Quality Account 2025/26

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Healthwatch Telford & Wrekin	
Healthwatch Shropshire	

Document Purpose

The Shropshire Community Health NHS Trust Board produce this document as required by the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the NHS Quality accounts Amendment Regulations 2011 and with additional reporting arrangements as per the Regulation schedule for 2017/18). These Regulations are cited as the National Health Service (Quality Accounts) (Amendment) Regulations 2017. These Regulations came into force on 1st November 2017. The Quality Account publication on the Trust website and submission to NHS England fulfils the Shropshire Community Trust's statutory duty to submit the account to the Secretary of State.

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

If you would like this report in a different format, such as large print, or need it in a different language, please contact our Patient Advice and Liaison Service who can arrange that on 0800 032 1107 or email shropcom.customerservices@nhs.net

Statement from the Group Chief Executive

It is my privilege to introduce the Quality Account for 2025/26. This report provides an overview of the quality of care we deliver, the progress we have made against our priorities, and the areas where we will continue to focus our efforts to improve outcomes for the communities we serve.

During the past year, we have remained firmly committed to delivering safe, compassionate and high-quality care. Our work has centred on improving patient safety, enhancing patient experience, and strengthening how we learn and improve as an organisation. This is reflected in our continued focus on reducing harm, amplifying the patient voice, and embedding a positive learning culture supported by quality improvement.

We recognise the challenges of delivering care across a large, diverse population. Our staff continue to demonstrate professionalism, compassion and dedication, ensuring care is provided closer to home and tailored to individual needs. We are grateful to our colleagues, patients, carers and partners whose contributions continue to shape and strengthen our services.

Looking ahead, we will build on this foundation by focusing on proactive prevention, personalised care and system collaboration through our neighbourhood health approach. Our priorities for 2026/27 reflect our commitment to delivering safer care, improving experience and outcomes, and developing the capability of our workforce to lead continuous improvement.

We remain committed to learning and working in partnership to ensure that quality remains at the heart of everything we do.

By order of the Board.

Jo Williams, Group Chief Executive

Quality Account 2025/26

Key Achievements

Patient Safety

Falls prevention with digital sensors – reduction of 16.9% in BCCH OBDs (Occupied Bed Days) in Q4
7,488 incidents reported with a very low 0.44% severe harm rate (reduced from 1.08% in 24/25)
Reduced medication-related harm

Patient Experience

45 Observe & Act service sessions conducted
97.81% positive feedback
98% treated with dignity & compassion
3,476 feedback responses

Quality Outcomes

Zero cases of bloodstream infections
NACEL audit – Improved recognition of dying – 2024, 79% improved to 98% in 2025
Children in care health review assessment – 98% rated as good

Quality & Improvement

27 QI projects delivered
25 QI projects currently in progress
Expanded staff training programmes – 26 colleagues attended QI training

Research & Innovation

341 research participants
18 active studies
Top recruiter in West Midlands

Data & Compliance

95.8% data quality maturity index above national target
HMP/YOI Stoke Heath CQC, OFSTED & HMIP inspection – assessed as reasonably good in the Respect Domain
Involved in JTAI in Telford

Part One
Introducing Shropshire Community Health NHS Trust

Our Vision / Key Strategic headline:

We will be at the heart of supporting our communities by providing fully connected services – so that everyone gets the right care, in the right place, at the right time, by the right people

Our Commitment

Working with primary care, we will provide evidence based, local care that is flexible and responsive.

We will move care from Hospitals to settings in or close to people's homes, with proactive treatment based on early interventions.

We will integrate community health and social care provision to ensure efficient and seamless services.

We will use our skills and expertise to support and provide a wider range of services that keep people well.

Achieving our Vision

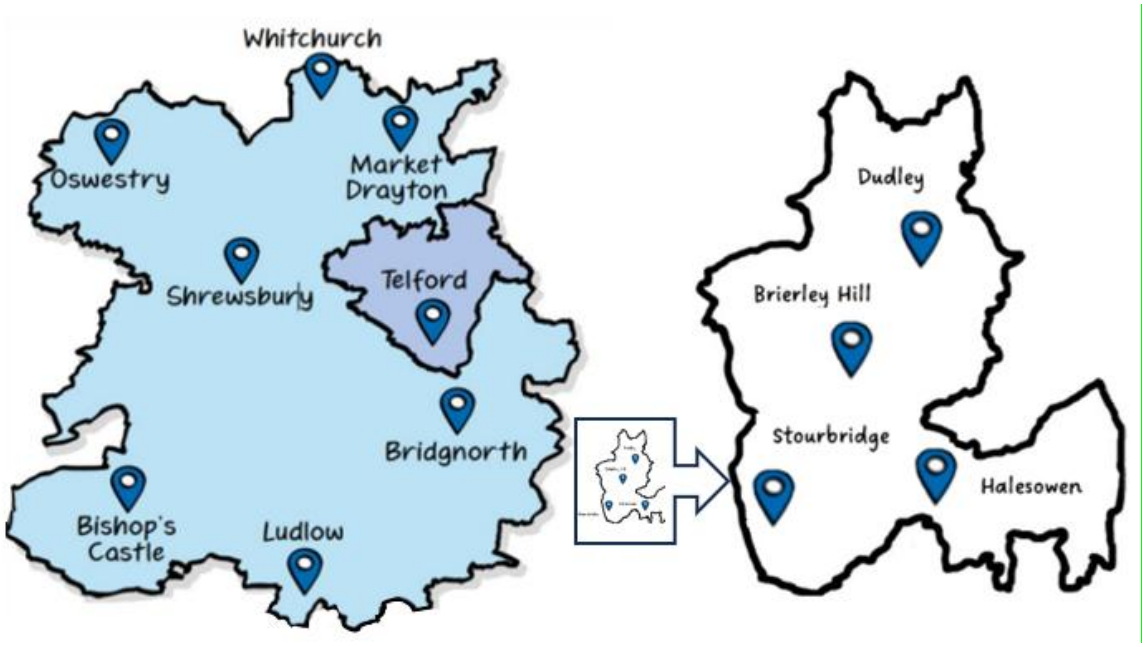
To achieve our vision, we are building a culture on 3 foundations: -

1. **Agility** – We create simplicity to allow us to respond at pace to meet the needs of our community.
2. **Cohesion** – We work together to deliver our services for our community.
3. **Empowerment** – Decisions are made by those with the best information.

Our mission is to ensure that these shared behavioural values are embedded across the Trust, supporting a compassionate culture of openness and transparency through our core values:

Who we are and what we do:

Shropshire Community Health NHS Trust (SCHT) provides a range of community and community hospital services for the population of Shropshire, Telford and Wrekin, totalling 582,407 people, and from April 2024 we also serve the 0-19 population of 73,938 in Dudley (figures obtained on 26.01.2026)



Shropshire is a mostly rural, diverse county with over a third of the population living in villages, hamlets and dispersed dwellings, a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation.

By contrast, Telford & Wrekin is predominantly urban with more than a quarter of its population living in some of the most deprived areas in England. As over a third of our population live rurally, our services are on the main are organised geographically to enable us to be as responsive as possible to meet the needs of our service users, their carers and families.

The Community Trust in Shropshire, Telford and Wrekin serves its population throughout life, with a wide range of services including but not limited to; 0-19 Children's Services, Community Therapy and Nursing, Urgent Care such as Minor Injury Units and Virtual Ward, Outpatients and Community Inpatient Wards, in addition the organisation serves the 0-19 Children's Services in the borough of Dudley.

As a member of Shropshire, Telford and Wrekin Integrated Care System, we strive to transform the provision of our services by working in partnership with others to meet the needs of those we serve.

Our Services:

Children's & Young Families Division

0-19 Public Health Nursing Service - Shropshire, Telford & Wrekin and Dudley (Health Visiting, School Nursing and Family Nurse Partnership (FNP) – including Emotional Health & Wellbeing team

Community Children's Nursing Service	Special School Nursing Service	Paediatric Diabetes Service	Paediatric Asthma Service	Paediatric Psychology Service
Child Development Centres	Community Paediatrics	School Age Immunisation & Vaccination	Children in Care Health Team	Shropshire Wheelchair & Postural Services
COVID Vaccination Service	Children's Physiotherapy	Children's Respite Service	Targeted Admin	Paediatric Audiology Service
Community Children's Occupational Therapy	Paediatric Continence Service	Community Children's Speech & Language Therapy	Dudley Youth Justice Health Worker	Dudley MASH

Community Services Division

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

Planned Care Services

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

Urgent & Emergency Care Division

- Minor Injuries Units and Xray
- Single Point of Referral
- Care Transfer Hub
- Virtual Ward
- Integrated Front Door Team
- Outpatient Parenteral Antibiotic Therapy (OPAT)
- Diagnostic, Assessment & Access to Rehabilitation and Treatment (DAART)
- Enhanced Care Home Service
- Community Respiratory Team
- X- Ray
- Urgent Community Response Team (including 2 Hour Domiciliary Team)

Corporate and Support Services

- Quality Improvement Team
- Temporary Staffing Team
- Digital Services
- Safeguarding Team
- Communications
- Medicines Management
- Health & Safety
- Complaints & PALS
- Workforce Services
- Organisational Development
- Occupational Health
- Finance & Contracting
- Governance & Risk
- Hotel Services
- Emergency Planning
- Estates
- Clinical Education Team
- Infection Prevention, Education & Advisory Team (IPEAT) Team
- Strategy, Planning & Business Development

Integrated Care System (ICS)

Shropshire Community Health NHS Trust is part of the Shropshire, Telford and Wrekin ICS

ICSs are partnerships of organisations that come together to plan and deliver joined up health and care services to improve the lives of people who live and work in their area. 'NHS Shropshire, Telford and Wrekin' is the statutory commissioning body within our ICS

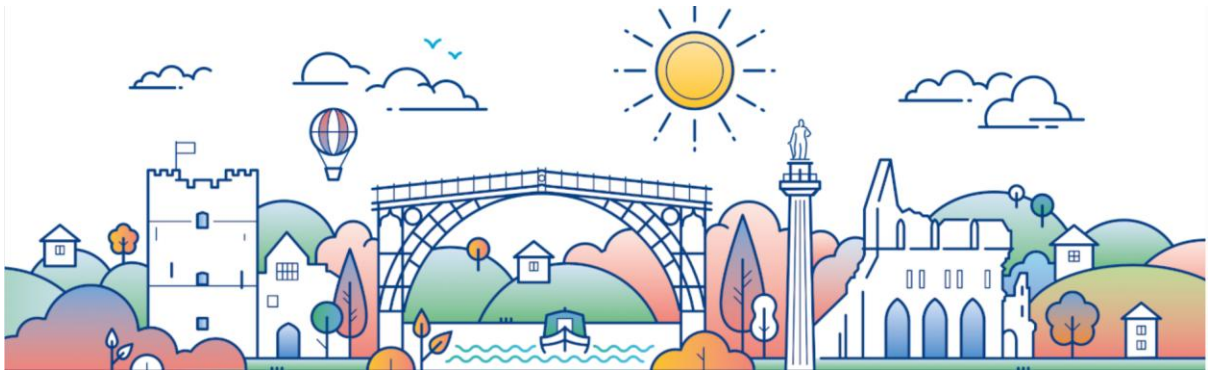
ICSs have four key purposes:

- improving outcomes in population health and healthcare.
- tackling inequalities in outcomes, experience and access.
- enhancing productivity and value for money.
- supporting broader social and economic development.

Our fellow Health & Care providers are:

- The Shrewsbury and Telford Hospital NHS Trust
- The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
- Midlands Partnership NHS Foundation Trust
- West Midlands Ambulance Service Foundation Trust
- 50 GP practices across nine Primary Care Networks.
- Shropshire Council
- Telford & Wrekin Council

Our relationships with are partners are essential to help us provide the best care possible for our local population.



Part 2.1 Looking back – Quality Account Priorities 2025/26

In 2025/26 SCHT focused on 3 quality priorities that incorporated national and local agendas and that linked back to our four Clinical Quality Ambitions included within our Clinical Quality Strategy 2024-2027: SCHT Clinical Quality Strategy 2024 - 2027

- Clinical Quality Ambition 1: Delivering Safe Integrated Care
- Clinical Quality Ambition 2: Listening to and supporting the patient voice.
- Clinical Quality Ambition 3: Learning and Improving together.
- Clinical Quality Ambition 4: Delivering Equitable and Sustainable Services

Quality Priority 1: Enhancing Patient Safety and Reducing Harm (Linked to Clinical Quality Ambitions 1, 3 and 4)

We said we would:

- **Learn from Falls:** While no single intervention has been proven to effectively reduce falls, it is estimated that a combination of multiple interventions, carried out by a multidisciplinary team working collaboratively and tailored to each individual patient, can reduce falls by 25-30%. We have continued quarterly thematic reviews adopting a systems-based approach that will offer greater insight into the systems and processes that can be enhanced to minimise the risk of inpatient falls.

- **Learn from Medication Incidents:** Medication-related incidents remain one of the most frequently reported categories of patient safety incidents, accounting for about 10% of reported incidents nationally. Continuing our quarterly thematic reviews using a systems-based approach we have continued to deliver safety improvement actions aiming to reduce the number of medication errors resulting in patient harm.

- **Implementation of the Lower Limb Assessment pathway:** Lower limb assessment is a vital part of the National Wound Care Strategy, providing significant benefits to patients through early intervention. Regular monitoring and treatment of conditions such as leg ulcers are essential for preventing complications and improving patient outcomes. Implementing the Lower Limb pathway and ensuring timely assessment and intervention aims to improve wound healing rates.

We said we would demonstrate success by:

- A reduction in inpatient falls per 1000 occupied bed days
- A reduction in the number of falls resulting in harm
- A reduction in the number of medication incidents resulting in harm.
- Improved wound healing rates for patients with lower limb wounds.

We have:

Falls:

- Expanded and strengthened the SCHT Falls Task & Finish Group through regular meetings and wider stakeholder involvement.
- Scoped SCHT practice against NICE guidance and identified clear areas for improvement.
- Introduced Pharmacy led referrals for structured medication reviews on patient discharge.
- Reviewed and mapped current electronic patient record (RIO) assessments, identifying gaps against the National Audit of Inpatient Falls (NAIF) Multifactorial Assessment to Optimise Safe Activity (MASA) standards.
- Agreed Trust wide use of Clinical Frailty Score (CFS) as the minimum outcome measure, with Tinetti preferred where therapists are involved.
- Built and piloted the 4AT delirium screen and completed Bedside Mobility Tool (BMAT) development for rollout in 2026/27.
- We have piloted Ramble Guard Digital falls sensors on 2 wards in Quarter 2, completed a business case in Quarter 3 and rolled out to all 4 wards in Quarter 4. Initial pilot data evidenced a reduction in falls per 1000 occupied bed days. For the first month of the role out 2 wards have a reduced falls per occupied bed days rate (Bridgnorth and Bishops Castle. With Bishops Castle a significant reduction from 21.6 to 4.7 (reduction of 16.9 OBDS).
- Delivered a Falls Awareness Week audit and staff confidence/competence survey.
- Conducted an underreporting audit highlighting reporting behaviour and confidence in incident reporting.
- Mapped community falls service provision and shared with ICB to inform future priorities.
- The organisation was part of cohort 2 in the National Enhanced Therapeutic Observations of Care (ETOC) programme, increasing therapeutic interventions for patients through an enhanced Memory and Wellbeing Worker role to promote orientation, confidence and engagement, supporting reduction in falls risk.
- Staff participated in the deconditioning conference to enhance their understanding of deconditioning and its effects on falls.
- Drawing upon recommendations from collaborating NHS Trusts, a comprehensive literature review was conducted to evaluate the efficacy of non-slip socks in the prevention of falls.

