk assessments carried out in accordance with Trust guidelines • All patients to have an accurate care plan to meet their needs and reduce the risk of falls • Revised governance framework for the management of falls which reinforces accountability and embeds learning and actions from falls reviews.

	Priority 7: *Reduce the harms caused from patients developing a pressure ulcer when in our care*	This includes: • All patients to have risk assessments carried out in accordance with Trust guidelines • All patients to have an accurate care plan to meet their needs and reduce the risk of patients developing pressure related skin damage • Embed revised governance framework for the management of acquired pressure ulcers which reinforces accountability and embeds learning and actions from pressure ulcer reviews.
	Priority 8: *Reduce the number of avoidable healthcare associated acquired infection (HCAI)*	• Ensure that our staff consistently practice the fundamental aspects of IPC • Develop and implement a reportable bacteraemia reduction action plan (MSSA, MRSA, E.coli, Klebsiella and Pseudomonas) • Ensure our anti-microbial workplan is implemented across the organisation • Deliver all outstanding actions within the CDiff reduction action plan
Fundamentals in Care – Improving the Experience of Care	**Priority 9:** *Improve both written and verbal communication, documentation standards and experience of care*	This includes: • Develop a culture of listening and learning to ensure an approach that prioritise learning from complaints, compliments and learning from excellence • Ensure that people from minorities and under-represented groups have services that do not discriminate and meet their needs by learning and embedding actions from their experience of care • Strengthening our response to National Mandated Patient Survey ensuring these are systematically reviewed, actions are taken to address themes and trends and that actions and improvements are made in response

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 2025/2026 the Trust received 9 National Patient Safety Alerts. All have been actioned; none have breached their deadline.

Alert Identifier	Alert Title	Issue Date	Closure Target Date	Closed Date	Open/ Closed
NatPSA/2025/002/UKHSA	Shortage of Pancreatic enzyme replacement therapy (PERT)	26/06/2025	29/08/2025	26/08/2025	Closed
NatPSA/2025/003/DHSC	Shortage of Bumetanide 1mg tablets	03/07/2025	11/07/2025	08/07/2025	Closed
NatPSA/2025/004/MVA	Shortage of Antimicrobial Agents Used in Tuberculosis (TB) Treatment	29/07/2025	15/08/2025	12/08/2025	Closed
NatPSA/2025/005/NHSPS	harm from delayed administration of rasburicase for tumour lysis syndrome	09/09/2025	09/03/2026	09/03/2026	Closed
NatPSA/2025/006/NHPS	Harm from incorrect recording of a penicillin allergy as a penicillamine allergy	24/11/2025	20/11/2026	Remains open in date	Open
NatPSA/2025/007/NHPS	Supply of Licensed and Unlicensed Epidural Infusion Bags	02/12/2025	12/12/2025	12/12/2025	Closed
NatPSA/2025/008	Risk associated with adult breathing circuits lacking a patent exhalation route	11/12/2025	12/06/2026	Remains open in date	Open
NatPSA/2026/001/DHSC	Steriflex® No. 109 (1L) and No. 171 (2L): Potassium Chloride 0.15%, Sodium Chloride 0.45%, Glucose 2.5% Bags	14/01/2026	06/02/2026	03/02/2026	Closed
NatPSA/2026/002/MHRA	Recall of Quetiapine Oral Suspension (unlicensed medicine) manufactured by Eaststone Limited due to a potential for overdosing	29/01/26	05/02/2026	03/02/2026	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 2025/2026 there have been the following learning responses raised:

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

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

NEVER EVENTS 2025/2026

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 2025/2026 the Shrewsbury and Telford Hospital NHS Trust reported 5 incidents 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 families were informed of the investigation and kept informed throughout the investigation and supported by Family Liaison Officers who offered the opportunity to discuss the investigation findings and recommendations.

NEVER EVENTS			
SATH 2025/26	**National Average 2025/26**	**Best Performing Trust 2025/26**	**Worst Performing Trust 2025/26**
5	2.3	1	11

Date	**Description of Never Events 2025/26 at SATH**
April 2025	Wrong Site Surgery
July 2025	Overdose of insulin
September 2025	Retained foreign object post procedure - swab
October 2025	Retained foreign object post procedure - guidewire
March 2026	Misplaced NG Tube

Learning from Never Events in 2025/2026 included:

- Additional steps in patient processes for checking patients as a further safety net
- Training and development in relation to the use of insulin syringe in low use areas

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

The Trust received feedback from 5,464 people accessing the Emergency Departments during 2025/2026.

	National performance 2025/2026 (based on national data April 2025 to February 2026)			Trust performance 2025/2026 (based on data submitted April 2025 to March 2026)			Trust performance 2024/2025	Trust performance 2023/2024
	Mean	Best	Worst	Mean	Best	Worst		
Score	79.1%	98.1%	X54.4%	69.9%	72.2%	51.7%	68.2%	64.8%

Following a pilot of (SMS) within the Emergency Departments in September 2025, the use of SMS for FFT was introduced in the Emergency Departments, resulting in an increase in feedback and response rates. Themes of feedback have been shared with the service and the Urgent and Emergency Care Patient Experience Group, to support targeted improvements.

The Emergency Department has worked on a number of improvements and initiatives in response to feedback during 2025/2026, resulting in the March 2026 satisfaction rate increasing to 71.4%

Inpatient FFT

Inpatient services collected feedback from 1,469 people receiving inpatient care during 2025/2026.

	National performance 2025/2026 (based on national data April 2025 to February 2026)			Trust performance 2025/2026 (based on data submitted April 2025 to March 2026)			Trust performance 2024/2025	Trust performance 2023/2024
	Mean	Best	Worst	Mean	Best	Worst		
Score	94.5%	99.8%	78.3%	95.8%	97.4%	91.4%	98.4%	98.5%

Outpatient Department FFT

Outpatient services collected feedback from 546 people, providing insight into their experience.

	National outpatient satisfaction performance 2025/2026 (based on national data April 2025 to March 2026)			Trust outpatient satisfaction performance 2025/2026 (based on data submitted April 2025 to March 2026)			Trust performance 2024/2025	Trust performance 2023/2024
	Mean	Best	Worst	Mean	Best	Worst		
Score	94.1%	100%	83.3%	90.7%	99.0%	85.7%	98.6%	98.7%

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 (2024) was undertaken between January and April 2025 and included patients meeting the eligibility criteria who were discharged from the Trust in November 2024. 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.

Viable responses were received from 465 people accessing services, giving a response rate of 39%, compared to a national average response rate of 41%. Of the people sharing their feedback, 19% of patients were elective admissions, and 81% were emergency admissions.

Each patient's answer is scored from 0 to 10, with 10 representing the most positive experience. Additionally, each question is rated as better, about the same, or worse, based on expected ranges. This comparison is used to arrive at a judgement of the Trust's performance against others in the survey.

The majority (89%) of scores for the Trust are in line with other trusts. Four were somewhat worse compared to other Trusts, and one was worse than expected. Whilst identifying areas for focused improvement, findings reflect an improvement in comparison to the 2023 survey results, reducing the number of questions that scored worse than expected from 12 to 5.

