The Shrewsbury and Telford Hospital NHS Trust

Quality and Safety Assurance Committee Key Issues Report

Report Date: 23rd July 2020		**Report of:** Quality and Safety Assurance Committee (QSAC)
Date of last meeting: 22nd July 2020 Note that this was a virtual meeting		**Membership Numbers:** The meeting was quorate in line with its Terms of Reference
1	**Agenda**	The Committee considered an agenda which included the following: • Board Assurance Framework Risks • Emergency Department Assurance Committee Exception Report • Maternity Assurance Committee Exception Report • CNST Maternity Governance Requirements • Maternity Update including proposals for a revised maternity dashboard, a report about the Trust's improving performance with respect to perinatal deaths and the recent investigation into the Trust's handing of the RCOG report • Legal Report • Quality Improvement Plan and Assurance Process • CQC Section 31 Update • National Adult Inpatient Survey 2019/20 • Safeguarding External Review Action Plan • Safeguarding Committee Exception Report • Exemplar Update • Infection Prevention Control Committee Exception Report • Infection Prevention Control Annual Report • Dementia Strategy Quarter 4 Update • Patient Experience Report • Quality Governance Report • Complaints Annual Report • COVID 19 Update • Mortality Committee Exception Report • Medical Gases Exception Report • Corporate Risk Register The Committee considered reports from: • Infection Prevention Control Committee • Emergency Department Oversight Committee • The Maternity Assurance Committee • Safeguarding Committee • Quality Operational Committee • Medical Gases Group • Mortality Committee The committee also considered: • The Quarterly Dementia Strategy Update • The Patient Experience Annual Report

		• Safeguarding External Review Action Plan The Committee is recommending reports for review at the board due to statutory requirements • Annual Safeguarding Report (25 June 2020 – attached) • The Annual Infection Prevention and Control Report 2019/20 (attached) • The Annual Complaints Report (attached) • National Inpatient Survey 2019/20 (attached)
2a	**Alert**	• That work is required to ensure that there are appropriate schematics for piping and wiring within the Trust • There remains a potential risk to oxygen supply within the Trust should there be a significant 2nd wave of COVID-19. Work is planned to address this but similar work is required in many Hospitals • The patient experience report highlighted discharge as a key focus area for the Trust to work on and with partner organisations. This is both a clinical safety and patient experience issue • Despite the fact that the levels of falls are below national thresholds, there is rightly a focus on falls prevention given a number of significant events and potential CQC prosecution
2b	**Assurance**	The Committee wish to assure members of the Board that: • There is encouraging progress against the Quality Improvement Plan with evidence of achievement against actions and an effective assurance process. QSAC is involved in signing off actions that are "embedded" and 3 of the 4 items proposed for "blue" status had sufficient assurance evidence against them to be classed as blue • There has been an improvement in the number of Paediatric patients triaged within 15 minutes, although improvements are still required, especially at PRH to ensure when demand escalates, we can still ensure compliance with standards • There are now agreed, central drives where assurance data is held or review and retrieval • There is a greater focus on Infection Prevention Control consequent upon the pandemic and requirements for Infection Prevention and Control. The annual report demonstrates an encouraging position although this function must be supported within the Trust • The proposed Maternity dashboard looks excellent and will greatly assist assurance. It will be particularly enhanced as the new maternity IT system is deployed
2c	**Advise**	The Committee wish to advise members of the Board that: • The Committee note that the final numbers of cases within the scope of the Ockenden review is 1862 • Within the revised risk management approach the "risk appetite" needs to be reviewed. • There remains a key correlation between quality and safety and the status of our workforce. Members emphasised the need to work closely with the workforce committee • There is encouraging progress with the improvement plan for our emergency departments. The Emergency Department Oversight Group report that no actions are "off track" and around 65% are complete. It is notable, however, that 4 hour performance has slipped with increasing demand. Factors lined to this include the

		management of patients with mental health problems and bed availability within the current "cohorting" bed base. There remain instances where the Trust's processes still need improvement • The committee felt that the clinical leadership team which is now enhanced and also using external expertise is now making a significant difference. There also seems to be a "real willingness to get this right" amongst staff members • The Medical Director is developing and implementing a revised approach to mortality reviews. Mortality has spiked during the COVID-19 first wave and work is required to differentiate mortality linked to the virus as against mortality from other causes • The committee considered and reflected upon the NHS Investigation into the handling of the RCOG. Members reaffirmed their commitment to candour
2d	**Review of Risks**	

a) The Committee reviewed the Board Assurance Framework for Assurance on the following risks:

- BAF 1204 - IF our maternity services do not evidence learning and improvement THEN the public wil not be confident that the service is safe.
  Level of assurance provided: ***Moderate***
- BAF 1134 - IF we do not work successfully in partnership,THEN our current traditional service models for both unscheduled and scheduled care will be insufficient to meet escalating demand.
  Level of assurance provided: ***Moderate***
- BAF 1533 We need to implement all of the integrated improvement plan which responds to CQC concerns so that we can evidence to provision of outstanding care to our patients

  Level of assurance provided: ***Low***

  BAF 1746 If we do not have effective systems in place to consistently identify and escalate and manage patients with sepsis or other deteriorating conditions. THEN patients will not have the best outcomes possible

  Level of assurance provided: ***Low***

The committee also considered the BAF Assurance Risk linked to COVID-19 and set the level of assurance to moderate

b) In considering these risks, the Committee can confirm:

		Check box to confirm
1	**The BAF risks are up-to-date**	☒
2	**The direction of travel stated is current and correct**	☒
3	**The current risk rating is correct**	☒
4	**There is no additional/updated content (controls/assurances) or new risk(s) that needs to be added?**	☒

If there are changes to content or new risks identified the Committee recommends to the Board

BAF 1533 - IF we do not implement all of the 'integrated improvement plan' which responds to CQC concerns THEN we cannot evidence provision of improving care to our patients.
Recommendation: This risk requires revision within the new Board Assurance and Risk processes that are being developed

3	**Actions to be considered by the Board**			
4	**Report compiled by**	*Dr David Lee* *Chair of Committee*	**Minutes available from**	*Louise Allmark* *Committee Support*

The Shrewsbury and Telford Hospital NHS Trust

Cover page	
Meeting	Board of Directors
Paper Title	Annual Safeguarding Adults, Children and Maternity Report
Date of meeting	30 July 2020
Date paper was written	11 June 2020
Responsible Director	Maggie Bayley- Chief Nurse (Interim)
Author	Sharon Woodlands - Adult Safeguarding Lead Teresa Tanner – Children's Safeguarding Lead Sharon McGrath/Sally Burn- Safeguarding Midwife
Presenter	Kara Blackwell - Deputy Chief Nurse

Executive Summary

This report describes the activities during 2019/20 of the Trust's Safeguarding Team for adults, children and maternity. The report highlights the outcomes over the twelve months and gives assurance to the Trust Board on how the organisation has discharged its statutory duties in relation to safeguarding children under Section 11 of the Children Act (2004) and work within the guidance for adult Safeguarding.

In addition, the report outlines how the Trust has responded to local and national developments, both internally, and as a member agency of the Local Safeguarding Partnerships and the Adult Safeguarding Boards.

Previously considered by	*Trust Safeguarding Meeting – 22 June 2020*

The Board (Committee) is asked to:			
Approve	Receive	Note	Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☐ Safe	☑ Effective	☐ Caring	☐ Responsive	☐ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	*Are any Board Assurance Framework risks relevant to the paper?*

Equality Impact Assessment	Stage 1 only (no negative impact identified) Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	This document is for full publication This document includes FOIA exempt information This whole document is exempt under the FOIA
Financial assessment	*No*

SAFEGUARDING CHILDREN AND ADULTS AT RISK ANNUAL REPORT 2019/2020

INTRODUCTION

The purpose of this report is to provide the Trust with an annual report of the work undertaken by the Trust's Safeguarding Teams for adults, children and maternity during 2019-2020, giving assurance that the Trust is compliant with its safeguarding duties and those responsibilities specified under section 11 of the Children Act (2004), NHS Assurance Framework (2015) and current safeguarding adult legislation.