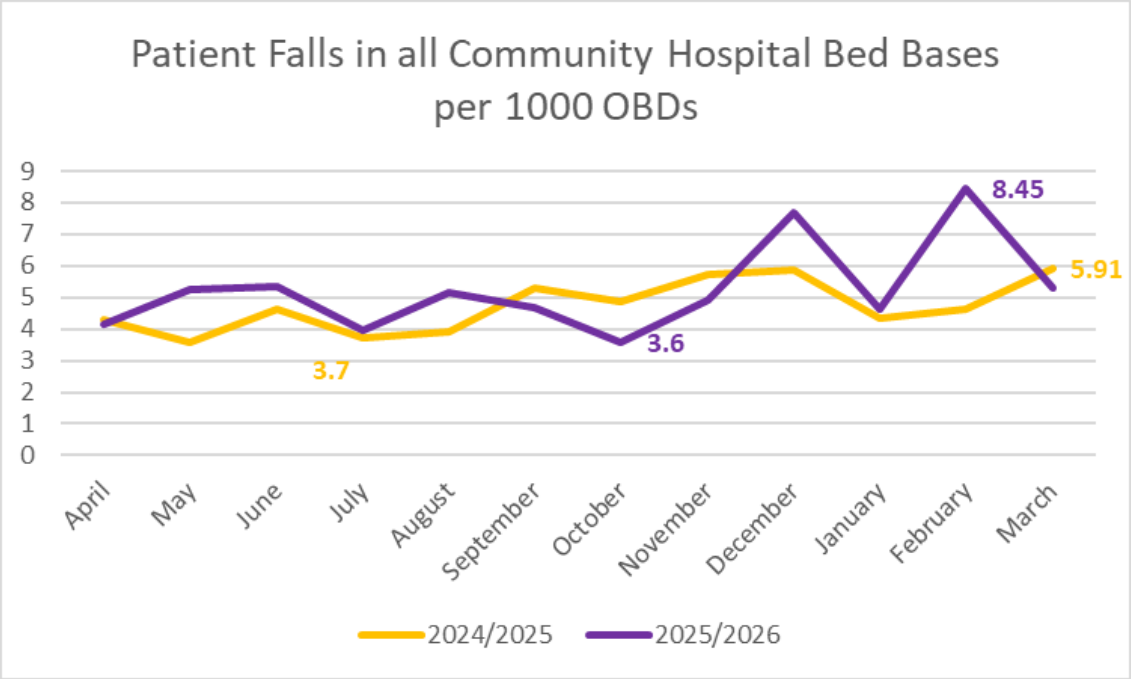
The Trust recorded 215 inpatient falls in 2025/26, representing a 16% increase compared to the year of 2024 / 25. This increase was partly due to expanded bed capacity, including Rehabilitation and Recovery Unit (RRU) beds in place until October 2025 and the use of Temporary Escalation beds during periods of higher system demand.

The Trust falls key performance indicator (KPI) target is 4.0 falls per 1000 OBD; the Trust met this target for 17% of the year, for 2 months within the 12 months of

2025/26 in July 2025, 3.7 and October 2025, 3.6 falls per 1000 OBD's. This is maintained from 2024 / 25 where we met the target for 2 months 17%.

The Trust also achieved 4.7 in September 2025 and 4.6 in January 2026. The highest falls per OBD were reported in the months of December 2025, 7.7 and February 2026, 8.9 falls per 1000 OBD's

Falls Per 1000 Occupied Bed Days:

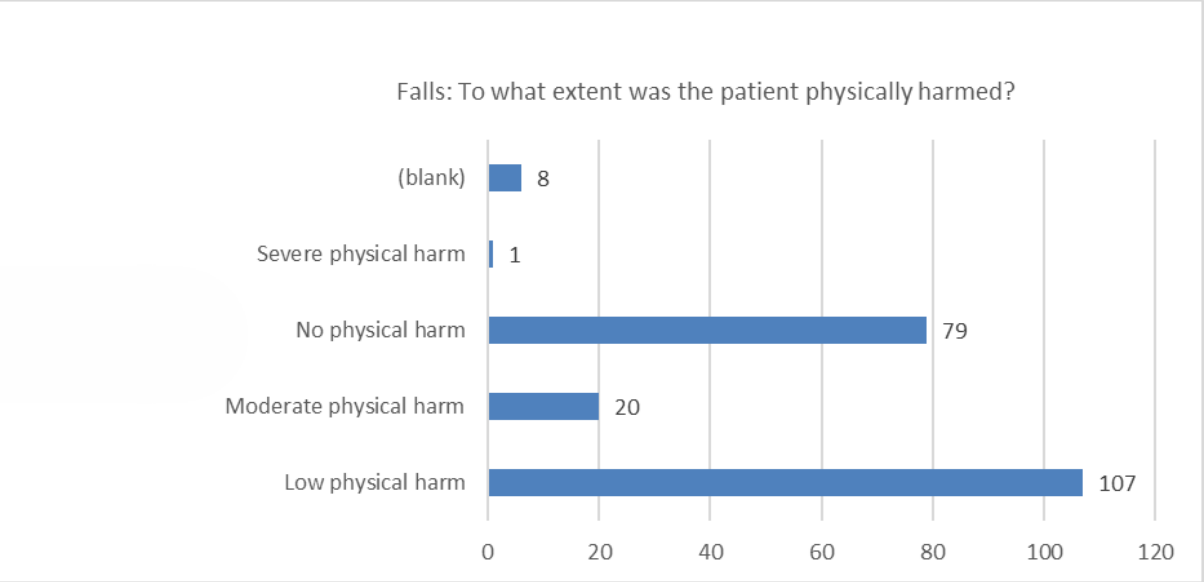


The Trust's Patient Safety Improvement Plan incorporates falls under its local priorities with weekly falls incident triage, monthly performance reporting against the falls KPI, regular falls task and finish group and quarterly thematic reviews to enable a quality improvement approach.

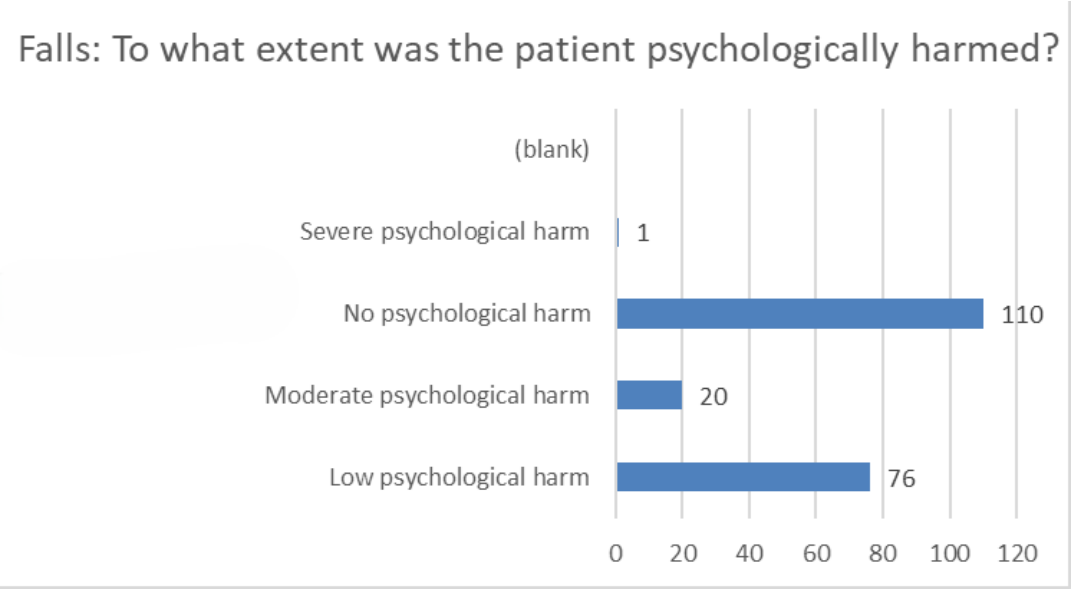
Level of Harm:

Falls related harm data for 2025/26 indicates that the majority of incidents resulted in no or low levels of harm. Physical harm most frequently fell within the low harm category (107 incidents), with 79 incidents resulting in no harm and 20 resulting in moderate harm; one incident was recorded as severe physical harm. Psychological harm followed a similar pattern, with 110 incidents resulting in no psychological harm and 76 recorded as low harm, while 20 incidents resulted in moderate psychological harm and one was categorised as severe. Overall, this data demonstrates that while falls remain a patient safety priority for the organisation, the severity of harm is generally low, with a very small proportion resulting in severe physical or psychological harm.

Physical Harm:



Psychological Harm

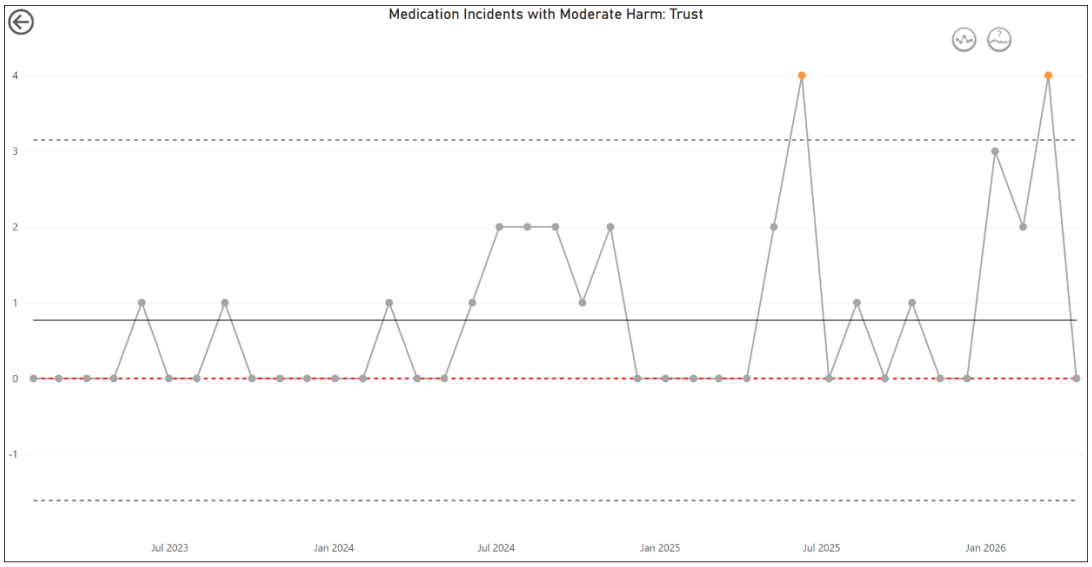


Learning from Medication Incidents:

- Medication-related incidents still remain one of the most frequently reported categories of patient safety incidents, accounting for about 10% of reported incidents nationally.
- Quarterly thematic reviews have changed to six-monthly to help better identify areas that require safety improvement support.

- Regular omitted dose audit spot checks within the inpatient setting help ensure patients receive medication on time, especially those that are time critical.
- Medication Incidents with moderate Physical and Psychological harm (see graph below)

Medication Incidents with Moderate Harm:



From Jan 26 the above graph includes both Physical and Psychological Harm. Prior to this date it only included Physical Harm.

Medication incidents resulting in moderate harm show an overall reduction in incidents associated with physical harm. However, since psychological harm reporting was introduced alongside physical harm from January 2026, the Trust has observed a slight increase in medication incidents recorded with psychological harm. This change is consistent with improved recognition and recording of psychological impact, and the Trust will continue to monitor both harm types to ensure learning and improvement actions address the full patient experience as well as physical safety.

Implementation of the Lower Limb Assessment pathway:

Lower limb assessment is a key component of the National Wound Care Strategy, offering significant benefits through early intervention. The implementation of the Lower Limb pathway supports prompt assessment and intervention, thereby improving wound healing rates. The pathway has been in place for over a year, with significant improvements observed, including earlier intervention with compression therapy, leading to improved wound healing rates.

Education and competency sign-off have been a key component of the Lower Limb Pathway implementation. This has focused on compression therapy and lower limb assessment, including the introduction of the lower limb assessment within RiO, which is required to be completed within 28 days of a patient being added to the caseload.

Assessment and diagnosis and treatment of lower leg wounds.

We have continued to use the CQUIN audit to identify whether patients referred to our Community Nursing teams with a lower leg wound were assessed within 28 days of referral, whether compression therapy was applied appropriately and whether a referral to vascular services had been made where indicated.

This audit assessed compliance with CQUIN requirements for the assessment and management of lower leg wounds within Community Nursing services. Overall compliance has improved from a baseline of 33% in Q4 2024/25 to 38% in Q1 2025/26, peaking at 60% in Q2, with Q3 performance at 42%, remaining above baseline despite increased service pressures.

Timely assessment within 28 days demonstrated sustained improvement compared to earlier quarters, rising from 38% in Q4 2024/25 to 49% in Q3 2025/26, while delivery of appropriate compression therapy has been more consistent, improving from 38% to 60%. Audit findings have directly informed improvement actions, including sharing best practice across teams, introducing toe dopplers to support assessment for patients unable to tolerate ankle doppler measurements, and implementing a RiO tracker to improve oversight of assessments. These actions provide assurance of a targeted and data driven approach to improving quality of care.

Quality Priority 2: Enhancing Patient Experience and Engagement (Linked to Quality Ambitions 1 and 2)

We said we would:

We recognise expanding the types of patient feedback we receive can help our patients feel heard, respected and involved in their care. People nearing the end of their life deserve to receive high quality and compassionate care and should be supported to live well and to die with dignity in a place of their choosing. Offering Advanced Care Plans aims to increase the number of people involved in discussions and decisions about their care.

How did we say we would achieve this?

- **Patient Feedback:** Develop innovative ways to capture and act on patient feedback, such as implementing 'Take Over Days' within Children and Young People Services and continued use of focus groups to help us understand our patient needs and improve services accordingly.
- **End-of-Life Care:** Ensure high-quality and compassionate care for people nearing the end of their life by ensuring patients have advance care plans in place.

We said we would demonstrate success by:

- Patient Experience Strategy developed outlining an increased number of ways that we can capture patient feedback
- Increased number of patients with advanced care plans in place

We have:

Patient Feedback:

- The Trust received 3476 Friends & Family Test results
- There has been an increase in positive patient experience from 96.85% to 97.81%.
- As part of Patient Experience workplan patient representatives have been identified and recruited to support both focus groups and Patient Experience Delivery Group to provide valuable insight from those with lived experience of our services or living with a medical condition.
- 45 Observe & Act Sessions were conducted.
- The Patient Experience Lead is an active member of the National Observe & Act Network Group, where best practices and common challenges are regularly shared.
- SCHT are in collaboration with Severn Hospice to design Observe & Act documentation that will support home visits.
- Focus groups serve as a forum for participants to engage in discussions on pertinent topics, identify opportunities for development, propose actionable solutions, and formulate strategies. The primary objectives include improving patient care and experience, fostering collaborative problem-solving, integrating patient feedback, and advancing service quality.
- The Patient Experience group has been established enabling systematic discussions across multiple topics. These encompass strategies for enhancing patient experience, techniques for incorporating feedback from service users, and measures to address challenges encountered in service delivery.
- Patient feedback is gathered through national benchmarking audits for Learning Disability & Autism (LD&A) and NACEL, and the findings contribute to our improvement plans.

End-of-Life Care:

- Personalised care strengthened through the introduction of a Trust-wide bereavement survey and improved capture of preferred place of care and death, supporting person-centred end of life planning.
- Workforce capability assured via a community nursing survey assessing confidence and competence in palliative, end of life and bereavement care, including ReSPECT and advance care planning, with findings informing a refreshed education and training framework.
- Quality and safety oversight enhanced through participation in the National Audit of Care at the End of Life (NACEL)
- Strategic leadership and governance strengthened by establishing a Palliative and End of Life Care (PEOLC) Steering Group and Task and

Finish Groups overseeing priority programmes, including education, digital care planning within RiO, and workforce competency development.

- Patient and carer experience improved through the development and launch of new palliative care, last days of life and bereavement information resources.
- System alignment and clinical assurance maintained through contribution to the system-wide palliative and end of life care strategy refresh and the review and update of syringe driver documentation.
- The Group have launched a Cancer Ambassador Programme and to date there are 10 staff from Shropcom who will be participating in the programme and initiatives going forward.
- We facilitated a community nursing audit to review the delivery of palliative and end-of-life care. This audit included measuring the implementation of advance care plans across all community services to give us a baseline.
- The results of this audit will be reflected in our Palliative and End-of-Life Care Improvement Plan, supporting our aim to increase the number of patients with advance care plans in place by the 2026/27 period.

Quality Priority 3: Enhancing of Learning Across the Organisation (Linked to Quality Ambitions 1 and 3)

We said we would:

We have identified a need to improve the dissemination of learning from incidents and events to reduce recurrence and highlight the improvements made. By enhancing how we share this knowledge, we aim to foster a culture of continuous improvement and ensure that lessons learned lead to tangible changes in practice.

How did we say we would achieve this?

We said we would enhance the communication of actions and learning from patient feedback, incidents, claims, complaints, and clinical audits across the Trust. This would be achieved by:

- Improving Communication: Developing robust channels and methods to effectively share learning and actions arising from events. This would include the sharing of Quality Improvement projects.
- Standardising Reporting: Implementing a standardised process for reporting actions and learning from incidents and feedback to ensure consistency and clarity.