Figure 1 – Comparison With Other Trusts 2023

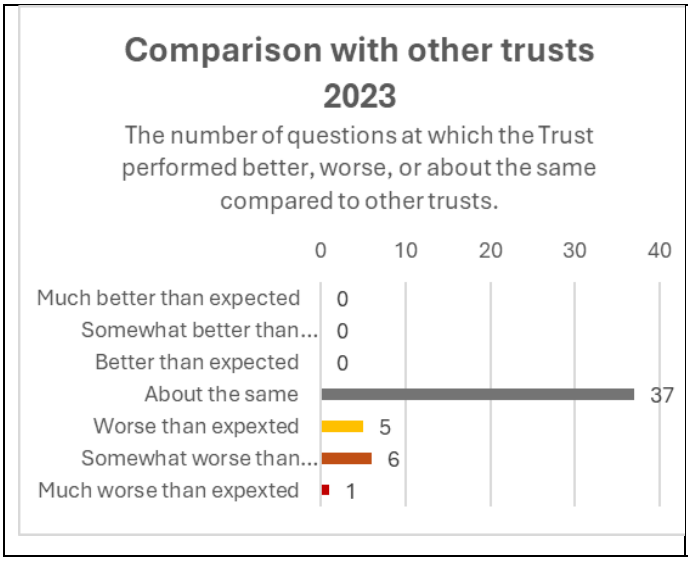
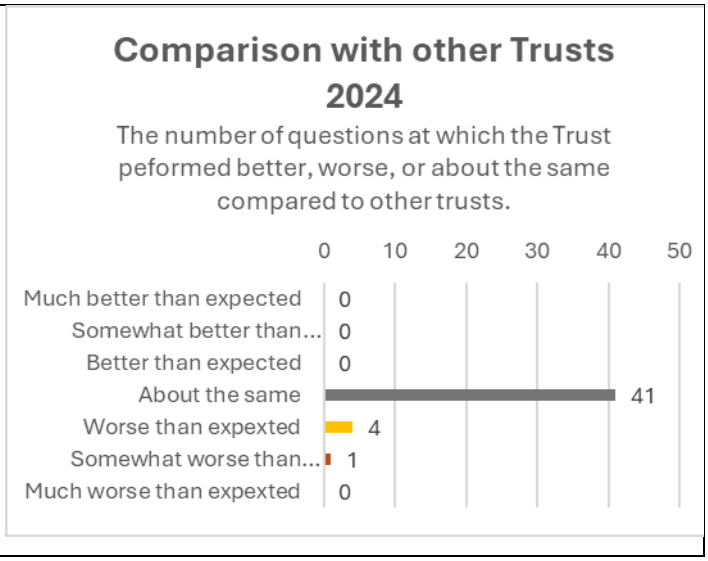


Figure 2- Comparison with Other Trusts 2024



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 3.

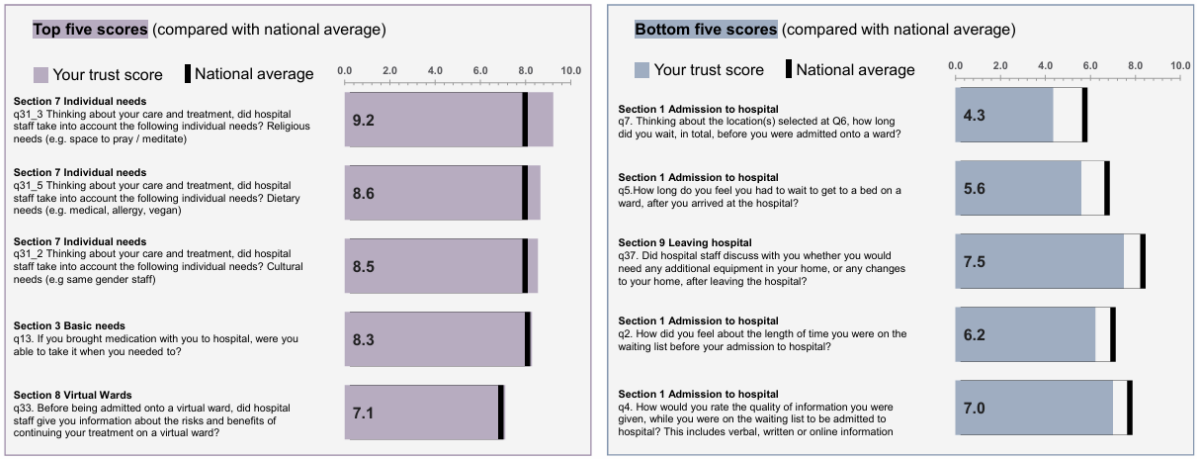


*Figure 3 – Top 5 and Bottom 5 Ranking Scores Compared with Trust Average (*National NHS Adult Inpatient *Survey, 2024)*

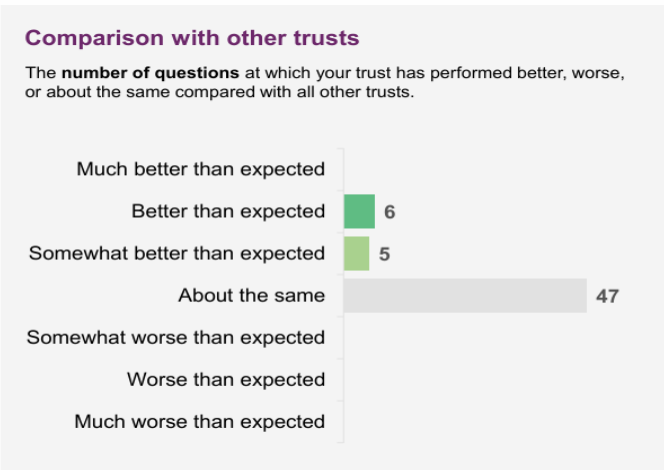
Following the Adult Inpatient Survey (2024) which was published in 2025 leads from each Division have reviewed the feedback, identified improvements that can be made, and developed action plans in response to the findings. The action plans address key areas for improvement highlighted by the survey, such as patient discharge procedures, wait times, and post-discharge support.

C. NATIONAL MATERNITY SURVEY

The NHS National Survey of Women's Experiences of Maternity Services (2025) was undertaken with patients meeting the eligibility criteria who were aged 16 years or older, who had a live birth during February 2025.

Viable responses were received from 132 people accessing services, giving a response rate of 45%, compared to a national average response rate of 39%.

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 58 scored questions, with additional filter questions and demographic data. These were divided into 6 focused sections covering Antenatal care, Labour and birth, Postnatal care and Complaints.



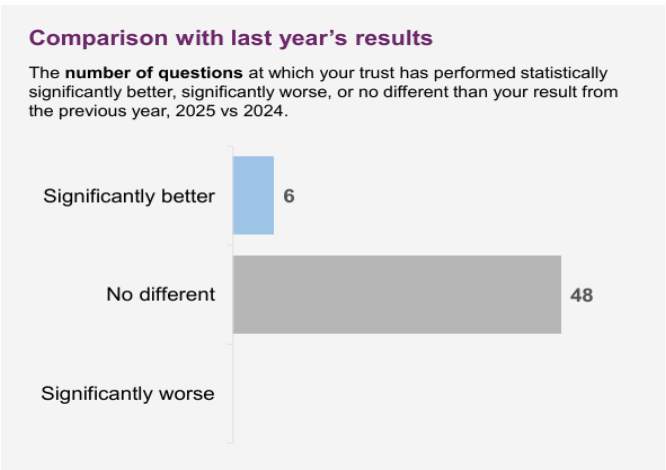


Figure 4 – Comparison With Other Trusts 2023

Figure 5 – Comparison With Last Years Results

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” (Figure 4).

- Of the 6 sections included in the 2025 survey, SaTH’s performance was rated ‘about the same’ as other Trusts for 4 sections, and ’better’ in 2 sections.
- Of the 58 scored questions, SaTH’s performance was “somewhat better than expected” in 5 questions, ‘better than expected’ in 6 questions, and ‘’About the same’’ as other trusts in 47 questions.
- SaTH performed statistically ‘Significantly better’ in 6 questions when compared with the previous year’s results (Figure 5).

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. 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 questions relating to ‘Triage’ and ‘Antenatal Care’ (compared with national average).