The report describes how the Trust has responded to local and national developments, both internally, and as a member agency of the Local Safeguarding Partnerships and the Adult Safeguarding Boards (SAB) including significant work undertaken within the Trust in relation to the national PREVENT agenda.

In addition, the proposed developments for 2020-2021 based on the local, regional and national safeguarding agenda are also presented.

The Trust is committed to recognising that all children and adults at risk have a right to be protected, that their safety and well-being is maintained and that they have a right to be protected from harm when in our care. Safeguarding encompasses:

- Effective responses to allegations of harm and abuse that are in line with local multiagency procedures
- Maintaining integrated governance systems and processes in reporting concerns or issues relating to Safeguarding
- Working with Local Safeguarding Partnerships (Child and Adult), patients, families and community partners to create safeguards for children and vulnerable adults.
- Prevention of harm and abuse through the provision and delivery of high quality care.
- Identification of potential risk factors in families with complex social issues and offering early help and / referral to social care

All staff within the Shrewsbury and Telford Hospital NHS Trust are fully committed to the safeguarding of children and adults with care and support needs.

NATIONAL SAFEGUARDING ARRANGEMENTS

The requirement for organisations to have robust processes relating to safeguarding were outlined by Lord Laming's review into Child Protection Procedures (2009), the Care Quality Commission (CQC) report reviewing Safeguarding Children within the NHS (2009) and for adults, the Care Act (2014).

The CQC also requires health organisations to take reasonable steps to ensure that commissioned services are compliant with healthcare standards relating to arrangements to safeguard and promote the welfare of children across the following areas:

- Arrangements have been made to safeguard children under Section 11 of the Children Act (2004).

- Work with partners to protect children and participate in reviews as set out in Working Together to Safeguard Children (2018), bringing together all the statutory responsibilities of organisations and individuals to safeguard children.

- Making it explicit that safeguarding is the responsibility of all professionals who work with children.

- Agreed systems, standards and protocols are in place relating to information sharing about a child and their family both within the organisation and with outside agencies, having regard to statutory guidance on making arrangements to safeguard children under Section 11 of the Children Act (2004).

- NHS England Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework

- A child centred coordinated approach to safeguarding
- Assessing the needs of children / unborn and providing early help.

Section 11 of the Children Act (2004) places a statutory duty on key people and bodies to safeguard children. All NHS Trusts are expected to identify Named Professionals who have a key role in promoting good professional practice within the Trust. We are compliant with this requirement.

CONTEST, the Government's national counter terrorism strategy, aims to reduce the risk to the United Kingdom and its interests overseas from international terrorism, so that people can go about their lives freely and with confidence. Preventing someone from becoming a terrorist or supporting terrorism is no different from safeguarding vulnerable individuals from other forms of exploitation. Therefore, the Trust's PREVENT Policy sits alongside the organisation's Safeguarding Vulnerable Adults Policy and the Safeguarding Children's Policy.

In 2019/2020 the Safeguarding team consisted of:

Director of Nursing & Executive Lead for Safeguarding	Barbara Beal
Deputy Director for Nursing & Operational Lead Safeguarding	Kara Blackwell
Safeguarding Children Lead (Named Nurse)	Teresa Tanner
Specialist Nurse for Safeguarding Children	Sarah Browne
Named Doctor Child Protection	Dr Ganesh
Safeguarding Adult Lead (Named Nurse)	Jane Newcombe (left February) Sharon Woodlands (acting March 2020)
Named Doctor Adult Protection	*Vacant
Named Midwife for Safeguarding and Domestic Abuse	Sharon Magrath / Sally Burns
Specialist Nurse for Safeguarding Adults	Louisa Bowen
Specialist Nurse for Safeguarding Adults	Post-holder acting into Named Nurse

*The Named Doctor from Safeguarding adults is being recruited to in Quarter 1 of 2020/2021.

KEY ACTIVITIES IN 2019/2020

During 2019/2020 the following key activities relating to Safeguarding took place within SaTH:

CHILDREN AND YOUNG PEOPLE

A key focus for the children's Safeguarding Team during 2019/2020 has been to continue to ensure all staff receive appropriate training. One of the key objectives that was a recommendation from the CQC inspection was to improve children's safeguarding training across the level 2 groups. The Safeguarding Team provide training on induction (Level One awareness) following which

appropriate staff should attend a Level Two course every three years. Additionally the Named Nurse provides training to specific staff groups who require Level three training such as Paediatric and Emergency Department clinical staff. At the end of March 2020 we reported the following levels of Safeguarding Children Training:

Table one: Safeguarding Children and Young People Training

Level	Rationale	Target*	Compliance
1	Safeguarding children training allows staff to be able to identify early any safeguarding risks and to know what actions to take. Level 1training is the introductory level training that is necessary for workers (Intercollegiate Document 2014).	100%	91%
2	Safeguarding Children training allows staff to be able to identify early any safeguarding risks and to know what actions to take. Level 2 training for all staff who see children in there working day (Intercollegiate Document 2014).	80%	91%
3	Eligible staff who have received Safeguarding Children training (as per the intercollegiate document 2014) in the last 12 months. Level 3	80%	88%

Target – CQC target is 80%, Trust Target is 90% and the CCG target for level 2 and 3 training is 98%

Within the last twelve months training has continued in its' present format of being on the Statutory Safety Update 3 yearly day with additional bespoke sessions for wards. Staff have been encouraged to undertake the Safeguarding Children module on line. The figures for Safeguarding Children level 2 also include medical staff which, at the end of March 2020 was 86% compliant; this is vast improvement on the 22% in 2019.

Throughout 2019, the recommendations from the Intercollegiate Document (2019) have been in the process of being implemented across the Trust. Level 3 training has increased from 6-8 to 12-18 hours over a three year period. To enable this, it was decided that all level 3 training for Paediatrics and Emergency Department staff from 2020 would be annual and of 4 hours duration.

Throughout 2019/2020 the Trust was involved in several Child Safeguarding Practice Reviews (CSPR). The Trust is currently involved in a further two serious case reviews, one for Telford and Wrekin, relating to neglect and physical harm, and one in Shropshire also relating to neglect. There is a joint case review ongoing involving adults and children. There have been other Child Safeguarding Practice Reviews in the County but they haven't involved the Trust.

Both Shropshire and Telford and Wrekin local authorities hold monthly Multi-Agency Risk Assessment Conferences (MARAC) meetings. The Named Nurse, the Named Midwife, the Specialist Nurses for Safeguarding Adults and Children have been attending the meetings, SATH has 100% attendance at both the Shropshire and Telford MARAC.

The Children Act (2004) places a statutory obligation on a number of agencies to safeguard and promote the welfare of children and young people whilst carrying out their normal functions. Following a national review of Safeguarding Children Boards (LSCB) these are now named Local Safeguarding Partnerships attended by the Local Authority, Police and CCG. The Trust receives feedback via the Executive Lead at the CCG.
With the change in Safeguarding Boards to Safeguarding Partnerships there has been a change in sub groups and who attends. The Health representative in more of the sub groups is coming form CCG, however, SaTH continue to be involved.

The Regional Named Professionals Network which Named Nurse co-chairs together with the Head of Safeguarding at New Cross Hospital has continued to strengthen throughout 2019/20, with the 6 monthly meetings taking place in Telford and guest speakers have included the partner agencies.

LADO (Local Authority Designated Officer) co-ordinate allegations made against staff who work with children. These are cases where there has been incident at work or at home and the member of staff works with children or young people within the hospital, as they work in a 'Position of Trust' they are referred to the LADO.