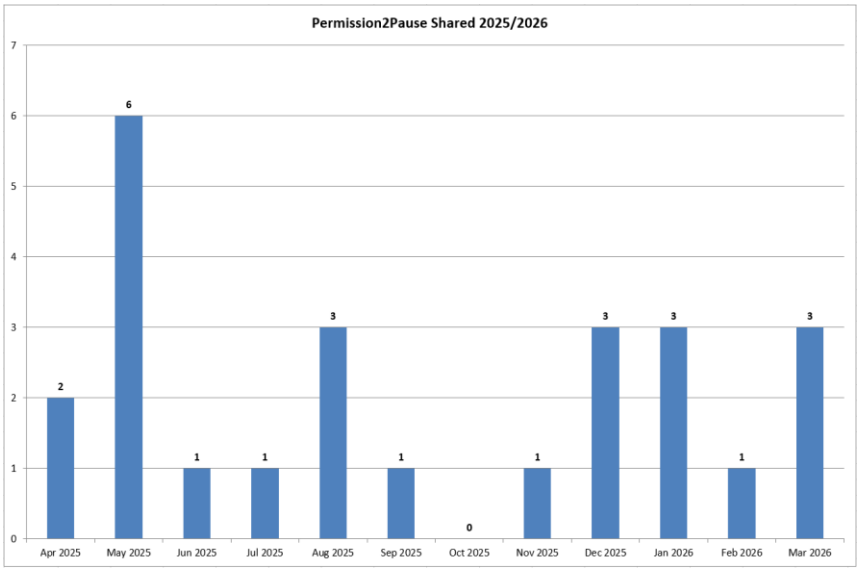
We said we would demonstrate success by:

- Reduced recurrence of themes
- Increased number of Quality Improvement projects shared

We have:

- 27 Quality Improvement projects have been shared in preparation for our Group model celebration showcase event in May 2026 leading to 4 projects being shortlisted for an award on 14th May 2026.
- There are currently a further 25 Quality Improvement projects are ongoing with in Shropcom
- Quality Improvement 1-day fundamental training is continuing to take place throughout 2026, a total of 19 staff attended the training to date
- Quality Improvement 4-day training sessions are due to commence in April 2026, and these dates are being communicated with staff who have attended the 1-day sessions. A total of 7 staff have attended and completed the course to date
- Trends and themes are shared at the system wide discharge improvement group. 98% of service users felt that they were treated with respect, dignity and compassion by staff.
- For the reporting period of 25/26 there were a total of 25 Permissions to Pause across the organisation. Permissions to Pause provide a structured mechanism for sharing learning from incidents, enabling staff to reflect, promote immediate learning, and support improvements in practice across teams and services. (see chart below):

Permission2Pause Shared 2025 / 2026



- We use System Engineering Initiative for Patient Safety (SEIPS) and thematic reviews or clusters of incidents to understand common themes, links or issues to facilitate appropriate learning responses
- In 25 / 26 there were the following reported and discussed:
  - 12 Patient Safety Incident Investigations (PSII'S)
  - 10 After Action Reviews (AAR'S)
  - 7 SWARM Huddles were registered over the year

This range of learning responses evidences a proportionate approach to patient safety, ensuring that our incidents are reviewed using the most appropriate methods to maximise learning and improvement across the organisation.

Part 2.2 Looking forward - Quality Account Priorities 2026/2027

The Trust published its Clinical Quality Strategy 2024 – 2027 with four Clinical Quality Ambitions:

Clinical Quality Ambition 1: Delivering Safe Integrated Care:

- Deliver safe, coordinated community care across all ages through strong partnership working.
- Support people to start well, stay well and die well, focusing on prevention, personalised care and care closer to home.
- Improve outcomes, experience and safety while reducing avoidable hospital admissions and delayed transfers of care.

Clinical Quality Ambition 2: Listening to and supporting the patient voice.

- Ensure patient, family and carer voices shape service design, delivery and improvement.
- Strengthen inclusion of underrepresented groups and enhance equality, dignity and personalised care.
- Improve experience, particularly for children, young people, people with learning disabilities, autism, dementia and their carers.

Clinical Quality Ambition 3: Learning and Improving together.

- Build a culture of continuous learning and quality improvement across all services.
- Equip staff with the skills, confidence and capability to deliver improvement using QI methodology.
- Use learning from audit, research and innovation to drive measurable improvements in care and outcomes.

Clinical Quality Ambition 4: Delivering Equitable and Sustainable Services

- Reduce health inequalities by taking a population health approach and improving access to care.
- Deliver equitable services that meet local and rural needs while supporting people to wait well.
- Provide sustainable, environmentally responsible care supported by digital transformation and modern estates.

In 2026/2027 SCHT will be focusing on:

Priority 1 **Enhancing Patient Safety and reducing harm** ○ Proactive prevention of deconditioning and reducing Falls ○ Focusing on Medication Safety with an emphasis on Syringe driver care delivery & Insulin administration ○ Focus upon Pressure Ulcer prevention & treatment
Priority 2 **Enhancing Patient Experience and Engagement** ○ Providing care closer to home the though the development of National Neighbourhood Health Model ○ Involvement of LD patients / Families
Priority 3 **Enhancing Learning across the organisation** ○ Quality Improvement training ○ Shared learning as a Group

Quality Priorities that support the delivery of these four ambitions. Staff engagement was vital to formulation of the strategy, which took the form of a Trust wide staff survey and focus groups.

Continuing to embed a culture of continuous improvement across the organisation by giving our staff the tools, skills and knowledge to carry our quality improvements will be integral to achieving all priorities.

Quality Priority 1: Enhancing Patient Safety and reducing harm – Linked to Ambitions 1,2 and 3

Proactive prevention of deconditioning and reducing Falls:

Why did we choose this?

Preventing deconditioning across all community services and inpatient settings is pivotal. Deconditioning, caused by inactivity or bedrest, leads to loss of physical, mental, and functional abilities, slowing recovery and raising risks such as falls, infections, and longer hospital stays.

Focusing on prevention improves patient outcomes, lowers fall rates and injuries, shortens hospitalisation, and enhances post-discharge quality of life. It also aligns with NHS goals for safety, high-quality care, and efficient resource use.

How will we achieve this?

To focus on reducing deconditioning and falls we will use a multi-pronged approach: display awareness materials in community hospitals, employ digital screening tools, update documentation, conduct intentional rounding and daily care prompts, and provide ongoing staff training. These steps support proactive prevention, early intervention, and effective monitoring of patient wellbeing.

How will we Demonstrate success?

- Reduction in patient falls per 1000 occupied bed days
- Capture evidence of deconditioning by measuring Clinical Frailty score on admission and on discharge from our planned care community service caseloads
- Pilot of digital Screening tools in UCR and Virtual Ward and completion of digital screening tools to identify risks early.
- Implementation of I-Stumble to improve falls response and initial clinical assessment, with the aim of reducing unnecessary transfers to acute services.
- Implementation of 4AT Delirium screening tool and pilot of Bed Side mobility assessment tool (BMAT)
- Improved quality and accuracy of patient documentation, reflecting early intervention and ongoing monitoring demonstrated through thematic reviews and audits.
- Evidence of regular intentional rounding and daily care prompts in practice.
- Staff engagement and application of enhanced therapeutic observations in daily care delivery evidenced by increased number of assessments and ETOC Behaviour assessment charts.
- Visibility of awareness materials contributing to greater staff and patient understanding of deconditioning and fall prevention.
- We will expand the memory and well being worker role to focus on all patients not just those with a cognitive impairment
- Establish timely shared learning from the NAIF Audit results on a quarterly basis.
- Repeat Falls Under reporting audit in Quarter 3
- Undertake a repeat snapshot audit for falls awareness week in September 2026.
- Following a thorough literature review and assessment of the efficacy of non-slip socks in fall prevention, we have decided to discontinue their use in the inpatient wards.
- We are working in partnership with NHS Wales regarding the potential adoption of the deconditioning dashboard.

Focusing on Medication Safety with an emphasis on Syringe driver care delivery & Insulin administration:

Why did we choose this?

Enhancing safety in medication delivery, specifically regarding syringe drivers and insulin administration. The objective is to decrease patient incidents and minimise harm by supporting best practices in both domains. Planned initiatives include comprehensive staff training, procedure standardisation, and improved documentation to achieve safe and effective medication management.

How will we achieve this?

Working with staff we will create a digital pathway for insulin administration and syringe driver documentation will be developed in the patient's electronic record, standardising, promoting and enhancing patient safety and best practice.

How will we Demonstrate success?

- Reduction in medication-related incidents and harm involving syringe drivers and insulin administration by improvement in medication related QSC metrics.
- Patient records will consistently and accurately document procedures, demonstrating both standardisation and compliance with best practices.
- Evidence of staff training undertaken.
- Positive patient feedback indicating improved safety, comfort, and dignity during medication administration.
- The following Audits will be taking place throughout 26 / 27:
    - Syringe Driver Usage – for referrals between UCR and Community Nurses
    - Medication Audits will include:

        - Safe and Secure Handling of Medicines audit. Annual. Inpatients, MIUs, The Bridge and Sevendale Special Schools, Virtual Wards, Shrewsbury, North West, Whitchurch, Church Stretton, Bridgnorth and Halesfield localities, Dental Service, Vaccination Service, SAIS, District Nursing.
        - PGD Operational audit. Annual. Any service who uses PGDs.
        - PGD Governance audit. Annual. Any service who uses PGDs.
        - Controlled Drugs audit. Inpatients (quarterly); MIUs (annual).
        - Omitted Doses audit. Inpatients. Annual.
        - Community Hospitals Antibiotic Compliance audits. Quarterly.

Focus on Pressure Ulcer Prevention & Treatment:

Why did we choose this?

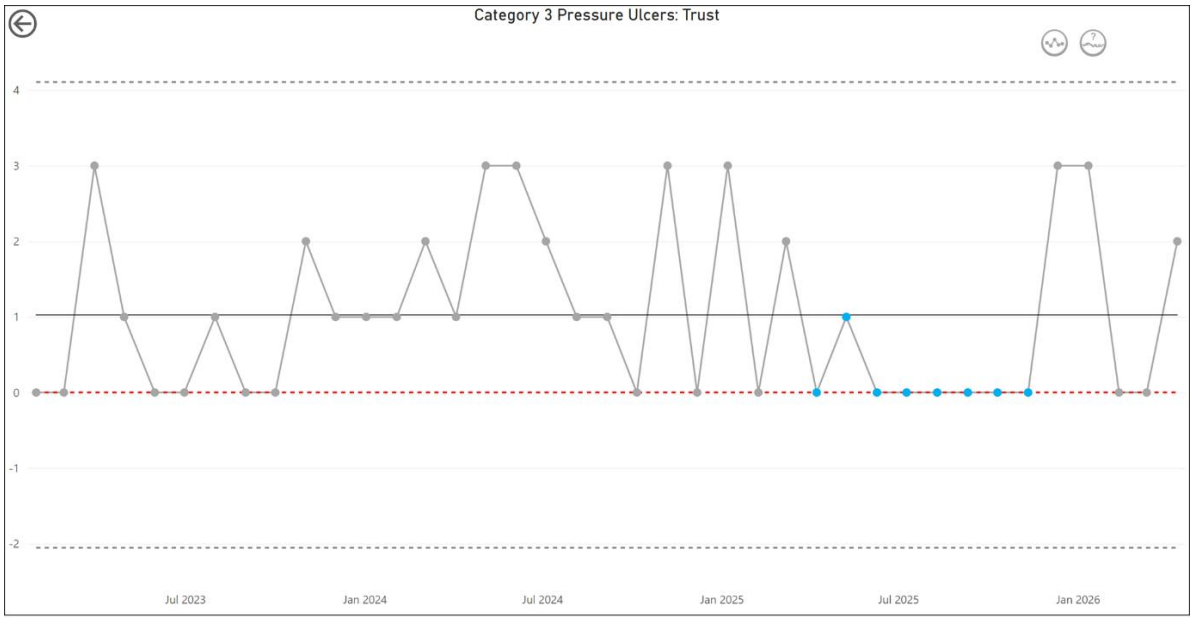
The Trust places a high priority on the prevention and management of pressure ulcers, recognising that these wounds present considerable risks to patient health,

including preventable complications, prolonged hospitalisation, and increased costs. Emphasising harm reduction and adherence to best practice standards enhances patient safety, comfort, and dignity, and contributes to improved clinical outcomes.

How will we achieve this?

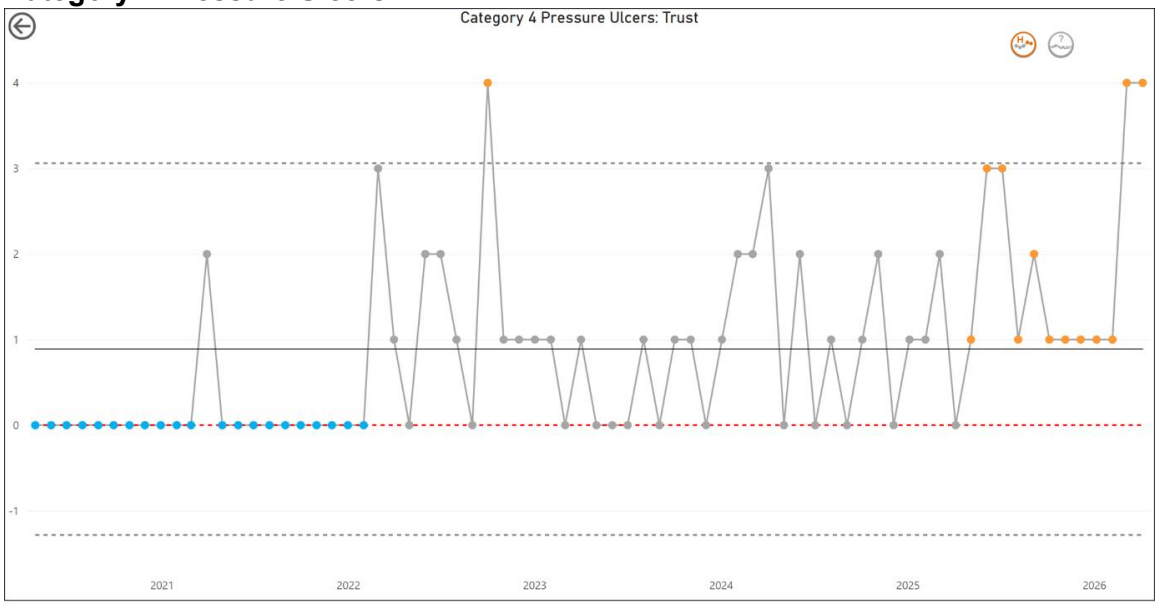
In order to uphold exemplary standards in pressure ulcer prevention and treatment, the Trust will adopt a multifaceted strategy encompassing ongoing staff education, and the implementation of best-practice guidelines grounded in current evidence. By ensuring early identification of patients at risk, staff can apply preventative measures such as appropriate repositioning, use of pressure-relieving equipment, and meticulous skin care. Multidisciplinary collaboration will be encouraged, ensuring that care plans are tailored to individual needs and reviewed frequently. Patient education will also be prioritised, empowering individuals to participate actively in their care and understand the importance of pressure ulcer prevention.
We will undertake a review of our Purpose T care plans to ensure alignment with best practice standards and to further optimise patient care.

Category 3 Pressure Ulcers



There were a total of 9 Category 3 pressure ulcers reported in 25/26.

Category 4 Pressure Ulcers



There were a total of 22 Category 4 pressure ulcers reported in 25/26

How will we Demonstrate success?

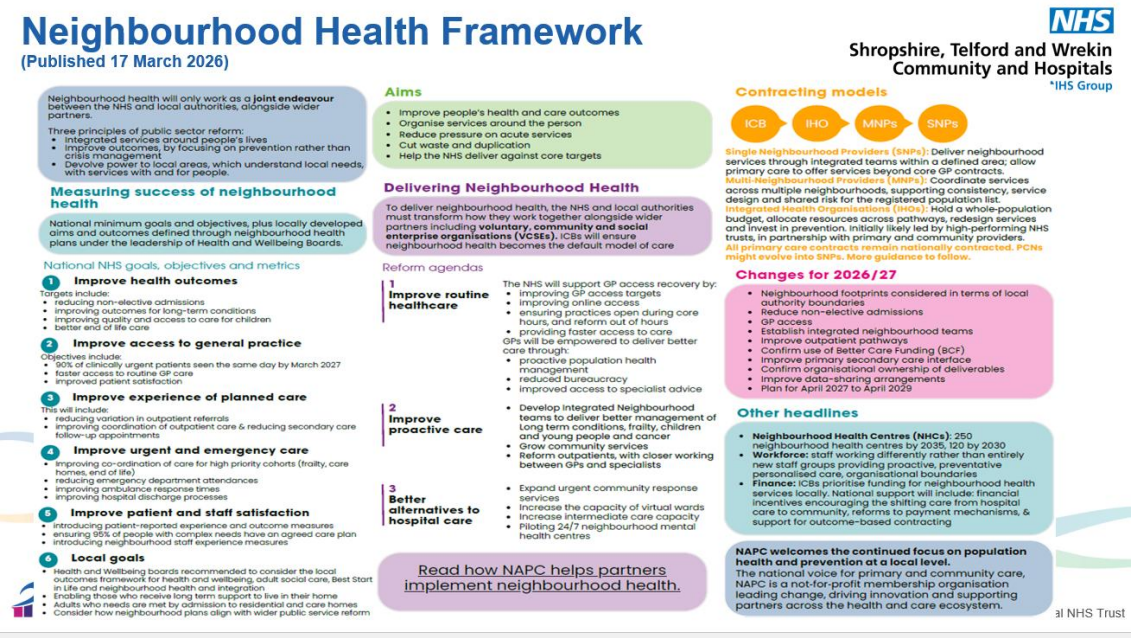
- Evidence of comprehensive staff training and practical application of enhanced skills in daily care routines aiming for 90 % of staff to achieve training compliance by 31.03.2027
- CQUIN 12 - Assessment and documentation of pressure ulcer risk audits and reviews showing safe, effective, and standardised pressure ulcer prevention and treatment practices.
- Positive patient feedback highlighting improved safety, comfort, and dignity during care provision.
- Demonstrable early identification and intervention for patients at risk, supported by tailored care plans and multidisciplinary collaboration.
- Active patient education initiatives, enabling patients to participate in their own care and understand the importance of prevention.
- A reduction on Trust acquired category 3 and 4 pressure ulcers compared to 25/26 measured through Quality and Safety Committee dashboard metrics.