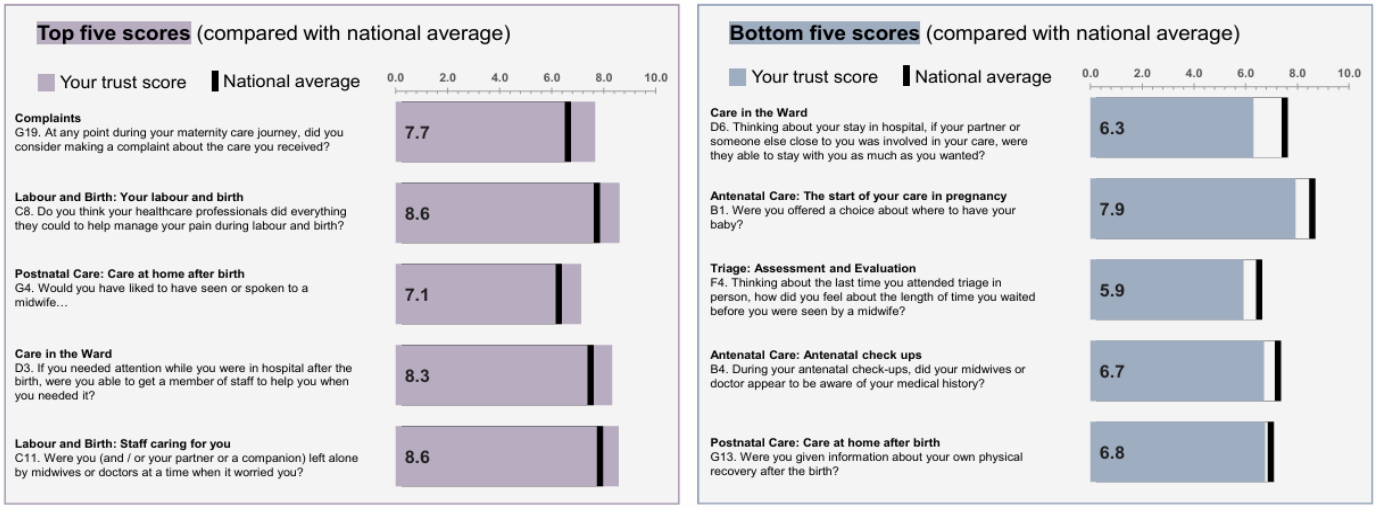


*Figure 6 – Top 5 and Bottom 5 Ranking Scores Compared with Trust Average (*National NHS Maternity *Survey, 2025)*

A gap analysis has been undertaken by the Maternity and Neonatal Voices Partnership (MNVP) and the maternity leadership team on the qualitative and quantitative data to ensure the Trust has a co-produced action plan that addresses service user feedback.

D. NATIONAL CHILDREN AND YOUNG PEOPLE’S SURVEY

The National NHS Children and Young People’s Patient Experience Survey (2024) was undertaken between August and December 2024 and included patients meeting the eligibility criteria who were discharged from the Trust between the 1st March and 31st May 2024. Patients were eligible for the survey if they were aged

between 15 days and 15 years of age. The 2024 survey had three questionnaire versions, tailored to three age groups.

Viable responses were received from 277 people accessing services, giving a response rate of 22%, compared to a national average response rate of 20%. Of the people sharing their feedback, 44% of patients were inpatient admissions, and 56% were day case admissions.

Each patient's answer is scored from 0 to 10, with 10 representing the most positive experience. Additionally, each question is rated as better, about the same, or worse, based on expected ranges. This comparison is used to arrive at a judgement of the Trust's performance against others in the survey.

The majority (78.8%) of scores for the Trust are in line with other trusts. Six were somewhat worse compared to other Trusts, and five questions were worse than expected, however, four questions were rated somewhat better than expected, and two were much better than expected.

Figure 7 – Comparison With Other Trusts 2023

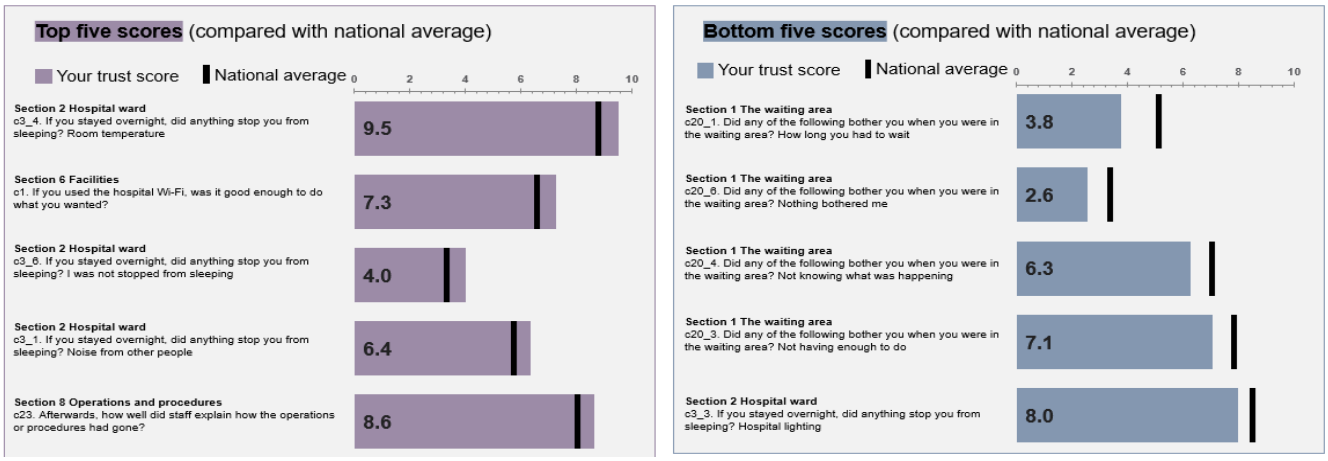


*Figure 8 – Top 5 and Bottom 5 Ranking Scores Compared with Trust Average: Children & Young People's Questions (*Children and Young People's Survey, *2024)*

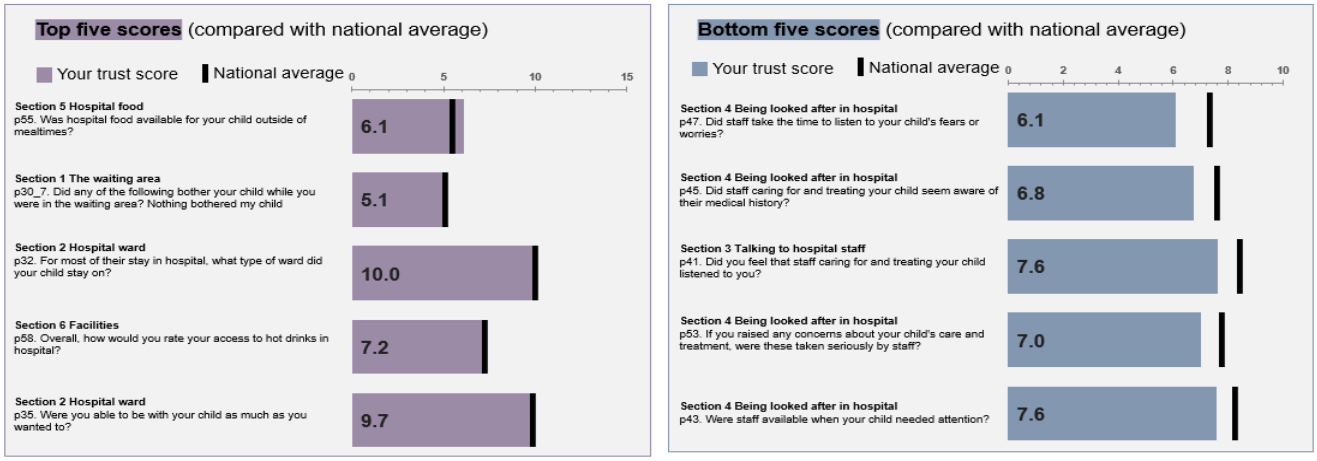


*Figure 9 – Top 5 and Bottom 5 Ranking Scores Compared with Trust Average: Parents and Carer's Questions (*Children and Young People's Survey, *2024)*

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).
- Involvement in procurement reviews, providing a user perspective.
- Patient Led Assessment of the Care Environment (PLACE) assessments.