SaTH is also involved in the Independent Inquiry into Child Sexual Exploitation in Telford. This Inquiry was set up following concern by a local Telford MP. Tow Crowther QC is leading the Inquiry and is currently speaking with witnesses and survivors of exploitation. Partner agencies, including SaTH, have been asked to provide minutes of safeguarding meetings, training, annual reports, all going back to 1989. It has been acknowledged that many agencies have changed over the last 30 years, however, SaTH has provided the information in respect of this request to the Inquiry.

MATERNITY

Safeguarding Supervision:

The midwife is often the first professional to work with new parents and therefore needs to be able to recognise early signs of neglect and abuse to safeguard the unborn. Safeguarding supervision has been identified as an essential protective factor in child protection work (Laming 2003, 2009) and focuses on the safeguarding supervisor providing support allowing practitioners to clarify situations which have legal, professional and ethical components. The current model of safeguarding supervision in Maternity is offered ad hoc and as such can be ineffective at supporting and empowering Midwives to safeguard their caseload.

In November 2017 the Maternity Safeguarding Supervision Policy was implemented however, compliance with the policy has been met with different challenges. Effective safeguarding supervision enhances the practitioner's knowledge and skills whilst also enabling gaps in knowledge to be highlighted. Through this supervisory relationship personal development is encouraged which will enhance the response to safeguarding concerns through providing time for the practitioner to think and reflect about cases and responses they have made.

The average number of safeguarding supervision sessions offered on a 121 basis per month	1
The average number of group supervision offered per month	1

Ad hoc supervision is also offered daily with a member of the Safeguarding team available for advice and support Monday to Friday (this has included weekends during Covid 19).

In February 2020 a further 5 midwives completed their safeguarding supervision training with a total of 12 Midwives now trained across the Maternity service.

A plan is in development for 2020-2021 to ensure that all midwives receive safeguarding supervision over the next 12 months with more group safeguarding supervision plus opportunities for one to one supervision for community midwives with complex cases.

Capacity for Community Midwives to safeguard the unborn / be compliant with Working Together 2018:

Models of Maternity care are being explored to be able to offer a more flexible service to those women who are unable or choose not to attend their hospital appointments. Continuity of carer is being implemented across the service which will increase continuity for all women. With the adoption of the continuity of carer model, safeguarding issues are more likely to be identified and the risk of drift occurring should decrease with the community Midwife getting to know their caseload and the complexities within them.

Community Midwives have adopted a team approach to caring for women with complex social needs, this has increased the attendance at case conferences and other safeguarding meetings.

A monthly meeting is offered to all the community Midwives offering care to women with complex needs, this provides a forum to share best practice and offer support and ideas on what works well.

Safeguarding and Supporting Women with Additional Needs (SSWwAN)

All pregnant women who engage with antenatal care are assessed at their booking appointment. This questioning includes medical and social questions to be able to assess both obstetric risk and potential social risks. Any woman who is identified as having social complex needs that may require additional antenatal support and / or early help are referred through the Safeguarding and supporting Women with additional needs (SSWwAN) pathway.

Community Midwives offer early help assessments and all cases are discussed at the monthly multi-agency SSWwAN meeting. The meeting is chaired by the Named Midwife with support from safeguarding support Midwife. The meeting is attended by Health Visitors, Community Midwives, and the Midwife for Improving women's health, an early help representative and a social worker.

The meeting not only provides the opportunity for management oversight of all the complex social cases in Maternity but is an opportunity for information sharing from the multi-agency team to promote the safety and welfare of the unborn and other siblings within the family.

The minutes of the SSWwAN meeting are shared with all agencies that attend the meeting and a summary of the information is added to each patient electronic record

The following table shows the number of bookings each month where a woman presented with at least one complex social factor (NICE 2010) and a current or history of mental health issues that may require additional support during pregnancy to promote the safety and welfare of herself and her unborn. It is evident that the numbers have increased.

Maternity Bookings with at least one complex social factor is featured 2018/2019 and 2019/2020.

Month	Shropshire		Telford and Wrekin	
	2018 /19	2019 / 20	2018 / 19	2019 / 20
April	45	40	46	41
May	46	53	46	50
June	35	46	44	46
July	40	56	28	73
August	40	46	28	33
September	40	45	38	32
October	31	54	37	29
November	336	39	38	43

December	38	39	38	44
January	45	34	50	44
February	34	34	30	36
March	33	41	41	37
Average /Total	**38/463**	**44 / 527**	**39 / 470**	**42 / 508**

The table below shows the number of women with additional needs that were discussed at each monthly SSWwAN meeting.

Table four: Women discussed at each SSWwAN meeting 2018-2019 and 2019/2020

Month	**Shrop 18/19**	**Shrop 19/20**	**T&W 18/19**	**T&W 19/20**
April	46	30	44	29
May	29	50	43	48
June	22	37	26	48
July	40	46	50	50
Aug	39	43	52	35
Sep	37	24	55	63
Oct	44	24	55	44
Nov	41	24	42	36
Dec	29	34	44	33
Jan	47	22	44	41
Feb	31	26	59	33
Mar	30	28	37	36
Total average	**36/month**	**32/month**	**46/month**	**44/month**

Domestic Abuse:

The Named Midwife for Safeguarding and Domestic abuse receives domestic incidents from the Harm Assessment Unit (HAU) where a pregnant woman has been identified within the household. This information is logged on Maternity electronic records and information with an action plan is shared with the community Midwife / teams

All women are asked the marker question for domestic abuse at booking if it is appropriate. Where partners are present, the midwives are advised to repeat the marker questions later in pregnancy. The Midwife is encouraged to use the Multi-Agency Risk Assessment Conference (MARAC) form as a risk assessment tool following a disclosure of Domestic Abuse.

Midwifery MARAC Referrals	12
Number of Domestic Violence Maternity cases heard at MARAC	18
Number of HAU Incidents Received	540 (average 40 per month)
Number of HAU reports completed	331

The outstanding HAU reports are currently being undertaken with a trajectory for completion by August 2020.

NB: Not all Maternity cases heard at MARAC are assessed and referred to MARAC by Maternity services hence, the discrepancy between the figures above.

Training

The Women and Children's Compliance for level 3 training remains above 90% on 31/05/2020.

All maternity staff are mandated to have Level 3 safeguarding training (Intercollegiate document 2019). This requirement of 12-16 hours (level 3 training) is over a 3 year period. Staff can accumulate these hours in a number of ways. Level 3 safeguarding children's training is offered at the monthly mandatory training day; a 2 hour safeguarding session was also included in the annual Statutory Safety Update in 2019/2020. Staff are requested to complete other e-learning or attend face to face training to ensure they meet the requirements of the intercollegiate document. All training is logged on their personal "Safeguarding Training Passport". The training passport is monitored at the annual appraisal by their line manager.

Training will also include:

- Female Genital Mutilation
- Domestic Abuse
- Radicalisation
- Child Exploitation (CE)
- Neglect
- Early Help

Female Genital Mutilation (FGM):

There were only a small number of referrals in regard to FGM this year. There is a requirement from NHS England that for every baby girl who is born who has a family history of FGM that an alert is added (manually) to the National Spine, to improve communication with health care providers. SaTH have now gone 'Live' with the national FGM-IS (Information Sharing) in September 2019. As we have the least recorded number of FGM referrals we are in the last branch of the national roll out. This will be done by our Named Midwife safeguarding leads. This is the hyperlink for more information:

https://digital.nhs.uk/services/female-genital-mutilation-risk-indication-system-fgm-ris.

SAFEGUARDING ADULTS WITH CARE AND SUPPORT NEEDS

The Adult Safeguarding Team is responsible for all adult safeguarding training, MCA and DoLS. The team is also responsible for supporting staff across the Trust in submitting safeguarding concerns to the Local Authority as well as conducting enquiries into safeguarding allegations made against the Trust by external agencies**.**

The team members also attend Adult Safeguarding Board Sub-group meetings, and comply with requests by the Safeguarding Boards by contributing to audits and assurance reports. The Safeguarding Adult Lead is responsible for collecting, collating and providing data as requested by the Trust hospital and external bodies. The team provides information on current and past patient conditions for both the local authority and the police if requested as part of ongoing safeguarding enquiries. Reports are also provided as requested for Serious Adult Reviews and Domestic Homicide Reviews.