Quality Priority 2 Enhancing Patient Experience and Engagement – Linked to ambitions 1,2 and 4:

Why did we choose this?

The Neighbourhood Health Model approach is beginning to be embedded within the Trust, enhancing patient experience through the delivery of integrated, preventative, and person-centred care by multidisciplinary neighbourhood teams working seamlessly across community, acute, primary care, and wider partners. Care is coordinated around local populations, with prevention and early intervention at its core, thereby improving access to timely urgent and routine services closer to home.

As a result, patients will benefit from smoother care pathways and more cohesive support. This approach will improve outcomes, by reducing avoidable admissions, and strengthening both the continuity and experience of care within our local communities.



How will we achieve this?

We will achieve this by embedding the Neighbourhood Health Model across the Trust, fostering multidisciplinary collaboration and integrating care delivery with a focus on prevention and early intervention. Clinical leadership and evidence-based practice, supported by shared digital records and population health intelligence, will underpin proactive and equitable care. This coordinated approach will enhance patient experience, reduce avoidable admissions, and strengthen continuity of care within local communities.

How will we Demonstrate success?

- Regular analysis of patient feedback, including satisfaction surveys and engagement forums, to assess improvements in patient experience.
- Increased participation from patients and families.
- Evidence of reduced waiting times and improved access to urgent and routine services, demonstrating smoother care pathways.
- Enhanced continuity of care within local communities, as reflected in improved patient outcomes and reduced avoidable admissions.
- For 26 /27 the metrics will be based on the INT Southwest Pilot and focus on the following:
    - Reduction in avoidable hospital admissions and saved bed days per GP practice through avoided admissions
    - Reduction in ED attendances from locality top 10% risk stratified patients
    - Increase in Virtual Ward utilisation

A key focus is on Involvement of Learning Disability (LD) Patients / Families:

Why did we choose this?

Enhancing patient experience and engagement for individuals with learning disabilities is regarded as a quality priority for the Trust, as it directly contributes to patient-centred care, dignity, and safety. The Trust places particular emphasis on ensuring that patients with Learning Disabilities (LD) and Autism and their families receive tailored support and have equitable access to services. Patients with learning disabilities and autism and their families are actively encouraged to participate in feedback forums and support groups, which inform service development and highlight areas for improvement. Prioritising involvement and engagement enable services to remain responsive to diverse requirements, facilitates improved communication and satisfaction, and promotes a culture of respect and inclusion.

How will we achieve this?

To achieve our quality priority of enhancing patient experience and engagement for individuals with learning disabilities and autism, the Trust will place particular emphasis on providing tailored support and ensuring equitable access to services for patients and their families. Active involvement in feedback forums and support groups will inform service development and highlight areas for improvement. This includes the systematic use of the digital Reasonable Adjustments flag within shared care records so that required adjustments are visible, trusted and acted upon at every point of care.

By prioritising responsive and inclusive services, we will strengthen communication, satisfaction, and trust in healthcare, ultimately improving health outcomes within our local communities for all, with particular attention paid to supporting patients with learning disabilities and their families.

How will we Demonstrate success?

- Provide tailored support and ensure equitable access to services for patients with learning disabilities and autism and their families.
- Encourage active participation in feedback forums and support groups to inform service development and highlight areas for improvement.
- Implementation of the national Reasonable Adjustments Digital Flag.
- Strengthen communication, satisfaction, and trust in healthcare for all members of the local community, with particular attention to patients with learning disabilities and their families.
- We will review the national bench marking results in collaboration with SaTH to improve workstreams.

Quality Priority 3 Enhancing Learning across the organisation – Linked to Quality Ambitions 1 and 3

A Focus on Quality Improvement training:

Why did we choose this?

Quality improvement (QI) is central to the Trust's approach to delivering safe, effective and person-centred care and is a core enabler of the NHS IMPACT programme. Through structured QI training and application of improvement methods, staff are equipped to use data, evidence and patient feedback to identify variation in care, test changes and embed sustainable improvements in practice.

By investing in QI capability, the Trust supports a culture of continuous improvement, accountability and shared ownership of quality. This alignment with NHS IMPACT ensures that improvement activity is not episodic, but embedded in everyday practice, driving measurable improvements in outcomes, experience of care for our patients.

How will we achieve this?

We will achieve this by increasing access to, and uptake of, quality improvement training across the Trust, ensuring more staff are equipped with the skills and confidence to apply improvement methods in everyday practice. By expanding training opportunities and embedding QI capability at team and service level, staff will be supported to use data, patient and family feedback, to identify gaps, test change and deliver improvements.

Our participation in the accreditation system for Community Hospitals aims to increase awareness of our organisational strengths and systematically identify areas for further enhancement.

How will we Demonstrate success?

- We will measure the Quality Improvement training impact by the number of completed QI projects throughout the Trust and the staff responses in the NHS Staff survey.
- Measures of success will be in line with the NHS Staff Survey Questions 3d, 3e, and 3f:
    - We will place greater emphasis and enhance communication around staff ability to make suggestions for improvement (**In reference to: Q3d: "Able to make suggestions to improve the work of my team/department"**), ensuring that all individuals are empowered to contribute ideas that drive positive changes.
    - Our training will actively support staff involvement in decisions affecting their roles (**In reference to: Q3e: "Involved in deciding changes that**

affect work") by fostering collaborative environments and inclusive decision-making processes.
    - We are committed to equipping staff with the skills and resources needed to implement enhancements within their areas (**In reference to: Q3f: "Able to make improvements happen in my area of work"**), providing practical tools and ongoing support.

- QI Fundamental one-day training will be offered to all staff, including apprentices and health professional students, further strengthening engagement and capability across all levels.
- QI Fundamental and Practitioner training will be embedded within Specialist Practice Students (SPQ) education, ensuring long-term sustainability of improvement initiatives.
- For 2026/27, we will ensure a minimum of 10 employees complete Practitioner-level training and at least 20 complete Fundamentals-level training, reflecting a measurable commitment to growth and development.
- Fostering a culture of ongoing organisational learning by regularly sharing lessons learned from patient safety incidents and near misses, supporting continuous improvement across departments.

Shared learning as a Group Model:

Why did we choose this?

Shared learning has become a key priority for several strategic reasons. By uniting the strengths and expertise of Shropcom and SaTH, this approach supports service improvements and encourages innovation through collaboration. This initiative is designed to advance patient outcomes and experiences, which are central to our organisation's mission. By focusing shared learning, we aim to build a robust and adaptable service that meets both current and future needs, ensuring our teams are equipped to deliver outstanding patient care.

How will we achieve this?

We will encourage participation in quality improvement activities, such as audits, research projects, and collaborative initiatives, to drive continuous improvement. Staff will be supported to develop leadership skills and take ownership of improvement projects, strengthening engagement and motivation.
Ultimately, our strategy is to foster a culture of openness and shared responsibility, where learning is integrated into daily practice, enabling all teams to deliver outstanding patient care now and in the future.

How will we Demonstrate success?

- Evidence of participation in quality improvement activities including audits, research projects, joint initiatives and awards.

- Staff involvement in leadership development programmes and ownership of improvement projects.
- Regular monitoring of progress using robust assessment tools and patient feedback.
- Adaptation of approaches based on feedback and evaluation to ensure continual development and excellence in care.
- Clear demonstration of a culture of openness and shared responsibility within teams.
- Integration of learning into daily practice, resulting in consistently outstanding patient care.
- With the introduction of our new Incident Management System (DCIQ) in 2026/2027 we will have the ability to automatically inform reporters of the outcome of their reported incidents following review and investigation, removing the requirement for manual responses from the incident handler.
- Measures of success will be in line with improvement to NHS Staff Survey Question 19D Response Feedback given on changes made following errors/near misses/incidents.

Part 3: Quality at the Heart of the Organisation:

This section of the Quality Account will show how we measure our day-to-day work in order to meet the requirements and standards that are set for us and how we evaluate that the care we provide is of the highest standard. Much of the wording of the statements in this section of the Quality Account is mandated by the NHS (Quality Accounts) Regulations.

During 2025/26, Shropshire Community Health Trust provided three NHS services, including Community, Prison and Urgent and Emergency Care Services. Shropshire Community Health Trust has reviewed all the data available to them on the quality of care in all of these health services. The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of NHS services by Shropshire Community Health Trust for 2025/26.

Participation in Audit & Research:

Participation in Local Clinical Audit:

Clinical audit involves improving the quality of patient care by looking at current practice and modifying it where necessary. The Trust is committed to a process of continuous quality improvement in the care and treatment we provide to our service users and recognises clinical audit as a validated and reliable means of achieving this. Audits where areas of non-compliance are identified result in an action plan for improvement, implementation of which is monitored by the relevant Service Delivery Group.

Audits included on the Trust Annual Clinical Audit Programme are prioritised according to a system developed by the Healthcare Quality Improvement Partnership (HQIP).

Participation in Local Clinical Audit: Priority 1 – External 'must do':

National Clinical Audit and the Patient Outcome programme (NCAPOP):

The National Clinical Audit and Patient Outcomes Programme is commissioned and managed on behalf of NHS England by the Healthcare Quality Improvement Partnership (HQIP). The programme comprises audits relating to some of the most commonly occurring health conditions. Participation by NHS Trusts in all relevant national audits is mandatory.

The Trust participated in 4 national audits throughout 2025/26:

National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme Pulmonary Rehab (PR):
The aim of this project is to audit the quality of PR services for COPD and other chronic respiratory conditions in England and Wales. It measures provision against national standards, aiming to improve patient access, completion rates and clinical outcomes.

2025/26 results show the Trust performed strongly on process completion and discharge planning, achieving 94.6% for completing two walk tests at initial assessment (above Midlands 82.3% and National 77.0%) and 100% for written individualised discharge exercise plans (above Midlands 93.9% and National 93.0%). Two-walk tests were only introduced by the service in April 2025, so performance against this indicator is very encouraging. Timeliness for starting PR within 90 days is 68.0%, which is below Midlands (73.3%) and National (72.1%) but above the Trust's 2024/25 figure (63.3%). Discharge assessment completion is 82.5%, exceeding both Midlands and National (each 66.8%), although the Trust's 2024/25 figure is higher still (89.9%). Outcome measures show lower improvement rates than regional and national comparators: 46.8% achieved Minimal Clinical Important Difference (MCID) in at least one walk test at discharge (vs 60.6% Midlands and 58.1% National) and 56.4% achieved MCID in at least one health status questionnaire (vs 80.3% Midlands and 76.2% National), with the Trust's 2024/25 figures at 62.9% and 66.7% respectively. Current patient information leaflets are being revised and will be combined into a single information booklet.

National Audit of Care at the end of Life (NACEL). Inpatients:
NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission to hospital.
The Trust's results for 2025 showed strong performance on several key indicators when compared with the peer group, country and the overall NACEL sample. Recognition of dying was notably strong: a higher proportion of deaths were expected in the final admission (97.9% vs peer group 89.2%, country 87.9% and

sample 87.1%), and SCHT has improved markedly since 2024 (98% vs 79%), with shorter average times from admission to recognition of dying (356 hours vs 530 hours in 2024) and from recognition to death (132 hours vs 208 hours). Communication about hydration is also above benchmark, especially with those important to the person (87.2% vs peer group 75.3%, country 76.0% and sample 74.5%), and case-note evidence of hydration review is strong (100% vs peer group 95%), improving from 68% in 2024. Symptom management is mixed: pain and agitation review are high (both 96%, broadly in line with peers) and actions are consistently implemented (100%), but dyspnoea review is below the peer group (85% vs 93%). For determining appropriate interventions, anticipatory medicines being prescribed for likely symptoms is lower than peer performance (89.1% vs 97.3%) despite improvement since 2024 (76%), while individualisation of anticipatory prescribing is very strong (98% vs 95% and up from 85% in 2024), and documented active decision-making remains slightly below the peer group (92% vs 94%) but improved from 68% in 2024. The most prominent gap remains personalised care planning: participation in advance care planning conversations is very low (6% vs peer group 58%) and discussions about the likelihood of dying with the person are also lower than peers (60% vs 82%), although communication with those important to the person is high (94% vs 96%) and improved from 63% in 2024. Equity indicators are strong for ethnicity documentation (100% vs 94.8% comparators). Overall, SCHT 2025' audit demonstrates sustained and, in places, substantial improvement since 2024, with strengths in recognising dying and key communications, while priorities include anticipatory prescribing rates, dyspnoea review, and strengthening patient involvement in advance care planning and conversations about dying.

National Diabetes Foot Audit (NDFA). Podiatry:
The NDFA enables diabetes footcare services to measure their performance against NICE clinical guidelines and peer units and to monitor adverse outcomes for people with diabetes who develop diabetic foot disease.
Trust results for 2025/26 show that compared with national averages, a higher proportion of cases were recorded as less severe ulcers (68.3% vs 57.4%) and that more patients self-referred (41.5% vs 31.4%), but that fewer patients were seen within 0–13 days (54.2% vs 68.7% nationally). Outcomes at 12 weeks were better than the national average (53.7% alive and ulcer-free vs 42.7% nationally), although this represents a slight decline from the Trust's 2024/25 position (59.3%). Actions for improvement are focused on maintaining a safe skill-mix by allocating suitable high-risk patients to a Band 4 assistant practitioner with clear safety-netting and escalation, improving patient engagement through a pressure-plate system to visualise ulceration risk, and further embedding and promoting the duty podiatrist role to enable quicker remote triage and timely intervention, alongside regular face-to-face support and liaison with community nursing teams.

National Audit of Inpatient Falls (NAIF). Inpatients:
This audit examines the quality of falls prevention prior to a fall on our inpatient wards and the immediate post-fall management against the Multifactorial Assessment to Optimise Safe Activity (MASA) key performance indicator (KPI). For

2025, the scope of NAIF was expanded from patients who sustained a femoral (hip) fracture whilst in hospital to include those who sustain any fracture, spinal, or head injury. Trusts are now responsible for identifying eligible cases which, has been included within the portfolio a Clinical Lead for Quality supported by the Clinical Effectiveness Lead. Three cases within SCHT were identified for inclusion for the 2025 audit: 2 fractures and 1 Head Injury. Areas for improvement from these incidents has been shared with key stakeholders including ward MDT members (Medical, Nursing and Therapy); QI team; Head of AHP's; Patient Safety and Risk Management and Clinical Effectiveness. The Trust would benefit from a dedicated Falls Lead as NAIF expectations for the 2026 audit is for quarterly KPI reporting, rather than just the annual reporting. NAIF have published recommendations that there is an organisational capacity for a Board member with responsibility for falls and a Trust Falls Lead.

NHS England (NHSE) Learning Disability Improvement Standards project (Year 7). Adults Services:

The project evaluates organisational compliance with NHSE Learning Disability Improvement Standards to find improvement opportunities. The findings show that, across Standards 1–3 (Respecting and Protecting Rights; Inclusion and Engagement; Workforce), the Trust's results are broadly aligned with national and peer organisation positions, with variation across individual measures highlighting areas of relative strength and areas requiring further development. These include strengthening of policies, training and education. From April 2026 onwards a new champion group will be formed with SaTH in light of the new group model, to align actions on improvement plans and give the opportunity for joint working.

Leaving Care Health Summaries. Children in Care Service:

This biannual audit is required by Commissioners to provide assurance in relation to the quality of Leaving Care Health Summaries. The results showed full compliance with the majority of audit standards including a summary of medical history and immunisations being recorded, the young person being registered with a GP and health promotion being offered.

Priority 2 – Internal 'must do':

Initial Health Assessments for Children in Care (CiC). Community Paediatrics:
This is a biannual audit aimed at improving the quality of initial CiC health assessments. Results show that the overall standard of recording remained high, with the majority of assessments rated good/outstanding and demonstrating clear, comprehensive use of available information. A very small number of assessments were rated inadequate due to insufficient depth, limited evidence of the child's voice, and incomplete/absent sign-off. Recommendations are to continue auditing with timely feedback to clinicians, sustain and reinforce trainee doctor training (including emphasis on quality at Induction), ensure trainee reports are routinely reviewed by supervisors to support progression from good to outstanding, and maintain

escalation with external stakeholders where referral/history information is missing so that assessments can be fully completed with SMART action plans.