- Recruitment through participating in stakeholder groups.
- Chairing the Trust Independent Complaints Review Group and undertaking reviews of complaint cases.
- 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.
- Facilitating 15 Step Challenge visits within clinical areas.

MATERNITY IMPROVEMENTS

Saving Babies Lives Care Bundle v3.2 (SBLCBv3)

The SBLCBv3.2 was published in April 2025. In order to meet the requirements of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS) year 7, Trusts were required to undertake quarterly quality assurance meetings with their ICB partners. The Trust met with the ICB as required and demonstrated improving ambitions through the use of a national implementation tool. Full implementation is no longer a requirement of CNST, but Trusts must demonstrate improvement/working towards actions plans with standards that are not fully implemented or achieving a target compliance. The Trust declared it had met the CNST year 7 requirements for 2025.

The Trust's compliance position after the launch of SBLCBv3.2 (April 2025) was 86% but as the table below confirms the Trusts position at the end of 2025/2026 was 96%. Action plans were in place to address the 4% shortfall.

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)
Element 1	Smoking in pregnancy	Partially implemented	80%	Partially implemented	80%
Element 2	Fetal growth restriction	Fully implemented	100%	Fully implemented	100%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	96%	Partially implemented	96%

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 submitted to Trust Board including representation from SaTH's NHS England National Maternity Improvement Advisor in January 2026. Year 7 self-verification has been submitted declaring compliance against all 10 safety actions, NHS Resolution has since formally confirmed our position for Year 7, funds will be received in due course.

Year 8 has been published in March 2026 with a change to six core safety actions. Work will commence to meet the safety actions for CNST Year 8 in 2026/2027.

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 was published in December 2020, and was followed by the final report, 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 2026, is, as follows (rounded percentages):

- 196/210 (94%) have been delivered fully, and evidenced and assured as working as they should be
- 6/210 (2.5%) actions are on track to be delivered within their expected timeframes
- 1/210 (0.5%) actions off track
- 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

The Integrated Maternity and Neonatal Report now includes progress on the Neonatal Review Action plan 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 and neonatal 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 2025 results showed a significant improvement compared to previous 2024 results with the service performing better than expected and somewhat better than expected in a number of questions. The service also performed significantly better in a number of questions compared to 2024. There are some areas of improvement required, and the Trust is working alongside the Maternity and Neonatal Voices Partnership (MNVP) to develop a co-produced action plan.

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 for 2026/2027.

- Continue to deliver the outstanding Ockenden actions as part of the Maternity Transformation Plan
- Deliver NHS Resolutions Maternity (and perinatal) Incentive Scheme Year 8
- Work towards full implementation of the single delivery plan (incorporating the maternity and neonatal three-year plan and the Quality and Equity Strategy)
- Implementation of the NHS England Maternal Care Bundle and Improving Postnatal Care
- Continue to increase the workforce and developing future leaders

PAEDIATRIC TRANSFORMATION PROGRAMME.

The Paediatric Transformation Programme (PTP) commenced in July 2023, following a thematic review of the quality and safety of our paediatric services. As a result of this review, recommendations for improvement were made. These actions from the thematic review were combined with actions from subsequent visits from the West Midlands Children's Network (WMCN) which includes Paediatric Surgery and Paediatric Critical Care, NHS Shropshire, Telford and Wrekin ICB, the Shrewsbury and Telford Hospital NHS Trust (SaTH) Staff Survey 2023 and the CQC visit and a CQC self-assessment to develop an overarching transformation programme for our paediatric services. One hundred and twenty-six actions were identified to be included in the Paediatric Transformation Programme.

Oversight and assurance in relation to the PTP was gained via the Paediatric Transformation Assurance

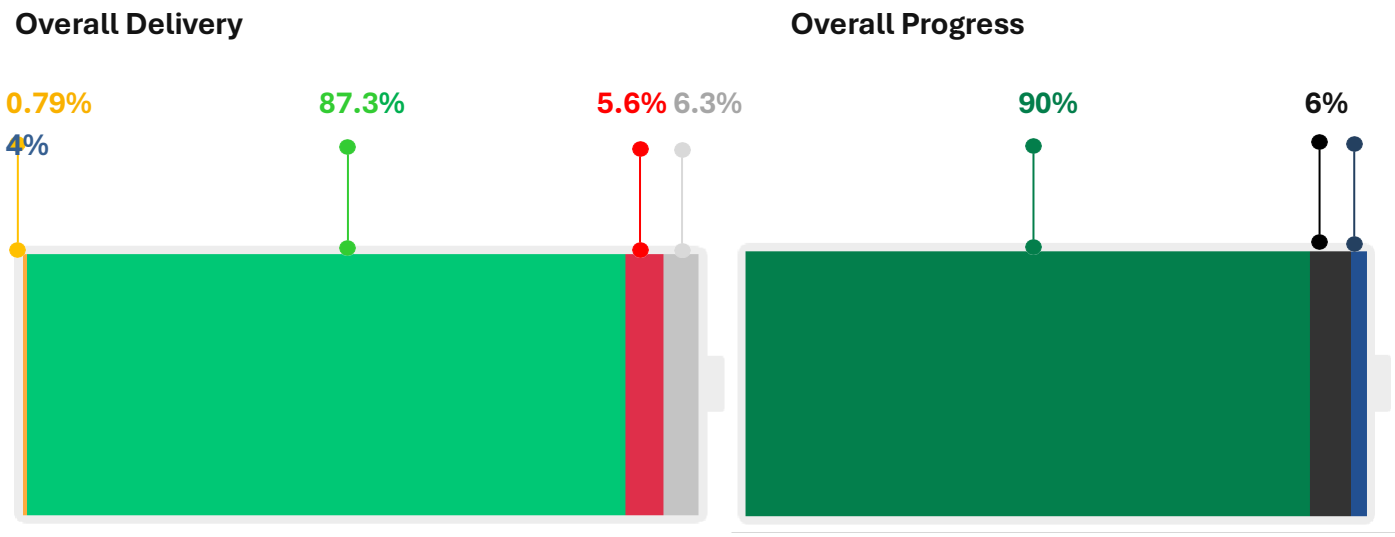
Committee (PTAC), chaired by the Executive Medical Director. The Committee included a wide group of key stakeholders including ICB colleagues, medical and nursing staff from paediatrics, a non-executive director, colleagues from the wider Trust, and external stakeholders to include NHSE and WMNC.

For almost 3 years the PTP has undertaken improvements and delivered many of the actions included in the transformation programme. The Paediatric Transformation Assurance Committee has provided the oversight and received assurance in relation to the quality and safety improvements made within our paediatric services. In April 2026 the PTAC met for the last time, the decision was made that the PTAC oversight and PTP had delivered in relation to providing the structure for driving improvements and this would now transition into a Paediatric Stakeholder Group which will drive forward paediatrics in the next phase of its transformation journey enabling the paediatric services to work more closely with over services across the Trust and Shropshire Community Health NHS Trust who deliver services and care to our children and young people.

Paediatric Transformation Programme Delivery Progress

Progress against the accumulative action plan has been reviewed, monitored and validated at the monthly Paediatric Transformation Assurance Committee (PTAC), and monitored locally within the Women and Children's Divisional Committee, Executive Performance Review Meetings (PRM) and at the Quality, Safety and Assurance Committee.