Sub-groups of the Safeguarding Adult Board

During 2019/2020 the Safeguarding Boards have undergone major changes with their statutory membership limiting this to a much smaller group of attendees. The Trust still has a requirement to attend the sub- groups and are compliant with attendance at all required groups including which include:

- Quality and Performance (T&W)
- Audit and Performance (Shropshire) – plan to divide into two separate groups.
- MCA and DoLS (combined authority group)
- Learning and Development (T&W)
- Adult Learning and Development (Shropshire).
- Serious Adult Review Panels
- Criminal exploitation (Adults)

The sub-groups play a central role in providing assurance to the Safeguarding Adults Boards of both Shropshire and Telford. The Adult Safeguarding Team contributes to these sub-groups in order to provide the assurance that the Trust's safeguarding processes are effective and meet the demands of the *Care Act* 2014 and the *Mental Capacity Act* 2005 (19).

The safeguarding team is also involved in a number of multi– agency audits and task and finish groups.

Serious Adult Reviews (SAR)

The trust has been involved in two recent Serious Adult Reviews both of which have been closed.

Adult C

A response to the single agency recommendation has been provided and accepted. A short summary of this investigation has been published on the Telford and Wrekin Safeguarding Board website. The full investigation and outcomes have not been published at the family's request. Staff involved in the care of Adult C has been kept informed throughout the progress and outcome of this investigation.

Adult E

Responses to the recommendations for all agencies has been made and accepted. This investigation has also been published in a shortened form on the Telford and Wrekin Safeguarding Board website. In relation to the Trust the self-discharge documentation was altered as a result of the findings to include a specific question around the patient's, mental capacity.

Currently two further applications for a SAR are under consideration one of which will be a joint Children's and Adults review.

Training.

The implementation within the Trust of the Intercollegiate Safeguarding Competency document has necessitated major changes to the Trust's existing training programme. This has introduced an increase in hours required to meet compliance targets set nationally. The majority of clinical staff within the Trust will require Adult Safeguarding at level 3, which comprises of 8 hours over three

years with a minimum of 50% face to face with the ability to top this up with self-directed learning. The introduction of an adult safeguarding passport will enable assurance and collection of auditable data to give assurance that targets are achieved.

An overall review of all the safeguarding training provided by the Trust began in January 2019. The newly introduced face to face two hour training package for MCA and DOLS has been well received by staff. Adult Safeguarding levels 1and 2 have been reviewed and updated to meet Trust and local safeguarding priorities for the coming year, including an introduction to the Liberty Protection Safeguards however the emphasis remains on Making Safeguarding Personal. A new five hour adult safeguarding level 3 has been commenced and has received very positive feedback. Compliance for level 1 and 2 remains stable and although there has been a significant increase in level 3 and MCA and DoLS compliance these remain well below national target.

Level 1	Rationale	Target	Compliance
1	Safeguarding Adults training at Level one introduces the core competencies of adult safeguarding including identification of abuse and responsibility in acting on information (Intercollegiate document 2018)	**100%**	**91%**
2	Safeguarding Adults at this Level 2 is for all patient facing staff. It builds upon level one identification and immediate actions needed to safeguard patients at risk of abuse, actual or anticipated. (intercollegiate document 2018)	**85%**	**89%**
Mental Capacity Act	Training focus on the legislation and staff responsibility to maintaining patient choice. Consent and documentation completion, mental capacity assessments and best interest decisions	**85%**	**16%**
Deprivation of liberty Safeguards	Covers the legislation, and the circumstance when an application for an authorisation is required with instruction on how to complete the documentation	**85%**	**14%**

*****MCA/DoLs 2 hour face to face sessions commenced in February 2020 but were initially cancelled due to Covid 19. These sessions are now available each week for staff to book onto. The training is also accessible via e-learning.

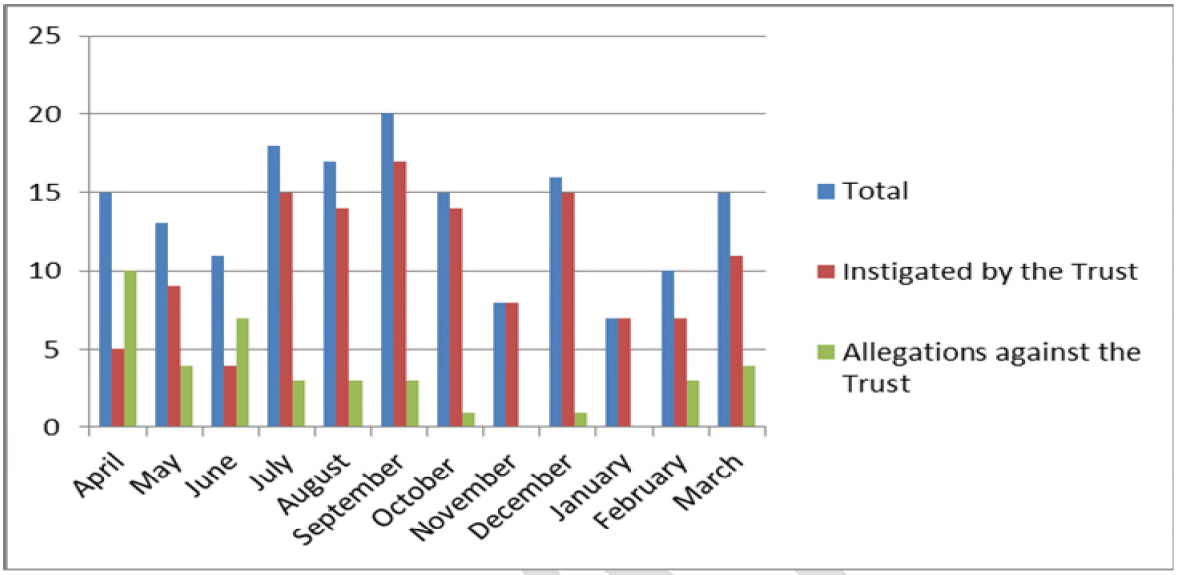
Safeguarding Adults training for all clinical band 5-8 builds upon level 1,2 training with emphasis on supporting staff to fulfil their responsibilities, completing safeguarding enquiries as requested and applying lessons learned. This training is available in the Trust in 2020/21 via a face to face study day or via e-learning modules.

PREVENT training continues to be a statutory requirement for NHS staff with a compliance target of 85%. Corporate induction continues to deliver basic PREVENT awareness training. Compliance with this training increased significantly in 2019/2020 with the target being achieved this the end of the year.

Level 1		Target	Compliance
Basic Prevent	Delivered as part of induction, and introduces reporting pathway and indications of radicalisation	**85%**	**89%**
WRAP 3	Government recommended training on the process of radicalisation and staffs responsibility in noticing and sharing information via the Chanel Panel	**85%**	**90%**

Adult Safeguarding Concerns April 2019 to March 2020

The graph below shows the total number of safeguarding concerns raised each month, there were 165 safeguarding concerns for 2019/2020. There were 39 allegations made against the Trust. This compares to 134 safeguarding concerns raised in the previous year with 32 raised against the Trust.



The relatively high referral rates against the Trust in April and June were primarily due to discharge issues. Similarly to the previous year key themes relate to care around discharge.

Deprivation of Liberty

There has been a significant change in the Trust's interpretations of the legislation since November 2019. Previous to this change the Trust acted on the principle that patients who were likely to regain capacity within a short period of time would not need a deprivation authorisation request. This was based on the Deprivation Of liberty Code of Practice.