Review Health Assessments for Children in Care (CiC). Children in Care Service:
This biannual audit uses a quality assurance tool to review assessment documentation. Between 98%-100% of review health assessments were rating as Good overall, with full compliance on many measures including recording of the child's/young person's wishes and feelings, carers' views being sought, GP registration and the child/young person being given the opportunity to be seen alone by the nurse. An improvement was observed in the proportion of children/young people being asked the question "Who is important to you?".

New Early Warning Score (NEWS2). Inpatients:
The aim of this audit was to identify adherence to the Trust policy on NEWS2. Results over repeated data collections during the year show that NEWS2 charts were initiated for all patients in the audit cohorts, and that improvements were made in the recording of air/oxygen, pulse, consciousness and temperature observations, although the recording of total NEWS2 score remained low at 78%. Adherence to the required frequency of observations based on NEWS2 scores of 0 improved as did that for scores of 1-4, although compliance remained below the expected standards. Improvement also needs to be made in the frequency of observations and adherence to escalation protocols for scores of 5 and above.
Improvement actions focus on making observation compliance easier to track and improve in real time, including introducing ward "production boards," fortnightly spot checks with feedback, and a buddy system for new staff during observation rounds. They also include strengthening monitoring and longer-term reliability through an MS Forms compliance tool, progressing a digital/eObs solution (target Q2 2026/27), and reinforcing practice via training follow-ups, safety huddle prompts, and a NEWS2 prompt added to the nurse-in-charge checklist.

Dental and Immunisation update. Children in Care Service (CiC).
The audit found that found that 77% of children and young people in care were up to date with six-monthly dental checks and 70% with their immunisations. Uptake was higher in Shropshire County than in Telford & Wrekin, particularly for immunisations. Reported delays were most often linked to placement changes, children awaiting (or declining) initial/review health assessments, missed appointments, and data/recording issues (with the 'other' category more common than anticipated). The action plan focuses on addressing these barriers and improving the accuracy and timeliness of recording.

Mouth care audit. Inpatients:
The project included a patient records audit, a mouth care products questionnaire for Ward Managers, and a patient survey using the NHS England Mouth Care Matters toolkit. Results found that mouth care assessment on admission was low (23%) and documentation was inconsistent (oral problems 35%, mouth care in last 24 hours 59%, own products 22%), with limited escalation of concerns (29%) and that only

half of care plans recording the required support. All wards stocked basic mouth care products but only one provided non-foaming toothpaste for patients with swallowing difficulties. Patient feedback suggested many were not asked about their mouth care needs and bedbound patients did not reliably receive daily help with brushing. Improvement actions focus on adopting new assessment documentation, integrating mouth care documentation into the holistic assessment and MUST screen tool on Rio, revising the Mouth Care policy and developing a SOP (Standard Operating Procedure), and ensuring wards stock all required mouth care products.

Hydration audit. Inpatients:
The audit results showed that 63% patients had a fluid balance chart in place, 40% within 24 hours of admission. In addition, charts were often not continued for long enough (only 36% continued for at least 3 days), and for patients drinking under 2.5L/day charts were rarely maintained throughout admission or documented on handover.

Catheter re-audit. Inpatients:
Re-audit findings showed that most catheters were inserted prior to admission, but the reason for catheterisation was only documented in 64% of cases. Completion of the catheter care pathway document had declined but where pathways were completed, this was mostly recorded in Rio (electronic patient record). Catheter assessments were often delayed by several days and early holistic assessments missed essential catheter details. Overall assessment quality was variable, with important information often missing and a consistent absence of completed catheter care documents/pathways in the records reviewed.

PICC (Peripherally Inserted Central Catheter) lines documentation audit. Infection Prevention, Education and Training Team:
This audit was undertaken within our Community Nursing teams. Overall compliance with audit criteria was low, with most measures achieving less than or equal to 69%. The only areas with high compliance were documentation of device type (94%) and clinical reason for PICC (85%), while key IPC practice/documentation elements (e.g., bare below elbows, hand hygiene, PPE use, VIP scoring, hub/port decontamination and dry time) were inconsistently evidenced.
Improvement priorities are to standardise PICC documentation in Rio (via a vascular device form/template with device type dropdown) and improve data quality by training staff on correct coding and rationalising activity codes. In parallel, strengthen clinical governance by providing vascular device training with competency sign-off, producing a vascular devices policy/SOP, reinstating self-audits, and reviewing the most appropriate setting for PICC care

Clinical assessment re-audit. Inpatients:
The aim of the audit was to identify whether documentation of key clinical assessments had improved on our wards. The results showed that compliance had decreased in relation to 12 out of 20 audit standards. The recording of lying and standing BP remained unchanged at 20% and a fluid balance chart was in place in only 15% of cases. A small improvement in admission documentation being fully

completed was identified although compliance remained low at 65%. ReSPECT forms were more consistently documented in admission assessments, and more malnutrition assessments were carried out within 24 hours of admission. Full compliance was achieved in relation to the documentation of care provided in the previous 24 hours.
Admission assessments have been observed, and current digital and paper documentation on each ward is being reviewed. An admissions SOP and staff crib sheet will be developed. A Bishops Castle site visit investigated cannula use and bed rail assessment compliance. Monthly meetings with Ward Managers will review audit, CQC, and incident data. Ward Managers will ensure pressure ulcer cases are referred to Tissue Viability and Datix is completed. A brief staff survey will identify barriers in assessment processes.

Medicines Management audit – Severndale Specialist Academy School:
The audit assessed practice against the joint Severndale/SCHT School Medicines Policy, SCHT medicines policies, relevant SOPs and the Safe and Secure Handling of Medicines audit tool. It reviewed medicines documentation and inspected storage facilities used by the Special School Nursing Team (SSN), identifying five non-compliances across 41 criteria. Overall compliance was 100% for storage/safety/security (up from 89% due to evidenced cleaning), 85% for documentation (down from 100%), 100% for controlled drugs, 63% for temperature monitoring (down from 100%), and 100% for disposal and administration. Improvement actions include ensuring all Special School Nursing staff have read and signed required SOPs, that the current version of MAR is in use, that staff read and follow temperature recording SOPS and that they know how to reset fridge thermometers. This audit is undertaken annually.

Medicines Management audit – The Bridge School:
This audit assessed SCHT Special School Nursing (SSN) arrangements in accordance with the Bridge Medicines Policy, SCHT medicines policies, relevant SOPs and the Safe and Secure Handling of Medicines audit tool, via a review of medicines documentation and inspection of SSN-accessible storage. Eight non-compliances were identified across 39 criteria Overall compliance was 89% for storage/safety/security (89% in 2024/25), 64% for documentation (82% in 2024/25) and 25% for controlled drugs (50% in 2024/25). Storage issues were the main driver of reduced performance in storage and controlled drug domains, and procurement of a new ambient temperature cupboard is expected to improve compliance towards 100%.

Participation in Clinical Research:

The number of patients receiving relevant health services provided or sub-contracted by Shropshire Community Health Trust in 2025/26 that were recruited during that period to participate in research was 341.

The Trust is committed to providing its population with evidenced based care and believes that all service users, care givers, and staff should have the opportunity to participate in Research and Innovation (R&I).

- The R&I department undertook 18 studies in 2025/26 and recruited 341 participants into research, overperforming in several of these studies: an excellent outcome for the team.
- The R&I department undertook studies in over 11 different services which has increased from the 5 services originally involved in research.
- There are currently 4 research studies in the feasibility and set-up phase.
- We have one commercial study open.
- The research team are supporting a national early diabetes screening programme for children aged 2 years to 17 years; Shropcom have overperformed in the delivery of this study, becoming one of the top recruiters in the West Midlands. As a result, the team have been approached by the sponsor to become a partner within their strategic funding bid
- The Staff Research Champion initiative has continued to be well received by Trust staff in all departments. This initiative enables the research delivery team to take research opportunities to patients and local communities across all Trust services. We have continued to support other NHS Trusts in setting up similar schemes within their own organisations. The Research web page on staff zone is frequently updated to provide Trust staff an overview of what is happening within research in the Trust. There are also ongoing Continuous Professional Development (CPD) opportunities to develop staff knowledge of clinical research in health and social care posted on the web page.
- Bitesize research seminars that will help those clinicians working towards Advanced level fulfil pillar four (research and evidence), are being facilitated by the research team. These are being delivered virtually via MS teams to improve accessibility for staff.
- The R&I department have successfully achieved Regional Research Delivery Network (RRDN) strategic funding for the 'Shropshire Research Map' project – working across the geography with SATH, MPFT and RJAH to map Principal Investigator and Pharmacy provision for the delivery of research in collaboration
- We are members of the North-West Midlands Hubs of the Commercial Research Delivery Centre and of the Vaccine Innovation Platform both NIHR funded initiatives to grow the commercial research across Shropshire, engaging with all our communities bringing the research offer to them
- We continue to work closely with MPFT, UHNM, NSCHT, SATH and RJAH as members of the Staffordshire and Shropshire, Telford and Wrekin Health Research Partnership (SSHERPa) providing leadership through the system as a founding member of the partnership and sitting on the combined ICS R&I committee

Commissioning for Quality Improvement (CQUIN):

NHS England suspended the nationally mandated CQUIN framework in 2024/25, however, non-mandatory quality indicators remain available, and the Trust has continued to collect data for the projects listed below throughout 2025/26.

Assessment and documentation of pressure ulcer risk CQUIN12. Inpatients.
This audit looks at whether patients have received a pressure ulcer risk assessment on admission to hospital and whether any risks identified have been managed effectively and in accordance with national guidance.
Across the four reported quarters, overall CQUIN12 compliance has remained below the 80% target and has been variable. Indicator-level performance shows that completion of the Purpose-T risk assessment is consistently high (undertaken in 97% in Q4, 97% in Q3, 92% in Q2 and 97% in Q4 2024/25), but timely completion within 6 hours is lower and has reduced in Q4 to 60% (vs 76% in Q3, 74% in Q2 and 78% in Q4 2024/25). For care planning, a plan was in place for 88% of at-risk patients in Q4 (vs 94% in Q3 and Q2, 95% in Q4 2024/25), and completion within 24 hours was 72% in Q4 (vs 86% in Q3, 92% in Q2 and 92% in Q4 2024/25). For documented actions, the main contributor to low overall compliance is the quality/completeness of documentation. Overall, while assessment completion remains strong, improvements are required in timeliness and in documenting comprehensive, personalised and SMART care planning to achieve the CQUIN standard.

Assessment and diagnosis and treatment of lower leg wounds CQUIN13.
Community Nursing:
This is an audit to identify whether patients referred to our Community Nursing teams with a lower leg wound were assessed within 28 days of referral, whether compression therapy was applied appropriately and whether a referral to vascular services had been made where indicated.
Overall compliance has fluctuated across the last four quarters, reducing in Q3 2025/26 to 42% after a peak in Q2 2025/26 of 60%, but still up from 38% in Q1 2025/26 and 33% in Q4 2024/25.
At indicator level, performance shows leg wound assessment within 28 days in Q3 was 49%, down from 64% in Q2 but up from 45% in Q1 and 38% in Q4, and appropriate compression therapy (where applicable) was 60%, down from 67% in Q2, but the same as 60% in Q1 and up slightly from 38% in Q4. Referral to Vascular services (where indicated) was 36%, down markedly from 70% in Q2, 76% in Q1 and 67% in Q4.
Improvement actions have included sharing of the Telford teams' good practice across the Community Nursing service, purchasing toe dopplers for use with patients unable to tolerate ankle dopplers and development of a tracker in Rio to help identify missed assessments.

Malnutrition screening for community hospital inpatients CQUIN14. Inpatients.
For this CQUIN, malnutrition risk screening should be undertaken within 24 hours of

admission and, where indicated, a treatment plan initiated with actions or goals acted upon.
Across the four reported quarters, overall compliance has been variable and remains below the 90% target. Indicator-level results suggest that screening performance remains comparatively strong, with the MUST screen completed for 95% of patients in Q4 and 76% completed within 24 hours (vs 86% in Q3). Care planning for those identified at risk (MUST > 0) also remained high, with a care plan initiated for 91% of relevant patients in Q4 (vs 100% in Q3). The reduction in overall compliance in Q4 appears to be driven primarily by Indicator 3 (evidence that actions/goals within the management plan are acted upon and documented to the required standard), with nutritional support actions evidenced in 57% of applicable cases (vs 100% in Q3) and only 43% of care plans having all actions recorded as SMART (although this is an improvement from 30% in Q3). Overall, the main improvement opportunity is strengthening documentation and follow-through of actions/goals for at-risk patients to sustain compliance.

Patients readmitted to hospital within 28 days of a hospital discharge:

During 2025/26 the percentage of patients aged 0-15 years old, readmitted to the hospital within 28 days of discharge was 0% and for 16+ years old it was 11.7%.

No of Discharges	1578
No of Re-admissions within 28days	184
% Re-admissions within 28 days	11.7%

Shropshire Community Health Trust considers that these percentages are as described for the following reasons:

- No comparative data is currently available.
- Data includes readmissions from Shropshire Community Health Trust to the acute Trust where secondary care intervention is required before the patient is readmitted to the Trust

Shropshire Community Health Trust will take action to improve this percentage by:

- Improving understanding of readmission rates linked to transfers back to the acute Trust that require secondary care intervention and readmission.

Patients admitted to hospital who were risk assessed for venous thrombus embolism (VTE):

All inpatients should undergo a risk assessment for VTE to reduce their risk of Venous Thromboembolism (VTE) and Deep Vein Thrombosis (DVT). The risk assessment aims to help healthcare professionals identify people most at risk and describes interventions that can be used to reduce the risk of VTE. The target is 95% for patients admitted to our Community Hospitals must be assessed for the risk of developing a VTE.

National guidance, acute trusts are required to record VTE, while Community Trusts are not mandated to do so., however the Trust is currently working on all services accessing the digital assessment tool and the results of this will be recorded in 26/27.

Infection Prevention and Control:

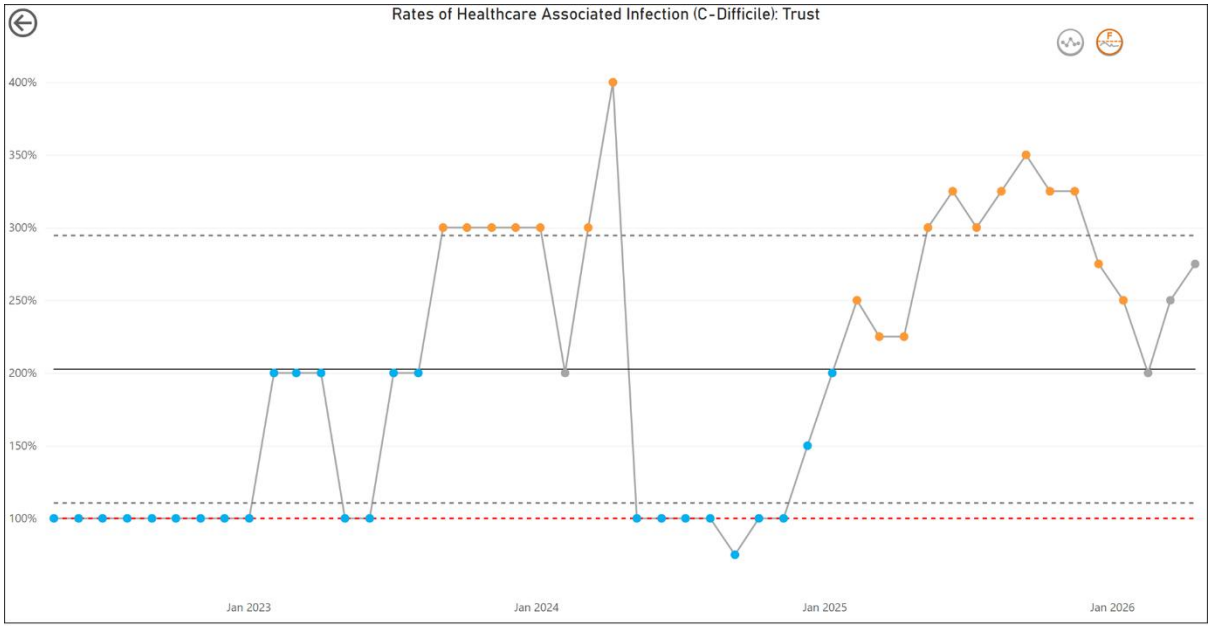
Shropshire Community Health NHS Trust Infection Prevention Education and Advisory Team (IPEAT) delivered a robust programme of assurance, surveillance and improvement activity throughout 2025/26, supporting compliance with the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and maintaining a clear focus on patient safety.

During 2025/26, the Trust recorded zero cases of MRSA bacteraemia, *E. coli* bacteraemia, *Pseudomonas aeruginosa*, *Klebsiella* species, MSSA, CPE or VRE bacteraemia. This continued absence of bloodstream infections demonstrates sustained effective infection prevention practice across the Trust's community inpatient services.