At the closure of the programme, 114 out of 126 actions have been fully implemented.



110 actions (88%) 'Evidenced and Assured'

1 action (1%) 'Delivered, Not Yet Evidenced'

114 actions (90%) 'Complete'

8 actions (6%) 'Descoped'

7 actions (6%) 'Not Yet Delivered'

4 actions (4%) 'Handed over' to other routes

8 actions (7%) 'Closed'

Of the 8 actions which are noted to be delivered, not yet evidenced and not yet delivered, these have all either been closed (3), carried forward to paediatric governance for monitoring (3) or carried forward to the Women and Children's Divisional Committee (2).

The Paediatric Transformation Programme provided a platform to enable practices for children and young people's services to be reviewed and delivered in a cohesive manner. Excellent progress has been made through the series of actions developed, to improve care and services for children and young people, parents and guardians throughout the Trust, and also has provided staff with a platform to deliver services in a safer way. Some of the improvements delivered through the Paediatric Transformation Programme have included:

1. Nursing Workforce

- Implementation of a Summer/Winter nursing workforce template to meet the seasonal activity and acuity.
- Splitting of nursing rosters over the 5 clinical areas of paediatrics has allowed choice of sub-specialty working, and the implementation of self-rostering have been received positively by staff.
- Robust induction programmes have been introduced for nursing staff of all levels, during which time staff work on a supernumerary basis, shadow mentors, complete a skills-based induction booklet and attend simulation training sessions.
- To support new nursing staff, student and nurse associates and non-registrant induction programmes, their ongoing training, and development, an additional Band 6 Practice Education Facilitator was appointed ensuring robust nursing induction programmes, monitoring and management of mandatory training, and has also been key to significantly improved retention of nursing staff of all levels.

2. Digital and Technological Improvements

- To ensure the improved safety of CYP, and to meet the move to nationally recognized and promoted digital recording systems, the 'Paediatric Vitals' was launched in all paediatric inpatient areas of the Trust in 2024
- The introduction of the national PEWS module to paediatric vitals was also implemented in late 2024.
- The new digital Sepsis Screening assessment was implemented in the paediatric areas and ED departments in September 2024.

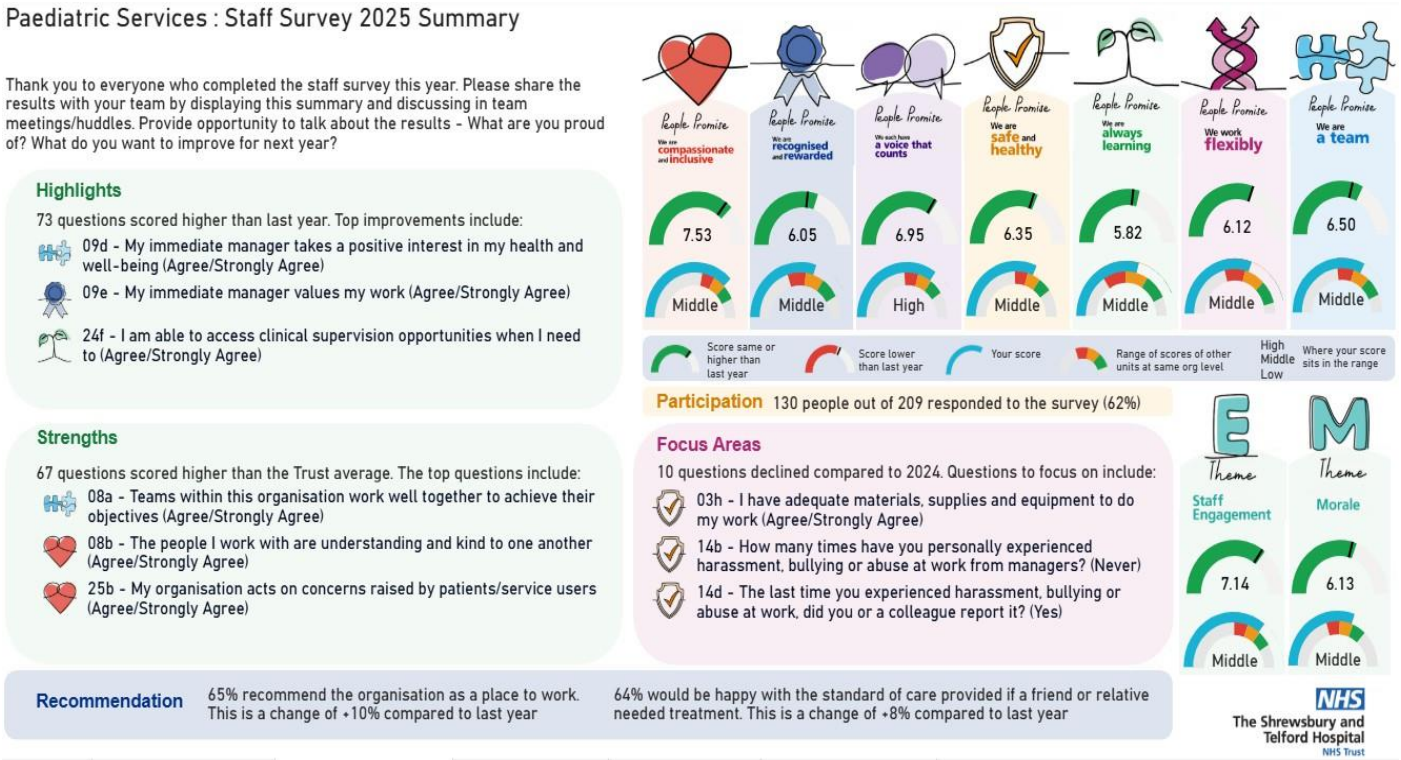
The implementation of the digital paediatric vitals system, national PEWS, targeted promotion of CYP sepsis awareness, and advanced sepsis training for the multidisciplinary team have significantly enhanced the rapid management of care which is a critical driver for improving clinical, operational and family reported outcomes for children and young people who are exhibiting signs of deterioration.

3. Improvements for Staff

The focus on staff improvement was largely generated from the results from both the National Staff Surveys and the quarterly internal Pulse Survey findings, together with key areas of regular concern raised with Ward Managers and at staff meetings and huddles.

- An action plan was developed following the results of the 2024 Staff Survey, where the key focus areas for improvement included the need for the immediate manager to ask staff opinions prior to making decisions which may affect their work, together with taking a positive interest in staff health and well-being and to take effective action to help staff with any problems which they experience.
- Open-door sessions, the introduction of a variety of methods of clinical supervision, staff psychology, debrief sessions after significant clinical occurrences and the introduction of the fortnightly Ward WRAP "5 Things You Need to Know This Week" pictorial summary, were all successfully introduced for all staff throughout the year.

Actions implemented in relation to staff experience resulted in significantly improved results in the 2025 National Staff Survey. Seventy-three questions answered scored higher than the previous year and in terms of the people promise, all areas scored the same or higher than the previous year. Top improvements included all of the issues raised as concerns from the 2024 survey, and additionally that 65% of staff would recommend the organisation as a place of work, a huge increase of 10% from the previous year.