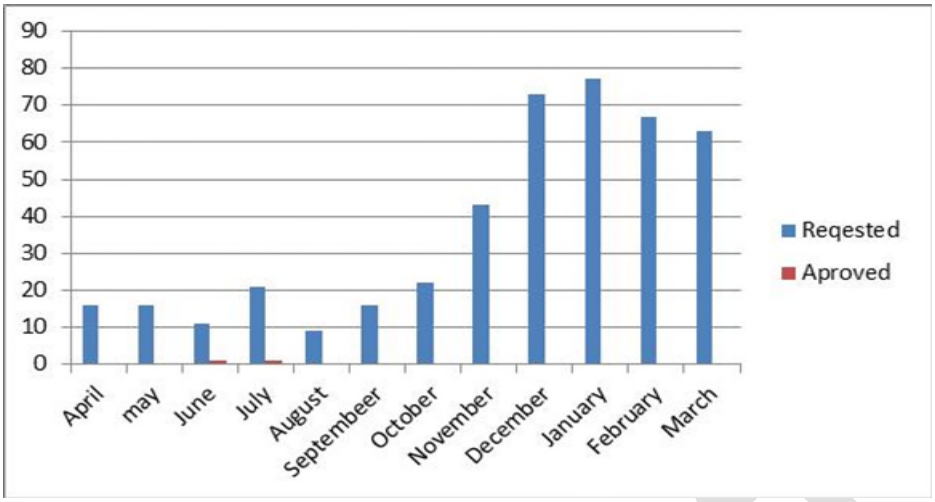
Sec 6.3:

> *"It would not be appropriate to give an urgent authorisation simply to legitimise the short term-deprivation of liberty"*[i].

Sec 6.4:

> *"Similarly, an urgent deprivation of liberty authorisation should not be given when a person is, for example, in an accident and emergency unit or a care home, and it is anticipated that within a matter of a few hours or a few days the person will no longer be in that environment."*

This 'short period' of time is not defined within the guidance and the Trust had adopted 36-72 hours as reasonable given most patients entering the Trust requiring a deprivation are suffering a temporary impairment and are discharged within timeframe. The Trust, based on the feedback from the CQC inspection have changed our policy by requesting a deprivation for all patients who lack capacity on admission regardless of the expectations of them regaining capacity. The graph below shows the number of DoLS application per month and the significant increase in these since the adoption of the new approach.



The low rate of approval, two in the past year is in part, due to the lack of capacity within the Local Authority DoLS teams but most patients applications are unauthorised by the Supervisory Bodies and are discharged before assessment.

Liberty Protection Safeguards

A three year review by the Law Commission made recommendations in relation to the current DoLS to be replaced with a new scheme called the Liberty Protection Safeguards. The Mental Capacity Amendment Act (2019) which introduced the new Liberty Protection Safeguards received Royal Assent on the 16th May 2019. The enforcement date of the changes detailed in this act is 1st October 2020. There is however, a growing body of evidence regarding a lack of preparedness within the health and social care community to push this start date into next year. This is primarily due to the lack of published guidance around systems, processes and individual staff requirements.

The LPS scheme in hospital:

- Is to enabling care and treatment to be given NOT for authorising care or treatment
- Can cover transport
- Can include arrangements to have a person returned to hospital
- Can NOT be used to restrict visitor's friends or family.

The hospital from enforcement will be the responsible body this is expect to entail:

1. Identifying the need for a deprivation and providing an Independent Mental Capacity Advocate.
2. Completion of a three part assessment – Mental Capacity, Mental impairment and necessary and proportionate. The third assessment must take into account wishes and feelings and consultation with family and friends. This cannot rely on previous assessments.
3. Conditions imposed submitted for authorisation
4. Authorisation / sign off by hospital staff unless Approved Mental Capacity Professional needs to be appointed.
5. A 72 hour window for completing all documentation and appointing an IMCA, a Responsible Adult and an AMCP if required.

The changes from the current Deprivation of Liberty process will require significant alteration to the way the trust works and records information. This will include an increase in the Safeguarding team and re- training of all staff likely to be involved in this process. It is currently not possible to work out a definitive plan until the national guidance is published. This guidance has been delayed for publication as it is currently been combined with the Mental Capacity Act guidance. This will be beneficially long term as one will only have to work with a single guidance covering both parts of the act.

Governance for Safeguarding within the Trust

Overall governance in relation to safeguarding within the Trust is overseen externally via the Safeguarding children and adult boards of the Local Authorities and through the CCGs.
Internally, the Trust has a Trust Safeguarding Committee that reports monthly to the Quality and Safety Committee chaired by the non-executive Director for Quality and through to the Trust Board.

The Trust Safeguarding Committee meets on a monthly basis and is chaired by the Chief Nurse or Deputy Chief Nurse. The Committee aims to ensure that whilst inpatients within the Trust, adults with care and support needs and children and young people are kept free from harm by enabling staff to:

- Work in a culture that does not tolerate abuse
- Work together with partners to prevent abuse
- Know what to do when abuse happens
- Share information about safeguarding with frontline staff via their managers.

In addition to Trust staff and Care Group representatives for safeguarding, the group is regularly attended by the Safeguarding Leads of the CCGs.

The Safeguarding Team (Adult and Children) complete and submit quarterly reporting templates in relation to safeguarding to the CCGs which are reviewed and discussed at the Clinical Quality Review meetings. In addition the Trust Safeguarding Team provide quarterly dashboards to the CCG and NHS England PREVENT leads to demonstrate compliance against the requirements of staff training and support.

The Trust fully participates in both internal and external monitoring processes such as self assessments, clinical audits and statutory reviews to ensure systems are in place and functioning effectively. These include:

- Serious Case Review, Internal Management Review and Domestic Homicide Review

A review of the Trust's compliance with Section 11 of the Children Act is completed and submitted to both Local Safeguarding Children Boards by the Named Nurse every six months. During 2019/2020, the self-assessment of the Trust was peer reviewed by the LSCB. This provided assurance to the LSCB that the standards of safeguarding processes and practice within the Trust are robust. One area that the Trust is not compliant relates to Safer Recruitment training.

External Review of Trust Adult Safeguarding

An external review of adult safeguarding was commissioned and undertaken in November to December 2019 with the report received in February 2020; the report findings and recommendations along with a Trust action plan to address these was reported to the Trust Quality and Safety Committee in March 2020. The aim of the review was to identify whether current

systems, processes and practices in relation to the Adult Safeguarding provision in the Trust reflected the relevant legislation and local requirements. The specific areas of consideration identified in the terms of reference for the review included:

-Benchmark adult safeguarding arrangements against the intercollegiate document;
-Consider all aspects that link with the service e.g. staff training, reporting mechanisms, pressure ulcers and safeguarding, Serious Incidents and safeguarding
-Determine how the Trust can best use existing resources to safeguard adults at risk;
-Identify alternative options for delivering the Adults Safeguarding Service within current resource
-Make recommendations about short, mid and long term arrangements to drive the safeguarding adults service forward to excellence, consider additional resources that may be required.

The action plan in relation to this report and finding included actions in relation to:

- Systems to manage and give assurance
- Systems for learning and improvement
- Policies and Procedures
- Staff specific responsibilities for safeguarding
- Workforce training, support and supervision
- Partnership with patients and other involved in care

The action plan in relation to this external report and recommendations includes 30 actions, currently 14 are completed and the others are in progress. This action plan will be updated and reported to the Quality and Safety Committee quarterly.

Looking forward 2020/2021

The Trust is committed to improving child and adult safeguarding processes across the organisation and aims to safeguard all children and vulnerable adults who may be at risk of harm.

Processes will be developed to empower, be person centred, preventative and holistic and we will continue to deliver the safeguarding agenda encompassing a multi agency and partnership approach. The governance arrangements for child and adult safeguarding will continue and systems will be put into place to allow for effective monitoring and assessment of compliance against locally agreed policies and guidelines. The Trust will work on findings of the CQC inspection in respect of safeguarding.