The Trust recorded 11 cases of Clostridioides difficile (C. difficile) infection during the year, exceeding the locally agreed threshold of four cases. All cases were subject to individual case review to identify learning. Many involved patients with complex clinical histories, including previous C. difficile infection, recent antibiotic use and significant co-morbidities. The Trust continues to monitor trends through a rolling 12-month surveillance approach and quarterly thematic reviews. Actions to reduce the risk of further cases included a rolling deep cleaning programme of inpatient areas, strengthened antimicrobial stewardship, and continued implementation of guidance to support the deprescribing of long term Proton Pump Inhibitors where clinically appropriate. Learning from case reviews was shared across clinical teams and system partners to support improvement.

As a Trust, we do not currently measure the incidence rate of C. difficile infection per 1000 bed days. However, we do monitor a rolling 12-month count of cases (please see graph below).

Rates of Health Care Associated Infection (C-Difficile)



The Trust aims to screen at least 97% of eligible patients for MRSA on admission each month. The average screening compliance for 2025/26 was 97%, meaning the Trust met its annual target overall, despite some monthly variation. Ongoing monitoring and feedback to teams supported timely improvement where compliance dipped below threshold.

IPC compliance is monitored through quality assurance audits, training compliance, incident reporting and divisional oversight, with performance reported to the Infection Prevention and Control Committee. During the year, the Trust implemented an electronic audit system across inpatient areas, improving consistency, visibility and ownership of IPC actions. IPEAT also introduced supportive visits to clinical teams. These visits focused on relationship building, real time advice and early identification of issues, with written feedback provided to team leads to support local improvement.

In preparation for winter pressures, IPEAT launched a Trust wide winter campaign, *"Protecting Patients Starts With You – Be Winter Ready"*, aligned with NHS England winter planning guidance. The campaign focused on outbreak prevention and management, early escalation, respiratory hygiene, and consistent use of outbreak documentation. Scenario based training was delivered to build staff confidence, using learning from previous winters.

Shropshire Community Health NHS Trust remains fully committed to protecting patients from avoidable harm through the consistent delivery of high quality infection prevention and control practice. Throughout 2025/26, the Trust has continued to strengthen its surveillance, assurance and education programmes, learning from incidents and responding proactively to emerging risks.

Information Governance:

For the 2024/25 assessment year, the Trust completed the Data Security and Protection Toolkit (DSPT) using the Cyber Assessment Framework (CAF) aligned approach, which reflects the National Data Guardian's data security standards and NHS England guidance. The Trust's published position for this period was "Approaching Standards", supported by an agreed improvement plan and ongoing risk management.

For the 2025/26 assessment year, the Trust will again complete an annual CAF aligned DSPT self-assessment, supplemented by an independent external audit undertaken by MIAA, in line with NHS England requirements. The final assessment outcome and compliance status will be formally approved and published by 30 June 2026.

The CAF aligned DSPT adopts an outcome focused, principles-based approach, requiring organisations to demonstrate that appropriate people, processes, and technologies are in place to manage cyber and information governance risks to essential functions. Rather than mandating prescriptive controls, the framework relies on informed judgement and proportionate assurance, supported by evidence mapped to indicators of good practice and assessed against defined levels of achievement for each contributing outcome.

In line with DSPT/CAF guidance, the Trust applies a best practice, risk-based approach to assurance activities, including clinical coding audits, ensuring that arrangements are proportionate, documented, and capable of demonstrating effective control and continuous improvement against the required outcomes.

Incident reporting:

The Trust monitors all incidents using a local incident reporting system called DatixWeb and has continued to use PSIRF to review and manage incidents to foster a collaborative learning environment. All incidents are categorised whereby relevant subject experts and line managers are notified via email to ensure review, comment and action. In addition, a Patient Safety Incidents Panel (PSIP) meets weekly to review incidents which have been flagged for concern and/or are moderate harm and above to identify an appropriate learning response. The meeting is chaired by the Director of Nursing or Deputy Director of Nursing and has representation from senior clinicians and the ICB.

7488 incidents were reported in 2025/26 demonstrating a further increase in reporting. This can be attributed to the positive reporting culture of employees and the increase of services provided.

The Trust receives a quarterly patient safety events data publication from NHS England. This data demonstrates in number of incidents reported per 1000 care contacts:
Q1 – incidents reported: 1504 which equates to 6.6 incidents per 1000 care contacts
Q2 - incidents reported: 1541 which equates to 6.7 incidents per 1000 care contacts
Q3 - incidents reported: 1574 which equates to 6.7 incidents per 1000 care contacts
Currently Q4 is unavailable for reporting. This will be published in June 2026.

As part of the Trust's transition to PSIRF, the review of Patient Safety Incidents follows an alternative methodology; with an emphasis on the use of System Engineering Initiative for Patient Safety (SEIPS) and thematic reviews or clusters of incidents to understand common themes, links or issues to facilitate appropriate learning responses. Where a learning response has been agreed, the response will follow the appropriate guidance and process outlined in the relevant documentation.

12 Patient Safety Incident Investigations (PSII'S) were registered over the year; 1 related to a Prison Death, 2 related to medication in an inpatient setting, 1 in the Community Services and 1 to the School Aged Immunisation Service, 2 related to Pressure Sores in the Community Services and 1 in the Community Hospitals, and 3 related to Patient Treatment/Discharge in the Community Hospital and 1 related to the Community Services.

10 After Action Reviews (AAR'S) were registered over the year; 2 across Clinical Governance, 3 across Community Nursing, 2 related to Community Hospitals, 1 related to Recovery and Rehabilitation Unit, 1 related to Virtual Ward and 1 involving HMP Stoke Heath.

1 Multi-Disciplinary Team (MDT's) was registered which involves discussions with system partners; 1 involving Community Hospitals.

7 SWARM Huddles were registered over the year: 1 involving MIU, 2 across Community Nursing, 1 involving Community Therapies, 1 related to Community Hospitals and 2 across Urgent Care Response/Virtual Ward.

Falls:

The SCHT Falls task and finish group met five times in 2025/26 and has expanded its stakeholders. In 2025/26 we scoped current practice against NICE guidance and identified areas for improvement. One improvement is that Pharmacy teams are now referring patients for a structured medication review upon discharge. The Clinical Lead for Quality with falls within their portfolio continues to attend the Regional Falls Network; now attends SaTH Falls Steering Group and the re-established Integrated Care Board (ICB) Falls Steering Group.

We have established what assessment templates and outcome measures are built within RIO electronic patient record system, what are used in practice and what are still used within paper formats. We have highlighted what elements of the National Audit of Inpatient Falls (NAIF) recommended Multifactorial Assessment to Optimise Safe Activity (MASA) elements that are included in our current RIO assessment templates and identified the gaps. We have gained consensus about SCHT approved outcome measures agreeing that the Rockwood Clinical Frailty Scale (CFS) is a minimum measure for all patients and ideally, if therapists are involved moving towards consistent use of the Tinetti gait and balance assessment to quantity falls risk. We have built in RIO and piloted the 4AT delirium screen and built the Bedside Mobility Assessment Tool (BMAT) for Nurses which, is now ready to go live in 2026/27.

As part of National Falls Awareness week 15-19th September 2025 we completed a snapshot audit of SCHT Inpatient Wards falls admission documentation and falls pathway. We have surveyed Nursing & AHP Confidence and Competence for Falls Assessment. A falls under-reporting audit was conducted as a snapshot audit for October and November 2025 which, established most staff, 72% (13) believed someone else reported the last patient fall on their ward, whilst only 15% (4) recalled they reported it themselves. Confidence in reporting is generally high; where the staff member reported the fall themselves 75% were 99-100% confident that they had completed the Datix report. Where the staff member recalled someone else reported the fall 77% were 99-100% confident that it had been reported on Datix. The current SCHT community services offer for falls patients has been mapped out and presented to the ICB Falls Steering Group Chair, Strategy Development Manager. Scoping the task and finish group and data from audit and surveys will drive our improvement priorities for 2026/27.

Pressure Ulcers:

PURPOSE T has been successfully launched across all nursing teams, including community hospitals. A rolling programme of training is underway to reinforce pressure ulcer classification, and the effective use of PURPOSE T. Pressure ulcer training has been agreed as mandatory, and work is in progress to add this to ESR as a virtual training package.

The Tissue Viability Team continues to deliver bespoke training sessions to identified ‘hot-spot’ areas where higher incidences of pressure ulcers are reported. This supports teams to ensure pressure ulcers are recognised and managed effectively.

Targeted support is also provided by the Lead Nurse to ensure incident reporting is consistent and accurate. This is reported through the Patient Safety Committee/Reporting Group, with any issues escalated as required. Bi-annual

thematic reviews are completed to identify themes and agree actions to address pressure ulcer-related issues.

Patient Safety Incidents and the percentage that resulted in severe harm or death:

Of the 7488 incidents reported during 2025/2026 of those 33 resulted in severe harm or death (0.44%). This is a reduction from 2024 /2025 where the percentage was 1.08%

The aim for 2026 / 2027 is to continue reducing the number of incidents resulting in patient harm.

Patient Experience / Complaints/ Observe & Act / Volunteers / Impatient Survey's / Focus Groups:

Inpatient Surveys:

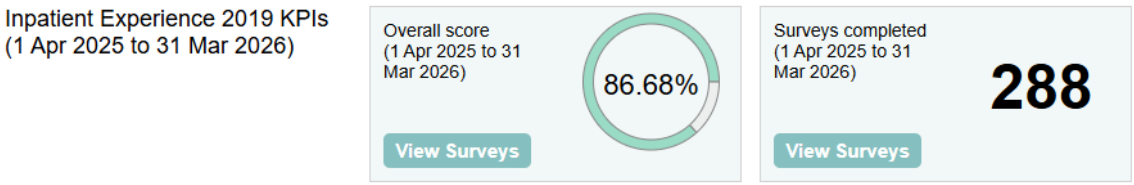
Compared to the previous year, we have seen a 4% rise in positive feedback from our inpatients. Discharge experience continues to receive the lowest score.

Shropshire Community Health Trust are collaborating with Shrewsbury and Telford Hospitals through the Patient Experience and Expectation Discharge Workstream, aiming to enhance the overall discharge process for patients. To ensure comprehensive feedback, several teams including Patient Experience, Complaints, Care Transfer Hub and Volunteers are involved in sharing insights.

Our objective is to create a discharge booklet that patients receive before leaving the hospital. This resource will allow them to record what matters most to them, facilitating meaningful conversations with healthcare staff about their concerns or uncertainties regarding life at home post-discharge. The booklet is designed to address both significant and seemingly minor details, such as whether someone is aware they are returning home or if the heating will be turned on, which can greatly influence their comfort and wellbeing. By providing patients with this booklet, we hope to empower them, promote clear communication, and ultimately improve their discharge experience.

The initial version of the discharge booklet is complete, and the teams are currently in process of reviewing. We are dedicated to making continuous improvements to ensure the booklet effectively meets patient needs and supports a smoother transition from hospital to home.

98% of service users felt that they were treated with respect, dignity and compassion by staff. There was also a positive rate of 98% regarding staff cleaning their hands before and after delivering care.



Observe & Act:

Our scheduling process remains thorough, considering themes from complaints, patient safety incidents, service discussions, and contributions from our Quality Team colleagues to achieve effective triangulation.

The overall picture is very positive, with consistently strong performance in Communication, Person Centred Care, and Safety. Staff were repeatedly observed providing professional, caring, unhurried and compassionate care, with service users reporting extremely high satisfaction. Environments were generally clean, safe, and accessible, though parking continues to be minor recurring issues in some locations.

Focus Groups:

Newly revised terms of reference have been developed for the commissioning and management of focus groups. Focus groups will be overseen and reported into the Patient Experience Delivery Group. Its objectives will be to facilitate focused discissions, identify key improvement areas, develop action plans and ensure inclusivity.

A new focus group has been established to address Community Nursing, aiming to improve the experiences of our service users.

Patient Experience Delivery Group:

Group meetings are convened monthly, with attendance from Operational Leads varying from session to session. The Head of Quality continues to play a pivotal role, guiding discussions and ensuring that plans and ideas are translated into tangible improvements.

As part of Patient Experience workplan Patient Representatives will be identified and recruited to support both focus groups and Patient Experience Delivery Group to provide valuable insight from those with lived experience of our services or living with a medical condition.

Embrace:

Following attendance at the 'Small Steps Big Difference' Conference in November 2025, The Trust has applied to join the SANDS/EMBRACE LGBTQ+ Covenant, a county wide commitment developed by *Safe Ageing No Discrimination (SAND)* to improve the experiences of older LGBTQ+ people accessing health and social care across Shropshire, Telford & Wrekin. By joining the Covenant, the Trust will be pledging to become more visibly inclusive, informed and responsive to the needs of LGBTQ+ communities, particularly those who may be at greater risk of isolation, discrimination or barriers to care as they age. Membership requires organisations to commit to five key actions, including providing high quality services for older LGBTQ+ people, learning from lived experiences, actively supporting LGBTQ+ groups, creating meaningful opportunities for LGBTQ+ people to influence service design and improvement.

Complaints & PHSO:

To further strengthen our approach to complaints management, we have adopted the Parliamentary and Health Service Ombudsman (PHSO) Complaints Assessment Tool, ensuring that our processes are aligned with best practice standards.
This will ensure that each case is assessed fairly and consistently. The process will include:

- Using the PHSO tool to evaluate how complaints are received, investigated, and resolved, benchmarking our performance against national standards.
- Documenting each stage of the complaints process, including initial contact, investigation, resolution, and follow-up, to promote accountability and learning.
- Regularly reviewing outcomes and identifying areas for improvement, with findings shared across teams to inform future practice.
- Ensuring complainants are kept informed throughout the process and that their feedback is used to further refine and improve the service.

Additionally, the Associate Director of Governance has facilitated Trust colleagues in participating in the PHSO's complaints investigation training, to equip staff with enhanced skills for handling and investigating complaints effectively. This is designed to improve the quality and consistency of our responses, support learning from feedback, and ensure that complainants receive a fair and thorough resolution to their concerns.

To enhance our complaints management process, the Patient Experience Lead now proactively reaches out to all complainants by phone or email, providing a dedicated opportunity to listen to their concerns and discuss their experiences in detail. This engagement is crucial, as it not only demonstrates empathy and a genuine commitment to resolving issues, but also fosters trust and transparency between the Trust and its service users. In these nine cases, early intervention and open dialogue resulted in the concerns being addressed promptly, with the complainants ultimately deciding not to proceed with formal complaints.

Proactively engaging with those who raise concerns is vital. It helps to de-escalate situations before they become more complex, allows for swift resolution of issues, and

reassures service users that their voices are heard and valued. By addressing matters early through personal communication, the Trust can improve patient satisfaction, strengthen relationships, and continuously enhance the quality of care provided.

Volunteers:

A newly recruited volunteer with lived experience of caring for a loved one with dementia and end of life care has proved an asset to the Dementia Environment project. She has been able to add the voice of the carer and realistic viewpoints. The Quality Team are committed to continue collaborating with the volunteer with plans to support Dementia Friendly walkaround sessions at Bridgnorth and Whitchurch Community Hospitals.

Volunteer recruitment campaign is now live. As part of the campaign, we will be looking to recruit those with lived experiences of services within the ShropCom, to become patient representatives.

Our online mandatory training, via eLearning For Health is progressing, with all of our volunteer group either having started or completed the nationally recognised modules.

Patient Stories:

In line with the Patient Experience Lead workplan, a range of patient and staff stories are being actively developed for presentation at Trust board meetings throughout 2026. Ongoing dialogue with Service Managers and Team Leads, along with a thorough review of staff and patient safety learning responses as well as complaint cases, ensures that potential stories are identified. This collaborative approach allows identification of meaningful experiences and examples of excellent and also provides opportunities for those involved to share their perspectives and contribute to organisational learning.

Staff Stories:

Pam Simmons – Interim MSO & Non-Prescribing Lead

What I do – I am currently the interim Medicines Safety Officer and Non-Medical Prescribing Lead for the Trust. I am based in the Quality Team but have a joint role across Medicines Management also. This is a vast role however I am primarily responsible for reviewing medication incidents and identifying learning outcomes from these to improve patient safety. I also work with NMP's within the Trust to ensure they feel confident and competent prescribing within their scope of practice

I am a paediatric nurse by background with a Specialist Community Public Health Degree and a V300 prescriber. I spent a large part of my career working in a specialist Children's Hospital where I was lead nurse for Dermatology. I have worked within the Trust since 2022 in community within the 0-19 service and recently taken on this interim role.

A bit more about me – I am a determined person who loves a challenge. I thrive in an environment where positivity and excitement are created! I love to learn and am always looking for a new venture!

I love travel and have lived and worked in Australia. I am lucky enough to return frequently!