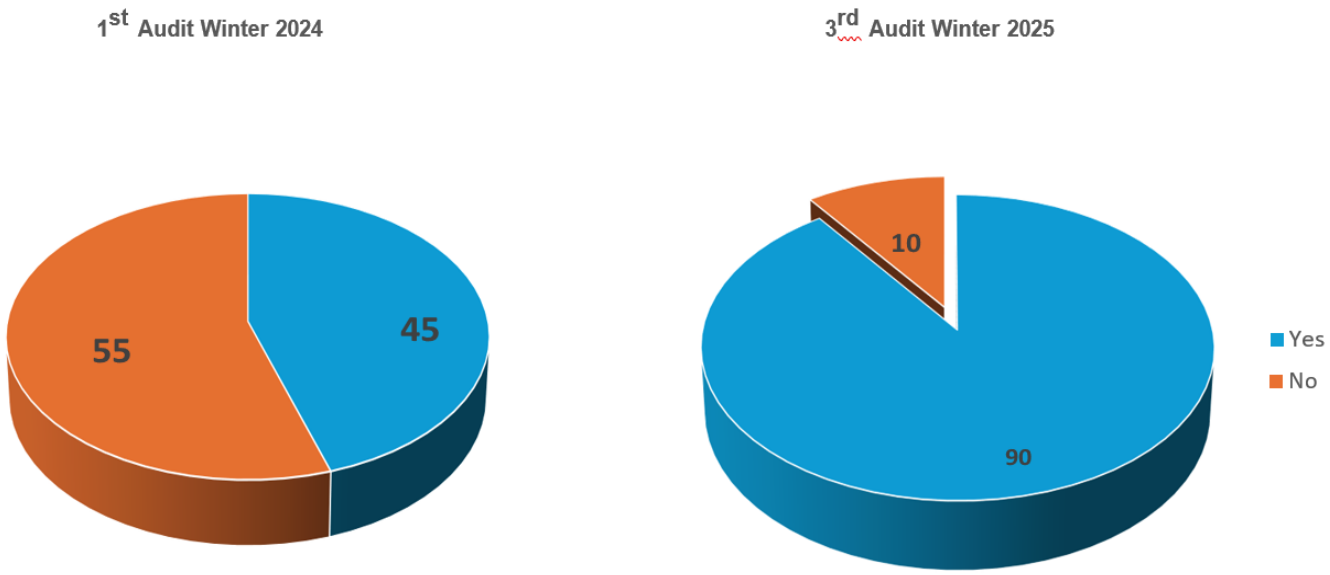


4. Improvements in Paediatric Processes

A significant part of the Paediatric Transformation Programme was to review many of the existing processes, to assess their validity and compliance with key standards, and to improve them where appropriate. There have been many improvements made, in terms of processes and guidelines, documentation, consultant reviews, waiting-time improvements, early initiation of treatment in the Children's Assessment Unit, and innovations, some of which are outlined below:

- **Consultant Review Within 14 Hours**

The Royal College of Paediatrics and Child Health standard outlines that every child admitted to a paediatric department with an acute medical problem must be seen by a consultant paediatrician with 14 hours of admission. The Paediatric Medical Team have made significant improvements in relation to this standard



- **Paediatric Waiting Time Improvements**

The paediatric teams have worked hard as part of their PTP to improve the waiting times for our children and young people throughout 2025/2026. Additional clinic capacity has been in place to ensure patients are seen in a more timely manner. In October 2025 the Trust achieved its target of reducing waiting times to 40 weeks or under.

May 2025

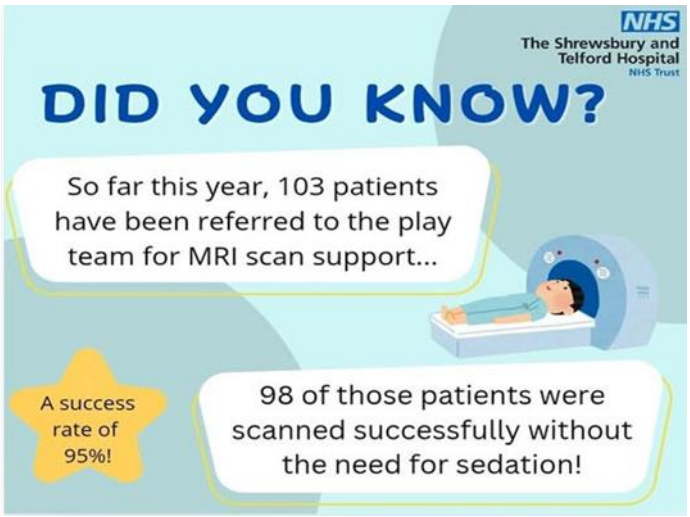
Specialty	Routine Wait	Urgent Wait
Respiratory	56 weeks	56 weeks
Allergy	55 weeks	55 weeks
General	38 weeks	29 weeks
Cardiology	69 weeks	61 weeks
Endocrinology	35 weeks	30 weeks
Nephrology	36 weeks	16 weeks
Rheumatology	16 weeks	0 weeks
Gastroenterology	56 weeks	52 weeks
Haematology	17 weeks	9 weeks
Epilepsy	33 weeks	33 weeks

October 2025

Specialty	Routine Wait	Urgent Wait
Respiratory	40 weeks	40 weeks
Allergy	39 weeks	39 weeks
General	32 weeks	25 weeks
Cardiology	39 weeks	40 weeks
Endocrinology	23 weeks	20 weeks
Nephrology	38 weeks	20 weeks
Rheumatology	16 weeks	0 weeks
Gastroenterology	40 weeks	39 weeks
Haematology	10 weeks	2 weeks
Epilepsy	28 weeks	23 weeks

- **Unsedated Magnetic Resonance Imaging (MRI)**

Paediatrics have implemented the use of distraction and melatonin to avoid traditional sedation prior to and during MRI scans. The Play Team has been working with Children and Young people when they require an MRIs. The support they have offered patients mean they are able to have their scans without the need for sedation; this also reduces waiting times for the family. We have successfully worked with children as young as 4.



The team has also started trials with a 'melatonin MRI' process which sees children undergo MRIs closer to their bedtimes with the help of melatonin so the images can be captured while they are sleeping. These initiatives have been put forward for national awards.

EQUALITY, DIVERSITY AND INCLUSION (EDI)

During 2025/26 the Trust has continued to strengthen its approach to Equality, Diversity and Inclusion (EDI) and Health Inequalities aligning activity with the NHS EDI Improvement Plan. The focus this year has been

on embedding inclusive leadership, improving the experience of patients and staff and ensuring that equity is considered consistently in how services are planned and delivered. Engagement across the organisation and wider system has remained central helping to build a clearer understanding of the issues affecting access, experience and outcomes

The EDI Champions network has continued to develop during the year. There are now 70 Champions across all areas within the Trust who are supporting local conversations about inclusion, awareness-raising and signposting. While the network is still maturing, it has contributed to a broader understanding of EDI issues and provided an additional point of contact for colleagues seeking support.

Band 7 to 8C clinical leaders across nursing, midwifery and AHP professions completed additional EDI training during 2025/2026. The programme was designed to strengthen their understanding of key concepts such as unconscious bias, the needs of marginalised groups and the importance of inclusive behaviours in everyday clinical practice. The training also reinforced the principles of civility and respect and encouraged leaders to consider how inclusive approaches can support both staff wellbeing and patient experience. Feedback from participants suggests that the training has supported them to have more confident conversations about inclusion and helped them to emphasise the importance of equitable and respectful behaviours in their teams.

The EDI Patient Advocacy Group has continued to play an important role in shaping patient-focused improvements, meeting monthly throughout 2025/2026. Recruitment has been strengthened through internal and external promotion, and the group now provides a consistent forum for lived experience insight helping ensure patient voices shape service improvement. This year the group has contributed to accessible patient information, digital accessibility scoping and service reviews. Their diverse experiences have helped ensure that changes to pathways and materials reflect the needs of a wider range of patients.

The Trust completed its annual EDS 2022 cycle with three stakeholder events held in November and December 2025 for the Domain One Patient Service Review. These events brought together patients, staff, community groups and partners to review evidence and provide feedback on Cancer Services, the Mental Health Liaison Service and the Children and Young People Asthma Service. Each service developed draft action plans based on this feedback, with further stakeholder events held in March and April 2026 to review and agree these. Oversight for delivery of these plans sits with the Patient and Carer Experience Panel (PACE) chaired by the Interim Chief Nursing Officer.