The known influences and policy drivers that are likely to be the focus of the safeguarding team for the forthcoming year are:

- To continue to provide attendance at LSP/LSAB sub-groups to develop practices and contribute to the development of multi agency training strategy and procedures.

- To continue to provide in-house local guidance to complement LSP/ LSAB procedures, protocols and practice guidelines.

- To ensure that SaTH adheres to the recommendations for staff training in child protection/adult safeguarding procedures

- Continue to work in partnership with local health and social care colleagues to keep children, young people and adults with a care and support need safe.

- To participate in Child Death Overview Panels, Safeguarding Adult Reviews, Child Learning Reviews and Domestic Homicide Reviews if required.

- To continue to work with Human Resource department in ensuring DBS checks and "Managing Allegations against Staff" policy and process are adhered to

- To continue to ensure that staff adheres to the training programmes and training figures continue to increase.

- Continue to engage with people at risk of abuse, their family, carers, relatives and external agencies.

- To continue to work with local partners with the National Child Protection Information System and new FGM information system

- To continue to be an active member of the West Midlands Regional Named Nurse for Safeguarding (Children) network.

- To meet the CQC recommendations following the CQC/Ofsted LAC review and the CQC comprehensive inspection of the Trust in 2016

- To ensure community midwives have capacity to meet their safeguarding responsibilities and are able to meet the requirements of Working Together (2018) - this continues to remain on the Maternity risk register.

- To ensure the new models of Maternity care support safeguarding supervision – this continues to remain on the Maternity risk register.

- To work with the Independent Chair of the Inquiry in Child Sexual Exploitation in Telford.

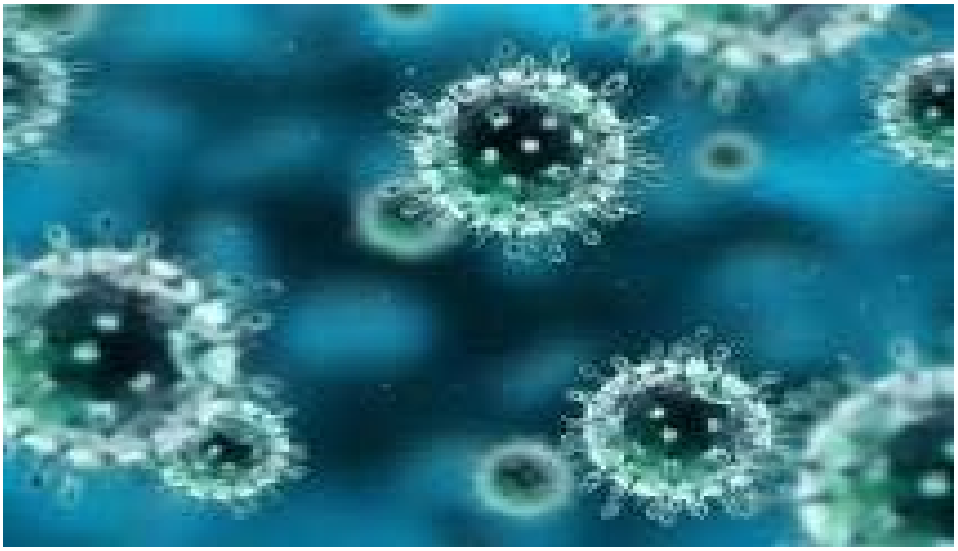
Recommendations

The Trust Safeguarding Committee are asked to:

- Receive the safeguarding report prior to submission to the Quality and Safety Committee

2019/20

Infection Prevention & Control Annual Report



Report compiled by: The Infection Prevention & Control Team
Shrewsbury & Telford Hospital NHS Trust
May 2020

Foreword by Director of Infection Prevention and Control (DIPC)

Infection Prevention and Control Annual Report 2019-20

This Annual report covers the period 1st April 2019 to 31st March 2020 and has been written in line with the ten criteria as outlined in the Health and Social Care Act 2008 Code of Practice in the Prevention and Control of Infection (updated 2015). The ten criteria outlined in the code are used by the Care Quality Commission to judge a registered provider on how it complies with Cleanliness and Infection Prevention & Control requirements detailed in the legislation. It looks at all aspects of IPC, including monitoring and surveillance, environment, cleaning, staff, policies and laboratory provision.

However the biggest challenge for Infection Prevention and Control this year is one that we will continue to face for the next few months at least, the COVID 19 pandemic.

SECTION 1: KEY ACHIEVEMENTS OF 2019-20

- Our Flu vaccine coverage for staff increased from 75% in 2018/19 to 83% for winter 2020/21, exceeding the 80% target. A total of 3875 influenza vaccines were given to our staff. . This great achievement was due to the hard work of our Infection Control Team, Occupational Health Provider; Team Prevent and other nurse vaccinators employed by the trust.

  Our MRSA bacteraemia target is zero. In 2018/2019 the Trust had one MRSA bacteraemia which was a reduction from the 5 cases reported in the previous year.

- A new Ultra Violet based cleaning system has been introduced to assist in the reduction of nosocomial infections

- Point of Care Flu testing on admission was introduced to facilitate rapid isolation of flu cases thus reducing spread to other patients

- The Trust was assessed by NHSE/I in June 2019 and then again in October 2019 at which time the RAG rating was improved from Red to Green

- The arrival of the COVID 19 pandemic at the beginning of 2020 introduced a new and very significant challenge to all acute services both in the UK and internationally. The IPC team was actively involved in planning for patients with COVID 19 and helping staff with their management. This involved continuous updating and training of staff as new guidance was released as knowledge about the virus increased. At the end of March 2020 we introduced in-house testing for COVID-19. Managing the pandemic and recovery from it will be an ongoing workload for the team in 2020/21

- Staff Training

    - One of our clinical scientists in microbiology attended the residential course on Engineering Aspects of Infection Control at Eastwood Park Training Centre. This covers very technical aspects of infection control such as ventilation, decontamination and water supplies

    - Further enhanced the knowledge and skills of our Infection Prevention and Control Nursing Team; One of our Band 7 nursing staff has completed the Infection Prevention and Control degree at Birmingham City University

SECTION 2: Abbreviations

AMR	Anti-Microbial Resistance
ASG	Antimicrobial Stewardship Group
CCG	Clinical commissioning groups
C *difficile*	Clostridium *difficile*
CCG	Clinical Commissioning Group
CDI	Clostridium *difficile* infection
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation Payment Framework
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DON	Director of Nursing
E coli	Escherichia coli
ESBL	Extended Spectrum Beta Lactamase
GDH Ag	Glutamate dehydrogenase antigen of *C. difficile*
GRE	Glycopeptide Resistant Enterococcus
GP	General Practitioner
HCAI	Health Care Associated Infection
IM&T	Information & Technology
IPC	Infection Prevention & Control
IPCC	Infection Prevention & Control Committee
IPCN	Infection Prevention & Control Nurse
IPCT	Infection Prevention & Control Team
MGNB	Multi resistant gram negative bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Meticillin Resistant *staphylococcus aureus*
MSSA	Meticillin Susceptible *staphylococcus aureus*
PCR	Polymerase Chain Reaction
PFI	Private Fund Initiative
PHE	Public Health England
PLACE	Patient-led assessments of the Care environment
PPE	Personal Protective Equipment
RAG	Red, amber, green
RCA	Root Cause Analysis
SaTH	Shrewsbury & Telford Hospitals
SSI	Surgical Site Infection
TWCCG	Telford & Wrekin Clinical Commissioning Group
VNTR	Variable number tandem repeat (a form of DNA typing)

SECTION 3: INTRODUCTION

The Trust recognises that the effective prevention and control of healthcare associated infections (HCAI) is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place for compliance with the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Trust set out to continue the commitment to improve performance in infection prevention practice. As outlined in the Health and Social Care Act 2008, at the heart of this there are two principles:

- to deliver continuous improvements of care
- it meets the need of the patient

Compliance with the Health Act is judged against 10 criteria which we will look at in detail in the next section.