I spend most weekends like many parents running around after my daughter who wants to be a

Cheryl Scarrott – Admiral Nurse Team Leader – Telford

What I do – I am the Admiral Nurse Team Leader in Telford, as a specialist dementia nurse, I support families and carers of people living with dementia in the community as well as supporting and developing my team. I am a qualified mental health nurse and have worked in health and social care for over twenty years. I have written a number of journal articles on health inequalities in dementia and teach student nurses on the subject.

A bit more about me –. I am a naturally positive and cheery person who is a little noisy and chaotic but full of love! I love hiking, dancing, live music, dogs, glitter and bright colours.

I consider myself as one of life's advocates and have always been a voice for those who are underserved in health, including carers, gypsies and travellers, members of the LGBTQ+ communities and those with autism and/or learning disabilities.

My biggest accomplishments in life other than my work and writing are my beautiful children and the fact that they are kind and compassionate human beings.

Holly Grainger – Infection Prevention Nurse

I joined the Infection Prevention Education and Advisory Team, as an IPC Nurse in March 2025, bringing with me a wealth of skills, knowledge and experience of community services from my previous role as a District Nurse. I've always been so incredibly passionate about high quality patient centred care and from my experience – Shropcom does this exceedingly well. As a District Nurse, I saw so many patients living in the community with chest infections, cellulitis and UTI's and on so many occasions these were some of the reasons why patients were referred to the District Nursing services e.g. frailty or general deterioration. From this my passion grew stronger to protect our patients by preventing infections. We all play such a vital role in preventing infections and keeping our patients well at all costs.

I joined IPEAT, as an IPC Nurse because I too wanted to play a vital role in supporting wider colleagues with the education and advice in keeping patients safe and well. Bringing with me my holistic approach to caring for our patients and communities. I am dedicated to high quality holistic care, preventing infections and ensuring our services maintain functionality, by supporting others to stop the chain of infection by giving safe and effective care. I visit a range of teams and services including the community hospitals, rapid response teams, podiatry and the wound healing services and complete regular audits to ensure we are maintaining safe environments and care for our patients. In IPEAT we do campaigns which involve providing education and resources to teams and staff to increase awareness. The winter campaign involved raising awareness of outbreak management and vaccines – we have seen less outbreaks on community wards and we believe this is linked to staff being armed with the knowledge of what to do if an outbreak of symptoms is suspected. Early identification and isolation is key in preventing the spread of infections.

One of my highlights is awarding teams and services with the quarterly Certificate of Excellence in Infection Prevention – teams and colleagues work tremendously hard to aim for and maintain high standards of infection prevention. It's great to work with colleagues who are also so passionate about preventing infections and keeping our patients safe. I'm currently working on a Quality Improvement project around being able to evidence in our documentation the great care we give in relation to Central Vascular Access Devices. District Nursing teams and OPAT are currently trialling the RIO form and so far, the feedback is looking incredibly positive. It's also one step forwards for the use of digital methods of documentation but also ensuring patients can continue to receive care of their vascular access devices in the community and prevent them needing secondary care as we can evidence the great care we are giving.

IPEAT is a small team, but I am proud to be part of a team making a difference every day to patients' lives and I am privileged to work with colleagues who have an abundance of knowledge of all things IPC within Shropcom.

Wendy Hallows - Operational Lead 0 – 19 (25) Service, Dudley

I joined the Dudley 0–19 Service as Operational Lead in February 2025, bringing with me a wealth of experience in nursing and a passion for integrated care. From the outset, I was struck by the dedication and resilience of the teams working across Dudley, and I've been proud to contribute to a service that places children, young people, and families at the heart of everything it does.

My previous roles have equipped me with strong leadership, strategic planning, and service transformation skills—qualities that have proven invaluable as we've worked to embed a unified 0–19 pathway. This integration has enabled us to streamline care, improve continuity, and respond more effectively to local needs.

One of the highlights of my time so far has been presenting our progress to the Dudley Health and Care Partnership Board, where I shared key achievements including increased antenatal contacts, sustained breastfeeding rates, and the continued success of the Family Nurse Partnership programme. These outcomes reflect the tireless efforts of our teams and the power of collaborative working.

I've also been actively involved in strategic groups such as the Improving Children's Mental Health and Wellbeing Strategic Partnership, Improving Children's Outcomes Partnership, and the SEND Strategic Partnership Board, helping to shape improvements in early intervention, speech and language outcomes, and data reporting. My ability to navigate complex operational challenges—whether in recruitment, financial mapping, or system migration—has supported the service through a period of significant change.

Above all, I'm proud to work alongside colleagues who share a commitment to compassionate, high-quality care. Together, we are building a service that not only meets the needs of today's families but lays the foundation for healthier futures.

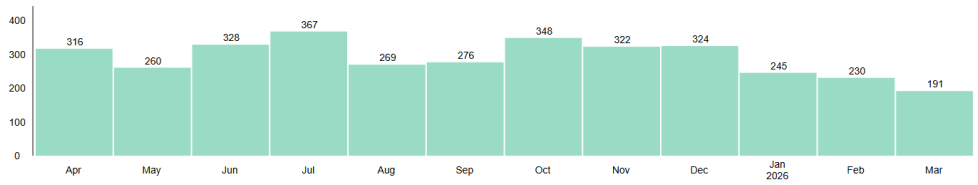
Friends & Family Test responses from our service users 2025/26:

The Trust received 3476 Friends & Family Test results, with 97.81% of respondents reporting the service was either good or very good. Although there has been a reduction in responses compared to the previous years, there has been an increase in positive patient experience from 96.85% to 97.81%.

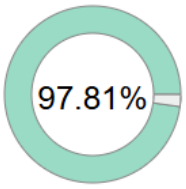
Submission rates continue to be reviewed. Regular contact is made with our service leads on the importance of promoting feedback and how to do so effectively, using all options available. It is also important to share the feedback with our teams to demonstrate the impact and the value of the survey submissions. This is done via our bi-monthly divisional reports and meetings.

Discussions continue with our Digital and Informatic colleagues in regards system integration to enable Friends and Family Tests to be sent to service users via text message. This option of gathering feedback has proved very successful for a partner Trust, with a considerable increase in response rates.

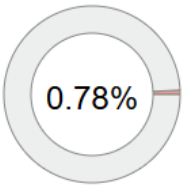
Number of surveys completed each month
(FFT All From 1 Apr 2025 to 31 Mar 2026)
3476 Surveys



Percentages of Very good/good and poor/very poor
(FFT All, 1 Apr 2025 to 31 Mar 2026)



% very good or good



% poor or very poor

FFT response breakdown
(FFT All, 1 Apr 2025 to 31 Mar 2026)

Response	Percentage	Number of times response selected
Very good	89.30%	3104
Good	8.52%	296
Neither good nor poor	1.21%	42
Poor	0.35%	12
Very poor	0.43%	15
Don't know	0.20%	7

Positive Feedback Received:

Feedback For Children & Families Division

- ✓ **Children's Occupational Therapy -** Helen, Verity and Amy were all great with my son, put him at ease and made him feel very comfortable so able to get most out of him during appt.
- ✓ **Public Health Nursing Service Central Shropshire** – *Longer sessions and more hands-on activities would be beneficial.*
- ✓ **Looked After Children** – *The nurse was sensitive to the needs of the young person and explained the process.*
- ✓ **Paediatric Psychology** - Amy's self-confidence has improved and she has been able to return to work etc. We have seen Amy largely overcome many of the obstacles which were in her way beforehand.
- ✓ **Wheelchair and posture service** – *Super and friendly service. So helpful and nothing too much trouble.*
- ✓ ***Wheelchair and posture service*** - The correct wheelchair was available straight away. Very impressed. Great advice and guidance given about the wheelchair.

Feedback For Planned Care Division

- ✓ **Falls Team** – *I cannot speak highly enough of the instructors. Friendly, encouraging and professional. I now have confidence to progress with an exercise programme.*
- ✓ **Community Dentistry Shrewsbury** – *Amanda was so caring and gentle. All the nurses have been wonderful too. Calming, reassuring, a positive experience.*
- ✓ ***TeMS Extended Scope Practitioner*** – *One of the best practitioners I have seen. Very good at examination and explained exactly what is wrong and coming up with a plan of action. Excellent communication*
- ✓ **APCS Oswestry** – *The first time I felt anyone had listened to my worries about my throat. Explanation of my problem was very reassuring.*
- ✓ **Community Dentistry Market Drayton** – Dentist and nurse were gentle, professional and friendly.

Feedback For Community Services Division

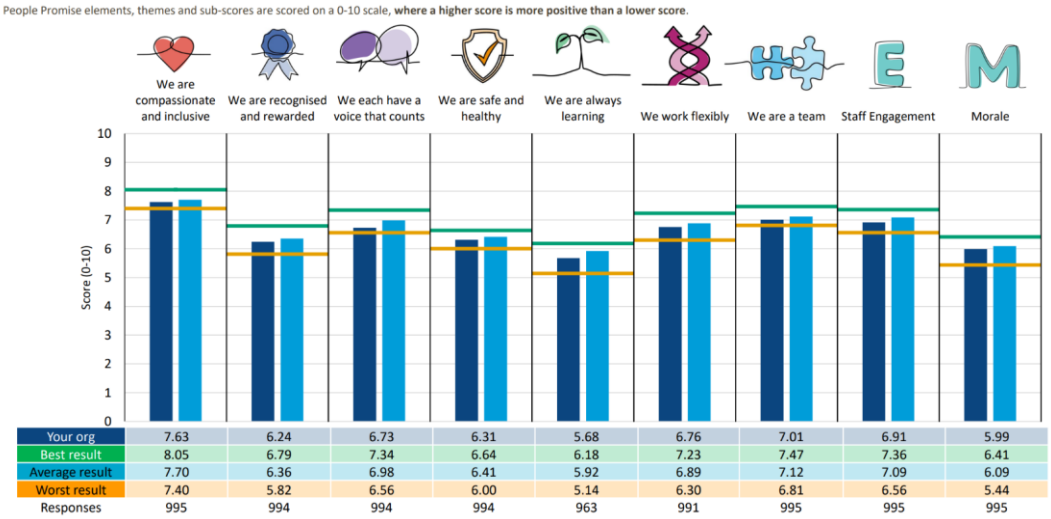
- ✓ Community Therapy Southwest – they are very kind and considerate
- ✓ Shropshire Admiral Nurses – I have appreciated very moment with Rebekah and have been able to speak openly with her.
- ✓ South Telford Community nursing – The nurses cheer me up every day, they are supportive and listen to me
- ✓ Continence Service – Jenny was very helpful and kind
- ✓ Whitchurch Community Hospital – Physio was excellent, I was treated very well and cannot fault a thing
- ✓ Ludlow Community Hospital – Staff were very kind and treated me with kindness
- ✓ Bishops Castle Community Hospital - Staff were amazing, patient and understanding
- ✓ Telford Wound Healing – The nurses are hardworking, friendly and very professional

Feedback For Urgent & emergency Care Division

- ✓ **UCR Northwest -** *Very caring and supportive and appreciate the time they have taken to get me better*
- ✓ **Shrewsbury DAART -** *Dawn and Jo were absolutely wonderful, very professional but also so kind and friendly, All efficient and professional*
- ✓ **Care Transfer Hub -** *Absolutely wonderful, Happy with discharge team and that I went home same day care package. Great communication with team & social care.*
- ✓ **Whitchurch MIU -** *Very efficient, helpful staff. Very good nurses & receptionist. Very good nurse who knew her stuff and covered all aspects of the injury and risks to it.*

NHS Staff Survey 2025 – Summary of results for Shropshire Community Health Trust:

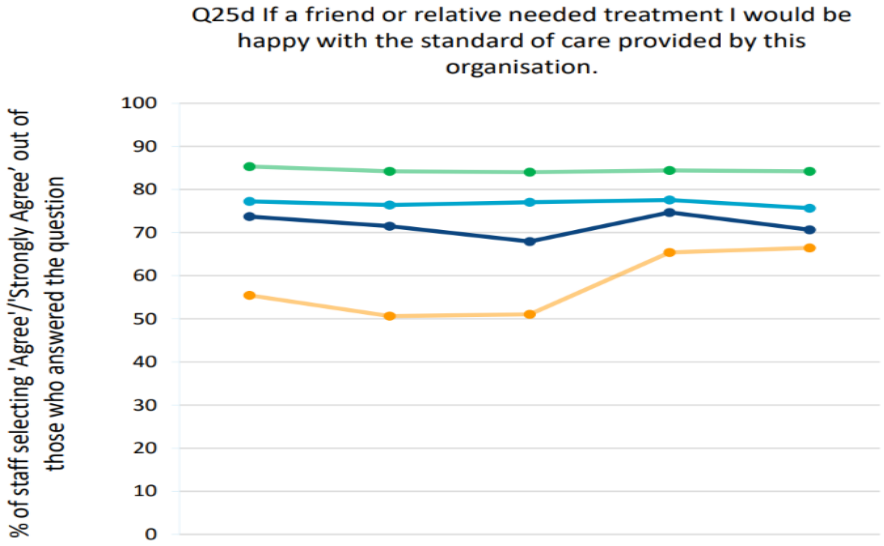
This year saw 995 members of staff completing the NHS Staff Survey (NSS). The attached document shows the results for each of the People Promise themes and elements.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.63	6.24	6.73	6.31	5.68	6.76	7.01	6.91	5.99
Best result	8.05	6.79	7.34	6.64	6.18	7.23	7.47	7.36	6.41
Average result	7.70	6.36	6.98	6.41	5.92	6.89	7.12	7.09	6.09
Worst result	7.40	5.82	6.56	6.00	5.14	6.30	6.81	6.56	5.44
Responses	995	994	994	994	963	991	995	995	995

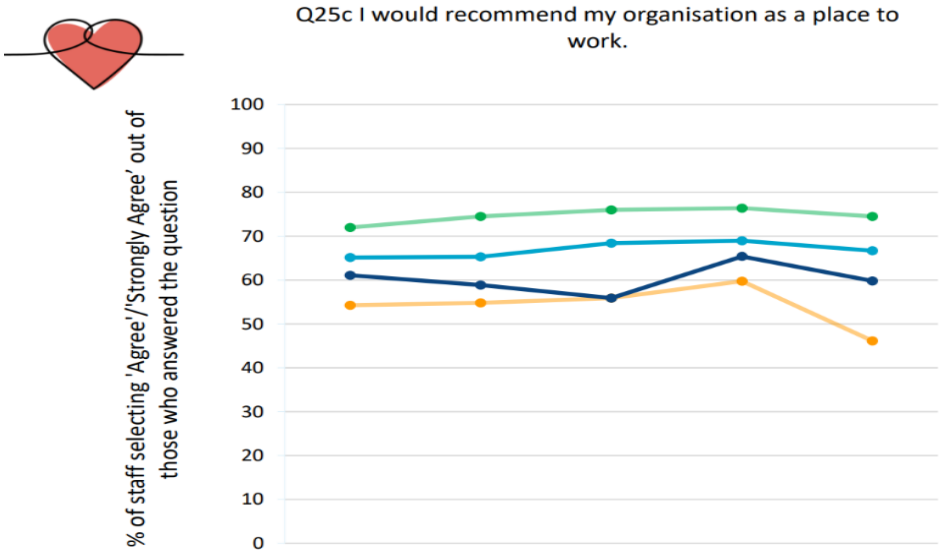
Fig 1 shows that SCHT's People Promise elements and themes are just below the benchmark average.

In the 2025 NHS Staff Survey, 70.65% of respondents said they would be happy with the standard of care provided if a friend or relative needed treatment.



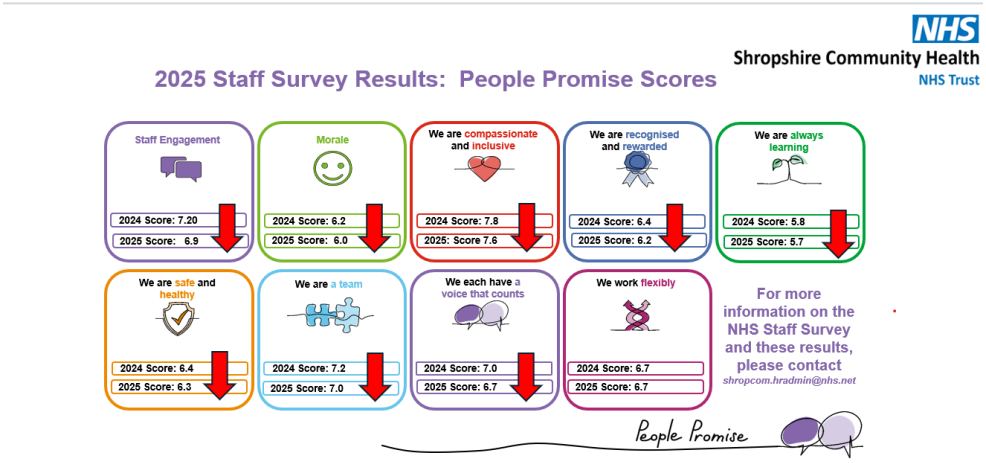
	2021	2022	2023	2024	2025
Your org	73.71%	71.50%	67.94%	74.69%	70.65%
Best result	85.33%	84.21%	84.02%	84.44%	84.24%
Average result	77.25%	76.42%	77.04%	77.57%	75.67%
Worst result	55.44%	50.63%	51.06%	65.41%	66.46%
Responses	915	775	843	1187	994

In the 2025 NHS Staff Survey, 59.82% of respondents said they would recommend my organisation as a place to work.