REDUCING HEALTH INEQUALITIES

During 2025/26 the Trust continued to support the NHS Shropshire, Telford & Wrekin's commitment to reduce health inequalities strengthening our organisational approach through improved leadership, governance and data quality. We have further embedded an evidence-led approach aligned to the Core20PLUS5 framework for adults and children and young people.

A strong focus has been placed on improving the quality and use of health inequalities data to inform service planning and targeted action.

Key achievements include:

- Improved data collection: Ethnicity and deprivation data are now more consistently recorded and used to identify variation and inform service improvement.
- Health inequalities dashboard: Developed to track population trends and support prioritisation against Core20PLUS5.
- Targeted interventions: Using JSNA, population health data and partner intelligence to segment and prioritise groups most affected by inequality, informing our Neighbourhood planning framework and service delivery models.

Local data continues to highlight significant variation across Shropshire, Telford and Wrekin, including differences in life expectancy, pockets of deprivation, smoking and obesity rates, mental health need and challenges accessing services in rural areas.

Priorities for 2026/2027:

In the coming year we will continue to work with system partners to accelerate progress by focusing on:

- Strengthening leadership and accountability across all services.
- Further improving data completeness and insight, particularly ethnicity and deprivation data.
- Delivering services inclusively, ensuring equitable access and experience for underserved groups.
- Reducing digital exclusion by identifying and supporting those unable to access digital routes into care.
- Accelerating prevention programmes aligned with Core20PLUS5 priorities.
- Embedding evidence-led improvement, supporting teams to use data and population health approaches to reduce unwarranted variation.

OUR DIGITAL TRANSFORMATION JOURNEY 2025/2026

The Shrewsbury and Telford Hospital NHS Trust remains committed to delivering digitally enabled care that is safer, more efficient, and more patient-centred. Building on the significant progress made throughout 2025/2026, we are now entering the next phase of our digital transformation programme, focusing on optimisation, integration, and expanding digital capabilities across the Trust.

During 2025/2026, the digital team continued to expand and enhance our CareFlow Electronic Patient Record (EPR) and supporting digital systems. This year's work focused on expanding functionality, improving user experience, and embedding digital processes consistently across all care settings.

Digital Improvements in 2025/2026	Benefits
Patient Engagement Portal (Dr Doctor) Expansion	Rollout extended beyond ENT into additional specialities. Patients now access appointment letters electronically, request rescheduling and receive digital reminders
CareFlow and Vitals Upgrades	Vitals and CareFlow upgraded introducing HPCA access, which improves information security, PDS and CP-IS integration and use of digital records using the Vitals app
SEW Adoption Across Specialities	Expanded use of Secretaries' Workstation 2 ensures faster, more consistent communication with patients and GPs, supported by standard templates and Clinical Portal integration
Windows 11 Upgrade Programme	Windows 11 implementation has been completed, ensuring compliance with NHS England's cyber security requirements and improving device performance and stability. The success of this upgrade has been celebrated and used as a template for other organisations
Data Warehousing using the Federated Data Platform	Innovative development of data warehousing capabilities utilising the Federated Data Platform

Laying Foundations for the Future:

- **Ambient AI Scribe Pilot**
  With close involvement from the Clinical Safety team the Heidi AI Scribe is being piloted across a limited number of outpatient clinics involving both medical and nursing staff with ongoing feasibility work for expansion across additional areas.
- **ICE Order Comms Implementation Preparation**
  The programme to modernise Radiology and Pathology requesting advanced into its final design stage, targeting a smooth Trust-wide implementation in early 2026.
- **Digital Medicines Programme Foundations**
  A successful business case for implementation of the CareFlow Medicines Management (CMM) ePMA system. Clinical and pharmacy teams are now in early planning stages.

Ambitions for 2026/2027:

As we continue to give our staff the digital tools they need to deliver excellent care, our priorities for the year ahead include:

- Rolling out CareFlow Connect/Workspace Trust-wide to improve communication and task management.
- Expanding the digitisation of clinical records with the introduction of Digital Nursing Assessments.
- Commencing the project to implement Badgernet Neonatal EPR
- Progressing the implementation of ePMA using the CareFlow Medicines Management system
- Expansion of Ambient AI into an increasing number of areas and expanded user cases.
- Expansion of Radiology Ordercomms to also include Pathology Ordercomms alongside upgrading the Laboratory Information Management System.

This list is not exhaustive and Divisional and Digital teams have growing ambitions for the use of digital to modernise and transform patient care and to release resources for organisational and clinical priorities. We also have opportunities ahead to collaborate with our colleagues in SCHT to ensure our systems capabilities support connected care, with access to the information our teams need for effective care, when and where they need it.

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 2025 and the results were issued in February 2026.

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

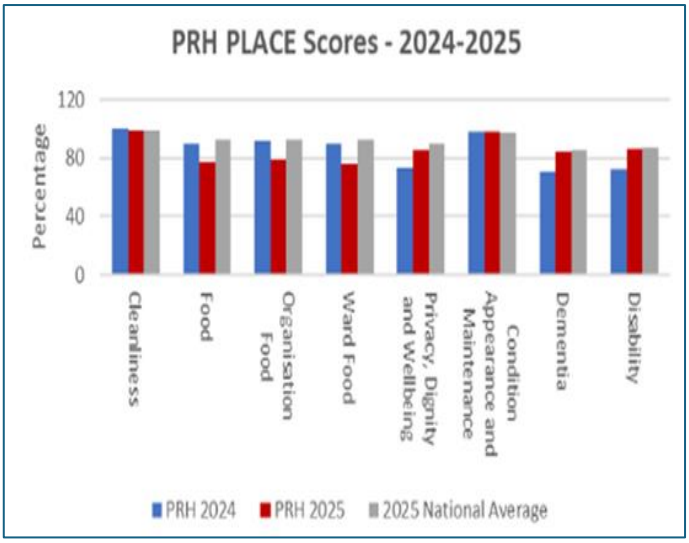


Figure 10: PRH PLACE Results 2024 & 2025

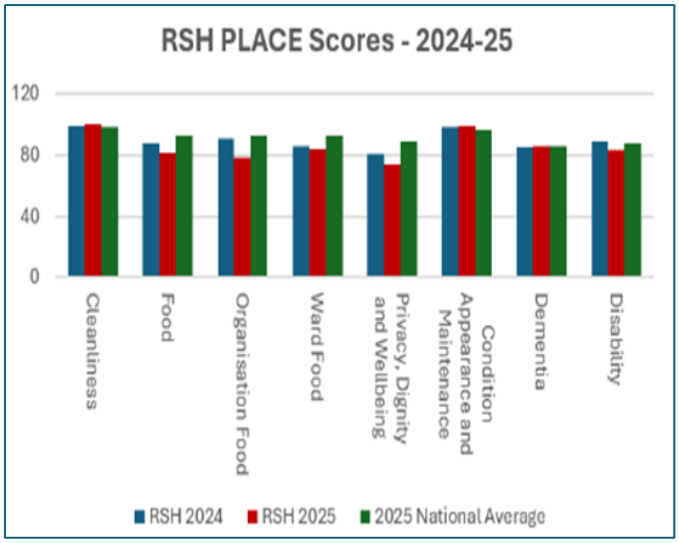


Figure 11: RSH PLACE Results 2024 & 2025

The Trust achieved scores which were above the national average in the cleanliness and condition, appearance and maintenance, and dementia (RSH) domains. Cleanliness and estate issues were addressed soon after the assessment where possible.