Criterion	Detail
Criterion 1	There are systems to monitor the prevention and control of infection
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and reduce the risk of adverse events and antimicrobial resistance
Criterion 4	Provide suitable accurate information on infectious to service users, their visitors and any person concerned with providing further support or nursing/medical care
Criterion 5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
Criterion 6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection
Criterion 7	Provide or secure adequate isolation facilities
Criterion 8	Secure adequate access to laboratory support as appropriate
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations, that will help to prevent and control infections
Criterion 10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

SECTION 4: COMPLIANCE

Criterion 1:

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

Infection Prevention Team

The Infection Prevention and Control Team (IPC) provided IPC advice and support to wards and departments. The team continued to support frontline staff and prioritise urgent IPC issues during winter pressures. The Trust IPC Team experienced a number of changes in personnel over the last year. This resulted in periods of low staffing levels due to the recruitment period.

At the Shrewsbury and Telford Hospital NHS Trust (SaTH) the Director of Infection Prevention and Control (IPC) has overall responsibility for the IPC Team; however the team is managed by Janette Pritchard (Lead Nurse Infection Prevention and Control). The structure for Infection Prevention and Control in the Trust is shown in Appendix 1.

Dr Patricia O'Neill as Infection Prevention and Control Doctor (IPCD) works for IPC part-time and is a Consultant Microbiologist. In addition another three consultant microbiologists continue to provide support to the IPC Team. Barbara Beal, Interim Director of Nursing & Quality, took over as Director of Infection Prevention and Control in June 2019.

The Trust was visited by NHSI on two occasions during 2019/20 to review IPC practices. Visits took place in May 2019 and then again in October 2019 when the assessment improved from RED to GREEN on the NHSE/I internal escalation matrix.

NHSE/I said the visit demonstrated a continued focus and energy on Infection Prevention. This was identified both during the meetings and the clinical visits to the six clinical areas across the two sites.

NHSE/I were also impressed with the following:

- A Trust Board IPC development session is being planned
- There is improved engagement with staff across the organisation
- Confirm and challenge meetings have been set up and have proven beneficial
- IPC nurses have now been allocated specific wards- this has improved ward relationships and engagement for which the Heads of Nursing were grateful for
- A formal IPC review of the Neonatal Unit (NNU) had been undertaken and actions completed
- Previous visit findings had been actioned.
- Cleaning checklists had been developed
- Post outbreak cleaning documentation and sign off has been devised.
- Cleaning hours: The Trust has reviewed its cleaning provision and cleaning is now being undertaken in ED until 10pm
- New UV cleaning system purchased.
- Cleaning technicians in place.
- Raised awareness of staff roles and responsibilities: the IPC team are undertaking Matrons masterclasses.
- Estates: there is a significant backlog which is being reviewed. The estates team provides regular updates on outstanding risks. Identified stronger relationship with IPC team.

- Microbiology support: at present there is a WTE vacancy which is proving difficult to recruit to (this is not a local issue but one which several trusts are identifying). This was due to the retirement of two of the consultant microbiologists. Patricia O'Neill has returned post retirement 2/7 week to continue the ICD role. We have appointed a Consultant Clinical Scientist in Microbiology but still have a WTE vacancy.

An action plan was developed to address the concerns with a cross reference to the Health Act as per NHSE/I recommendations. Additionally an improvement plan was developed to address issues flagged in the Emergency department; both were then monitored via the Infection Prevention Control Committee.

The Trust Infection Control Committee is held monthly and is chaired by the Director of Nursing, Midwifery & Quality or Deputy. Each Care Group is required monthly to report on IPC performance and key actions.

Infection Prevention & Control issues are raised at the monthly meetings of the Quality and Safety Committee, which reports directly to Trust Board and is attended by the Director of Nursing & Quality.

The IPC service is provided through a structured annual programme of work which includes expert advice, audit, teaching, education, surveillance, policy development and review as well as advice and support to staff, patients and visitors. The main objective of the annual programme is to maintain the high standard already achieved and enhance or improve on other key areas. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust. The annual programme is agreed at the IPC committee and then reported to the Trust Board.

Whilst writing this report at the end of the financial year the Trust started seeing inpatient cases of COVID 19. The National COVID 19 pandemic has caused significant pressures to the IPC Team & a business case is currently being written to increase the size of the team and to enable the provision of a 7 day service. Significant work has taking place regarding the correct placement of patients during their stay in SaTH. The Pandemic has also highlighted that the Trust has a significant issue with lack of side rooms.

During the Covid pandemic the IPC Team has been supported by staff that previously had IPC experience being redeployed to the team.

Committee Structures and Assurance Processes

The committee structure in relation to Infection Prevention and Control reporting are shown in Appendix 2.

Trust Board

The Code of Practice requires that the Trust Board has a collective agreement recognising its responsibilities for Infection Prevention and Control. The Chief Executive has overall responsibility for the control of infection at SaTH. The Trust designated Director of Infection Prevention and Control. The DIPC attends Trust Board meetings with detailed updates on infection prevention and control matters. The DIPC also meets regularly with the Chief Executive.

Quality & Safety Committee

The Quality & Safety Committee is a sub-committee of the Trust Board and is the committee with overarching responsibility for managing organisational risks. The committee reviews high level performance data in relation to infection prevention and control, monitors compliance with statutory obligations and oversees management of the risks associated with infection prevention and control.

Quality and Safety (Q&S) is responsible for ensuring that there are processes for ensuring patient safety; and continuous monitoring and improvement in relation to infection prevention. The Q&S forum receives assurance from IPCC that adequate and effective policies and systems are in place. This assurance is provided through a regular process of reporting. The IPT provide a monthly report on surveillance and outbreaks.

Antimicrobial Management Group

The Antimicrobial Stewardship Group (AMG) is a multidisciplinary group responsible for the monitoring and review of good antimicrobial stewardship within the Trust. The AMG reports directly to the Trust board through the Drug and Therapeutics committee and meets on a bi-monthly basis. The group drives forward local activities to support the implementation of international and national initiatives on antimicrobial stewardship including Start Smart then Focus and the European Antibiotic Awareness Campaign. The AMG produces and updates local antimicrobial guidelines which take into account local antibiotic resistance patterns; regular auditing of the guidelines; antimicrobial stewardship practice and quality assurance measures; and identifying actions to address poor compliance with guidelines.

Antimicrobial audit results related to compliance with the local antimicrobial guidelines are produced monthly. These are reported to the Clinical Governance leads that are tasked with onward dissemination. There is an escalation process for clinical areas that do not follow clinical guidelines and there is active engagement at Executive level with Senior Clinicians in Specialities with repeated non-compliance.

On average the Trust's prescribers choose antibiotics in accordance with the antimicrobial guidelines in approaching 90% of cases, which is a slight improvement over the last 12 months. Antibiotic course durations comply with the guideline in 75% of cases. This has remained the same over the last 12 months. Improving effective antibiotic prescription review is an on-going priority at the trust with the hope that this figure will improve over time.

The Antibiotic Pharmacists and Pharmacy Team are working hard to help the Trust meet the national requirements for reduction in antibiotic usage and take an active part in auditing and submitting information for CQUINs. Our well recognised narrow spectrum antibiotic policy has been instrumental in achieving 65% WHO access antibiotic usage against a target of 55%.

There is a separate **Local Health Economy Infection Prevention & Control and Antimicrobial Group** which is chaired by the Lead Shropshire CCG Nurse. The group meets quarterly, and has representation from all key stakeholders, including microbiologists. A regular report is submitted to IPCC.