	2021	2022	2023	2024	2025
Your org	61.10%	58.89%	55.90%	65.39%	59.82%
Best result	71.99%	74.51%	76.01%	76.41%	74.52%
Average result	65.14%	65.33%	68.41%	68.98%	66.68%
Worst result	54.25%	54.83%	55.90%	59.76%	46.14%
Responses	913	775	843	1189	995

The Trust continues to participate and improve the Staff survey results annually. Shropshire Community Health Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:



- Advocacy – making Shropcom a great place to work, and to receive care. These scores are often linked to psychological safety and relationships with line managers, so a key priority is to ensure our managers are supported to develop and understand the importance of their role.
- Involvement – ensuring voices are heard and staff are involved in changes and improvements that matter to them.
- Health and Wellbeing – too many of our colleagues are feeling the effects of burnout.

Two Q&A sessions to share highlights of our results, which are also available on the Staff Zone have taken place. A dashboard displaying these results is nearing completion and is scheduled for launch in April 2026. Additionally, we offer a Managers' and Team Leads' Toolkit to help area leads identify actionable steps within their teams.

With the results embargo now lifted, using the Managers' and Team Leads' Toolkit, teams are now being encouraged to hold local discussions about their results and to identify 2 – 3 actions that they'll work on until the survey for 2026 lands in Oct 2026.

The results will also by analysed to identify corporate level actions and focus groups will be implemented to target areas of low response rate in order to gain the Voice of those areas.

Learning from Deaths:

As a Community Trust the Trust does not submit data to NHS England with regard to the summary hospital-level mortality indicator (SHMI).

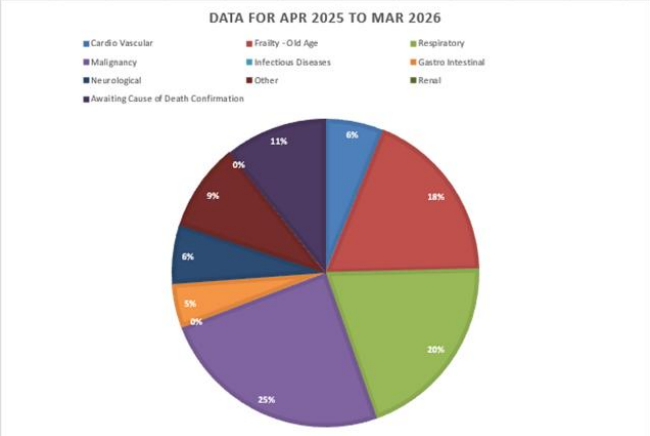
Learning from a review of the care provided to patients who die should be integral to a Trust's clinical governance and quality improvement work. To fulfil the standards and reporting set out for Community NHS Trusts, we should ensure that we give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not, to have resulted from problems in care. SCHT also ensure that we share and act upon any learning derived from these processes.

Deaths reported across the Community Hospitals, Rehabilitation and Recovery Units, and Virtual Ward totalled 74 in the year, with 8 being unexpected but explainable deaths.

1 patient had COVID-19 recorded as their primary cause of death in the year, and the main 3 causes identified were: Malignancy, Respiratory and Frailty of Old Age.

Our team engages in system and cluster LeDER meetings, where we review individual patient cases and contribute to the attainment of learning objectives.

Data Chart for April 25 to March 26:



During 2025/26 74 of Shropshire Community Health Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 19 in the first quarter; 20 in the second quarter; 19 in the third quarter; 16 in the fourth quarter

Our Commitment to Data Quality

We operate several different systems to manage our work across services, with the majority of services utilising an Electronic Patient Record. The requirement to ensure high standards of data quality is taken seriously and efforts continue to constantly improve our data systems and the quality of data held within them.

Shropshire Community Health NHS Trust submitted records during 2025-26 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics data. We are also compliant with the national requirement to submit Faster Data Flows and the Community Services Dataset.

The percentages of records in the submitted data, according to the SUS dashboards for 2025-26 (Up to month 11 year to date), which included the patient's valid NHS number were:

- 100.0% for Admitted Care
- 100.0% for Outpatient Care
- 99.6% for Emergency Care Data Set (Full Year)
- 99.9% for Community Services Data Set (from DQMI, cumulative position up to January 2026)

The percentages of records in the submitted data, according to the SUS dashboards for 2025-26 (Up to month 11 year to date), which included the patients valid General Medical Practice Code were:

- 100.0% for Admitted Care
- 100.0% for Outpatient Care
- 99.6% for Emergency Care Data Set (Full Year)
- 100.0% for Community Services Data Set (from DQMI, cumulative position up to January 2026)

    - NB – There are legitimate reasons why a patient may not have a valid NHS Number or General Medical Practice Code, i.e. overseas visitors to an Emergency Care Department.

The Data Quality Maturity Index (DQMI) is an assessment provided by NHS England on the completeness of datasets the Trust has submitted. For January 2026 data, Shropshire Community Health NHS Trust were at 95.8% against the 95% target and compared to the National Average of 71.3%. An action plan is in place.

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

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

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

- Data quality checks using a wide spectrum of measures and indicators, which ensure that data is meaningful and fit for purpose.
- Data Quality/Validation exercises are undertaken with services on both a regular and ad hoc basis.
- Functionality within Rio, the Trust's main clinical system, allows services to monitor and manage certain data quality items in real time and manage waiting lists and Referral to Treatment via the front end.
- Compliance with the Data Quality assurance section within the Data Security and Protection Toolkit.
- An Information Quality Assurance policy exists, defining roles and responsibilities for data quality including audits.
- The Trust's Information Asset Owners in conjunction with Service Managers are responsible for establishing a documented data quality procedure which describes how data quality is maintained, monitored and improved.
- There are a number of different roles and groups which have responsibility for data quality in the Trust. The Board has overall responsibility for monitoring data quality.
- External Data Quality metrics are reviewed, and actions are implemented where the position is off track.
- Data Quality is reported through operational groups and overall Data Quality Maturity Index is reported to Committee/Board.
- There is a Data Quality Subgroup that reports to the Data Security and Protection Assurance Group, where key elements of Data Quality including action plans are reviewed and any issues are progressed accordingly.
- Information Systems and any associated procedures are reviewed in line with national requirements eg Data Assurance Board notifications for information standards and data collections.
- All staff who record information, whether on paper or by electronic means, have a responsibility to take care to ensure that the data is accurate and as complete as possible. Individual staff members are responsible for the data they enter onto any system.

Our Care Quality Commission (CQC) Registration

Shropshire Community Health Trust is required to register with the Care Quality Commission, and its current registration is without conditions. The Care Quality Commission has not taken any enforcement action against Shropshire Community Health Trust in 2025/26.

Shropshire Community Health Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The last SCHT CQC inspection was in 2019 and as an organisation we recognise that re-inspection will be in the near future. The Quality Improvement Team over last year have been preparing clinical and corporate services for the changes to CQC inspections. Service briefcases have been created and cascaded. These contain information on the CQC's new ways of working, how to guides, a process for to evidence performance and successes, a toolkit for service self-assessment using the CQC key questions and I/we statements and a service development plan tool.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019
Community health services for children and young people	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019
Community health inpatient services	Good ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019
Community end of life care	Good ↑ Aug 2019	Good ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good ↑↑ Aug 2019	Good ↑ Aug 2019
Community dental services	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good →← Aug 2019
Urgent care	Good ↑ Aug 2019	Good ↑ Aug 2019	Good →← Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019
Overall*	Good ↑ Aug 2019	Good ↑ Aug 2019	Good →← Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019	Good ↑ Aug 2019

His Majesty's Inspectorate of Prisons (HMIP)

HMP / YOI Stoke Heath was inspected by CQC, Ofsted, and HMIP in late February early March 2026. The official report is expected to be released sometime early June 2026.

Special Educational needs and/or Disabilities Inspection

An Area SEND inspection of the Dudley Local Area Partnership was conducted from 20 to 24 January 2025.

Mock SEND inspections were conducted in Shropshire LA from February 3rd to 6th, and the final report has yet to be published.

Joint Targeted Area Inspection (JTAI)

The JTAI inspection was conducted in July 2025, with the final report subsequently released and published in September 2025.

A brief summary in relation to the health aspect of the inspection was provided (please see below)

Strengths:

- Committed to achieve the very best
- Strong leadership with continuous improvement
- Dedication for safeguarding is strong
- Strong response from Family Connect in view of referral to other services to meet the needs of children and families
- When a child needs to be safeguarded, this happens, and checks are completed and information provided by all agencies within working hours
- Support for homeless children has improved
- Effective response to children and young people at risk of exploitation from Family Connect and the Children Abused Though Exploitation (CATE)CATE Team
- Unaccompanied Asylum-Seeking Children – when identified out of hours there can be some delay however in hours needs are met
- Social Workers undertaken complex assessments and work using information shared from other agencies
- Tools are available and used to support practitioners working with families
- Pregnant women are supported by the Vulnerable Women's team and there is evident of robust partnership processes in place
- Adult substance misuse service (STaRS) work effectively with families who are child in need
- Think family approach is used throughout
- Considerable investment into Early Help
- Whilst families are waiting for allocation, they are visited and services provided to ensure their needs are met
- Education is highly committed being a 4th partner in the partnership
- Operation encompass is having a positive impact
- As leaders, there are refreshed structures for the reforms
- Mature partnership established with structures and functions
- Where necessary, escalation and challenge took place and led to agreement to review
- Strong Early Help offer with plans to enhance further
- Independent Scrutineer provides balanced and accurate input with oversight at subgroups

- Multiagency Case File Audits (MACFAs) are well embedded and allows for oversight and improvement
- Partnership training is positive
- Agile and continuous learning to areas of risk evidenced
- Performance reports identify trends and there is evidence of clear links between groups ie: observing the reduction in Maternity services resulting in action being taken
- Participation of children and young people and their families and the commitment to capture their voice – this is seen in the recent multiagency conference, safeguarding board and parent groups

There were Two actions relating to Shropshire Community Health NHS Trust (see below)

- Update to the Multiagency Safeguarding Hub Nursing Team Standard Operative Procedure to ensure all health providers patient records have been accessed for lateral checks have record of this and the rationale for accessing the record.
- To ensure that all professionals across the partnership are familiar with the threshold guidance and know how, and when, to make a referral to Family Connect
    - Health providers to be reminded of the threshold guidance and steps to be taken to ensure there is good understanding across the health community
    - Checks to be undertaken post the changes to assess if all health providers are demonstrating a good working understanding of the thresholds in T&W

    All actions relating to Shropshire Community Health NHS Trust were completed in September 2025

Statements from Our Partners

Our Quality Account has been shared with key stakeholders these are their comments

SCHT 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) welcomes the opportunity to review the Shropshire Community Health NHS Trust (SCHT) Quality Account for 2025/26.

The ICB is of the view that the Quality Account provides an accurate and balanced reflection of the achievements delivered by SCHT during 2025/26 and appropriately identifies priority areas for improvement, to the best of our knowledge. The Trust has demonstrated effective collaboration with partners across the Integrated Care System (ICS) to address population health needs and enhance the quality of services delivered.

The ICB would like to acknowledge the work undertaken by SCHT in relation to its patient safety priority, including the delivery of education, application of system learning, learning responses, and the integration of these elements with quality improvement activity.

The ICB recognises the positive developments within palliative care services, alongside SCHT's contribution to system-wide pathways and strategic development.

The ICB notes SCHT's continued commitment to embedding a culture of continuous improvement across the organisation, supported by equipping staff with the necessary skills, knowledge, and tools to undertake quality improvement.

The ICB was encouraged by the sharing of twenty-seven quality improvement projects at the Group Model Celebration Showcase event in May 2026, with four projects subsequently shortlisted for an award.

The ICB also notes the Trust's 2026/27 priorities, including the continued implementation of the Neighbourhood Health Model, strengthening multidisciplinary working, and further integration of care delivery with an emphasis on prevention and early intervention.

In conclusion, the ICB considers the 2025/26 Quality Account to present an accurate account of the challenges faced by the Trust and to provide evidence of improvement across key quality and safety domains. The ICB recognises SCHT's ongoing commitment to partnership working within the system to ensure the continued delivery of safe, high-quality services for the population of Shropshire Telford and Wrekin and looks forward to continued quality improvement across the system.

Yours sincerely

Vanessa Whatley
Chief Nursing Officer
NHS STW

Healthwatch Shropshire Response on the Draft Quality Account 2025/26
Shropshire Community Health NHS Trust

Healthwatch Shropshire welcomes the opportunity to comment on the draft Quality Account 2025/26 for Shropshire Community Health 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.

Overall, this is a detailed and reflective document that demonstrates a strong organisational commitment to improving patient safety, patient experience and organisational learning. We welcome the Trust's openness in recognising areas where improvement is still required, alongside clear evidence of ongoing quality improvement activity.

Patient Experience and Engagement
(Part 2.1: Enhancing Patient Experience and Engagement, pages 17–19; Part 2.2 pages 26–28)

The Quality Account demonstrates increasing recognition of the importance of patient voice and personalised care. Healthwatch Shropshire particularly welcomes:

- Recruitment of Patient Representatives
- Use of Observe & Act sessions
- Development of patient focus groups
- Bereavement and end-of-life care improvements
- The focus on Learning Disability and Autism involvement
- The commitment to neighbourhood-based care closer to home

The report highlights several mechanisms for gathering patient feedback and improving engagement. To strengthen future accounts, we encourage the Trust to include more direct patient stories and clearer examples showing how patient feedback has directly informed service changes and improved outcomes.

Learning Culture and Patient Safety

(Part 2.1: Enhancing Patient Safety and Reducing Harm, pages 12–16; Enhancing Learning Across the Organisation, pages 19–20; Audit and Research, pages 31–37)

Healthwatch Shropshire recognises strong evidence of a developing learning culture throughout the report. The Trust demonstrates openness in identifying areas requiring improvement, including falls prevention, medication safety, pressure ulcer prevention and advance care planning.

We particularly welcome the Trust's use of:

- Thematic reviews
- Permissions to Pause
- Swarm Huddles
- SEIPS methodology
- Quality Improvement training
- Audit and incident learning processes

The emphasis on Quality Improvement capability and staff development is positive and supports a culture of continuous learning rather than a purely compliance-based approach.

We would encourage future reports to demonstrate more clearly how learning from incidents, audits and patient feedback has translated into sustained improvements in outcomes and frontline practice.

Priorities for Improvement

(Part 2.2: Looking Forward – Quality Account Priorities 2026/27, pages 21–30)

The priorities identified for 2026/27 are appropriate and aligned with local patient safety and service challenges. Healthwatch Shropshire particularly supports the focus on:

- Falls and deconditioning prevention
- Medication safety
- Pressure ulcer prevention
- Learning Disability and Autism involvement
- Neighbourhood health models
- Quality Improvement capability

We welcome the inclusion of measurable indicators such as falls per 1000 occupied bed days, pressure ulcer reduction targets and Quality Improvement training uptake.

To strengthen future Quality Accounts further, we encourage the Trust to continue developing outcome-focused measures that clearly demonstrate the impact of improvement work on patient experience, safety and health outcomes.

Safe, Effective and Experience-Based Care

Across the three pillars of quality, the Quality Account presents a balanced and transparent picture:

- Safe care is supported through strong focus on falls prevention, medication safety, pressure ulcer prevention and patient safety learning.
- Effective care is evidenced through clinical audit activity, participation in national programmes, Quality Improvement methodology and evidence-based practice.
- Experience-based care is increasingly reflected through patient engagement activity, personalised care approaches and focus on Learning Disability and Autism inclusion.

Healthwatch Shropshire also welcomes the Trust's recognition of rurality, inequality and the importance of delivering care closer to home through neighbourhood models.

Conclusion

Healthwatch Shropshire considers this Quality Account to be a constructive and improvement-focused document that demonstrates a growing culture of openness, learning and patient-centred care.

The report moves beyond a simple regulatory exercise and shows meaningful commitment to quality improvement across safe, effective and experience-based care.

Continued focus on demonstrating how patient feedback leads to tangible service changes and measurable improvements in outcomes will strengthen future accounts further.

At the time of writing the Trust has worked with us to develop a patient survey for people who have been on the Virtual Ward, and this is hosted on their website. We look forward to sharing our findings from this survey in 2026-27 and continued engagement with Shropshire Community Health NHS Trust to support improvements that reflect the experiences and needs of local people across Shropshire.

healthwatch
Telford and Wrekin