Domains that scored below the national average were food, privacy dignity and wellbeing, dementia (PRH), and disability. Food scores have seen an overall drop of 13.24% (PRH), and 6.84% (RSH). Detailed analysis is being undertaken to identify scores resulting in this decrease and opportunities to improve.

At PRH Privacy, dignity and wellbeing, dementia and disability scores have increased in year by 11.16%, 13.43% and 13.67% respectively. At RSH privacy, dignity and wellbeing and disability have seen a drop in score of 6.56% and 5.62% respectively, whilst cleanliness and dementia increased slightly.

The longer-term actions will be discussed and prioritised at the PLACE Group which is a multi-disciplinary group including the Patient Representatives. In response to the PLACE (2024) audit findings improvement work was undertaken in 2025/2026 to improve the environment and experience for patients with dementia and disability which included hand-rails in some outpatient areas at PRH, additional rest stop seating on the ground floor corridor at PRH and clocks in the ward areas for our dementia friendly environment.

4.0 STATEMENTS FROM EXTERNAL ORGANISATIONS

Healthwatch Telford & Wrekin

Healthwatch Telford and Wrekin welcomes the opportunity to comment on the Shrewsbury and Telford Hospital NHS Trust Quality Account 2025/26. We recognise the significant work undertaken by the Trust to improve patient safety, clinical effectiveness and patient experience, particularly in relation to reducing harm from falls, improving care for deteriorating patients, strengthening discharge processes and enhancing support for people with learning disabilities and autism.

Whilst Healthwatch welcomes the progress made in several areas, we note that some important challenges remain. These include ongoing concerns around patient observation compliance for deteriorating patients, the increase in hospital-acquired pressure ulcers, the continued high number of inpatient falls, medication omissions and delays in implementing systems designed to reduce the risk of missed radiology results. We encourage the Trust to maintain a strong focus on these areas and to continue using patient and carer feedback to understand how these issues impact people's experiences of care.

We are encouraged by the Trust's focus on patient safety priorities, including reducing inpatient falls, improving the management of deteriorating patients and addressing omitted doses of time-critical medication. We particularly welcome the reduction in severe harm resulting from inpatient falls and the continued development of systems to improve the recognition and response to deteriorating patients.

Through our engagement work with local people, Healthwatch continues to hear concerns about waiting times, communication, discharge arrangements, and access to services. We therefore welcome the inclusion of priorities relating to emergency care, discharge planning and improving communication and patient experience. These are issues that matter greatly to patients and their families, and we encourage the Trust to continue involving patients in the design and evaluation of improvement work.

We are pleased to see the emphasis on partnership working across the health and care system and would encourage the Trust to continue using patient feedback, community insight and lived experience to shape future service improvements. Ensuring that the voices of seldom-heard groups are included in service development will be essential to delivering person-centred care.

Healthwatch Telford and Wrekin looks forward to continuing to work constructively with the Trust to ensure that the experiences of patients, carers and local communities inform quality improvement and help deliver services that are safe, effective and responsive to local needs.

Kind regards,

Jan Suckling | Chief Officer
Healthwatch Telford and Wrekin

Shropshire Telford and Wrekin ICB

SaTH Quality Account Statement from Shropshire Telford and Wrekin ICB 2025/26

Our Ref: VW

Re: Quality Account 1 April 2025 - 31 March 2026

NHS Shropshire Telford and Wrekin Integrated Care Board (the ICB) are pleased to have the opportunity to review the Shrewsbury and Telford NHS Trust (SaTH) Quality Account for 2025/26. SaTH has collaborated with partners in the integrated care system (ICS) as we continue to develop, to address the needs of the population and improve the quality of healthcare services within it.

It is the ICBs view that the account accurately identifies the priorities for 2025/2026 and reflects some of the improvement work and achievements shared in the quality account for this period. This account demonstrates an awareness of the areas that have been challenging and notes areas for further improvement.

This quality account demonstrates evidence of the significant work across the nine quality priorities and the ongoing improvement work.

A significant improvement noted in the percentage of patients receiving Initial Assessment (IA) within 15mins of arrival to our Emergency Department (EDs). The CQC Section 31 condition in relation to Paediatric Triage within 15 minutes of arrival to the Emergency Departments being removed by the CQC in December 2025 following a successful application by the Trust with recognition this area remains a focus.

The ICB recognises the joint working within the system wide discharge group and the improvement projects ongoing to improve discharge.

We note the R&I Department are currently developing a new five-year strategy and objectives and the Trust working towards creating a Group Quality and Safety Strategy during 2026/27.

It is pleasing to see improvements in elective pathways, over the last year the Trust has moved from the bottom decile for 18-week performance to being on the border of the upper quartile nationally (based on February 2026 data). Likewise for 52-week performance, aimed at reducing long waits for patients, the Trust has moved from the bottom decile a year ago, to being in the top performing decile nationally. Leading to being the most improved Trust in the country over the last year for both 18-week and 52-week performance.

The aim of the quality priorities for 2026/27 to continue the focus on embedding quality as the core principle underpinning how services are delivered and the improvements made ensuring that the care provided is safe, effective, person-centred, timely and equitable to ensure safe, effective, person centred care that is timely and equitable with stakeholders gives a clear Trust direction.

In conclusion, the ICB views the 2025/6 Quality Account as an accurate picture of the challenges the Trust faces and evidence of improvements in key quality and safety measures. There is focus on the core values outlined in the account and a clear vision to continue the improvement journey. The ICB recognises the Trust's commitment to working as a partner in the system to ensure the ongoing delivery of safe, high-quality services for the population of Shropshire Telford and Wrekin.

Yours sincerely
Vanessa Whatley
Chief Nursing Officer NHS STW

Healthwatch Shropshire Response on the Draft Quality Account 2025/26 Shrewsbury and Telford Hospital NHS Trust (SaTH)

Healthwatch Shropshire welcomes the opportunity to comment on the draft Quality Account 2025/26 for Shrewsbury and Telford Hospital NHS Trust. Our role is to provide an independent, evidence-based view on whether the account reflects patient experience, demonstrates learning, and sets out meaningful priorities that lead to real improvements in care.

Having reviewed the Trust's Quality Account 2025/26, we are satisfied that it provides a balanced and transparent assessment of quality improvement activity undertaken during the year. The report demonstrates a clear commitment to the three pillars of quality: safe, effective and experience-based care.

A particular strength of the report is the evidence of a developing learning culture. The Trust has demonstrated a willingness to examine underlying causes of harm and variation, particularly through its PSIRF priorities. The detailed review of omitted doses of time-critical medication, inpatient falls and care of the deteriorating patient shows a focus on understanding system-wide issues and using findings to inform improvement activity.

We are particularly pleased to see the report demonstrating how patient experience is influencing service development. Examples include the thematic review of Emergency Department complaints, ongoing patient experience surveys, Friends and Family Test feedback, and the involvement of patient representatives in improvement workstreams. These initiatives have informed actions to improve communication, patient involvement and overall experience of care.

The Quality Account includes a number of measurable improvement priorities and reports progress against them openly. It is encouraging to see significant improvements in areas such as severe harm from inpatient falls, ambulance handover times, elective care performance and diagnostic waiting times. Equally, the report is transparent where targets have not yet been achieved, including observation compliance, nutritional assessments and some discharge measures.

Overall, this Quality Account goes beyond a compliance exercise and demonstrates how data, patient feedback, audit findings and staff engagement are being used to drive service improvement. It provides assurance that the Trust remains focused on delivering safer, more effective and more patient-centred care, while recognising the areas where further improvement is required.

Powys Teaching Health Board and Llais

Powys Teaching Health Board and Llais were contacted for comment, but no response was received by the Trust within the specified timescale.

The Shrewsbury and Telford Hospital NHS Trust QUALITY ACCOUNT 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?	

Return to:
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