Decontamination Meetings

The Trust Decontamination Lead is the Chief Executive. The management of Decontamination and compliance falls into three distinct areas: Estates, IPT and the Equipment User, details are outlined later in the report.

Water Safety Group

The Water Safety group is a sub group of IPCC and meets quarterly. It is chaired by the DIPC / Deputy DIPC with multi-disciplinary representation.

Reports/Papers Received by IPCC

Monthly	Bimonthly
Scheduled Care Group Report	Occupational Health Report
Unscheduled Care Group Report	MRSA Bacteraemia Action Plan
Women and Children's Care Group Report	**Quarterly**
Support Services Care Group Report	Antimicrobial Stewardship Report
IPC Team Report	IPC Annual Programme Update
Cleanliness Monitoring Report	Water Safety Group Minutes
HCAI Update Report	Health and Safety Update (FFP3 / Sharps)
PHE Update	Decontamination Group Minutes
IPC Policies for approval	HCAI Self-Assessment Update
Annually	
IPC Annual Report for approval	
IPC Annual Programme for approval	

Groups/Meetings Infection Prevention Team Attend

Monthly	Quarterly
Infection Prevention and Control Committee	IPC Link Nurse Meetings
Policy Approval Group	BSI Reduction Group
Devices, Products and Gases Committee	Decontamination Group
Nursing, Midwifery and Allied Health Professionals Forum	Water Safety Group
Matrons Meetings	LHE IPCN Forum
Operational Risk Group	LHE IPC and Antimicrobial Prescribing Group
Housekeepers Meetings	Trust Antimicrobial Management Meeting
Ad-hoc	
C difficile RCA Multidisciplinary Reviews	
Post Infection Review Meetings	
Outbreak/Period of Increased Incidence Meetings	
Estates Refurbishment / Planning Meetings	
Site Safety Meetings	

Infection Surveillance (including external targets)

All organisms of IPC significance are monitored by the IPC team. Currently this is a very manual and time consuming process, involving daily lists generated by the Microbiology Department and emailed to the IPC secretaries. This is not a robust process and has proved particularly cumbersome during the COVID 19 pandemic. We hope to get an automated surveillance system in 2020/21 which is much more efficient in tracking patients and infections and should release time for IPC nurses, secretarial staff and consultant microbiologist staff.

Clostridium difficile

Clostridium difficile (C.difficile) is a bacterium found in the gut which can cause diarrhoea after antibiotics. It can rarely cause a severe and life-threatening inflammation of the gut called pseudo-membranous colitis. It forms resistant spores which require very effective cleaning and disinfection to remove them from the environment.

Infection is nearly always preceded by antibiotic treatment but antibiotics may have been stopped up to 6 weeks before the patient presents with symptoms. Although most antibiotics have been implicated, broad-spectrum agents such as cephalosporins, quinolones and carbapenems (e.g. Meropenem) are most likely to cause it as they wipe out the “normal flora” of the gut which usually holds C difficile in check.

The Trust reports all cases of C difficile diagnosed in the hospital laboratory to Public Health England. Prior to April 2019, only cases where the sample was taken later than the third day after admission were considered attributable to the trust. But this definition has now changed as of April 2019. Our target for C difficile in 2019/20 was no more than 43 trust apportioned cases in patients over the age of 2 years.

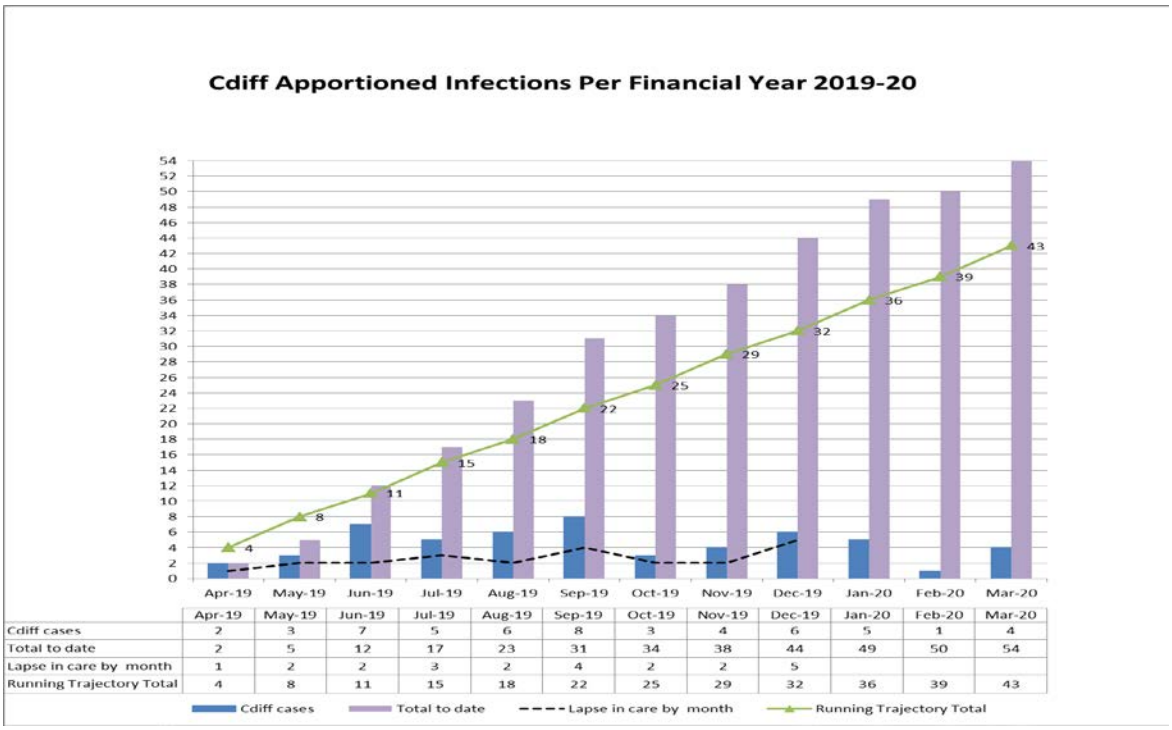
At end of the 2019/2020 year there were 54 trust apportioned cases so we have exceeded our limit of 43 trust apportioned cases. Of these, 26 cases were Hospital Onset Healthcare Associated ie sample taken in hospital more than 2 days after admission; and 28 cases were Community Onset Healthcare Associated i.e. patients were positive in the community but had been in hospital within the preceding 28 days. It is difficult to compare these figures with last year as the definitions have changed. Last year 2018/2019 we had 18 cases but this only counted cases diagnosed in hospital more than 3 days after admission.

The Trust continues to review all cases to assess whether there was a “lapse in care”. Through Root cause analysis (RCA) cases where the trust does not feel there was a lapse in care are sent for appeal to be reviewed by an external panel comprising members of the Clinical Commissioning Groups for Shropshire and Telford and Wrekin, Public Health England, and NHSE/I

Shropshire and Telford and Wrekin CDI Appeals Panel have reviewed 40 of the 54 CDI cases attributed to SaTH in 2019/20. In 20 cases the panel upheld the Trust’s decision that there were no lapses in care which directly or indirectly contributed to the patients acquiring CDI; however the panel believed that lapses in care had most likely occurred in the other 20 cases which directly or indirectly contributed to the patients acquiring CDI. Of the remaining 14 cases, 5 cases were not submitted to the panel as the Trust determined that lapses in care which directly or indirectly contributed to the patients acquiring CDI had most likely occurred. The nine cases reported in Quarter 4 have not yet been reviewed by the Panel as this was stepped down due the change in focus in response to the Covid-19 pandemic.

The commonest cause of C diff was antibiotic prescribing, but this was mostly within prescribing guidelines. Preventable causes included:

- In two cases issues with cleanliness noted so cross infection could not be ruled out
- prescribing antibiotics outside of guidelines
- Lack of samples before antibiotics so unable to change to a narrow spectrum agent.
- delay in isolation before a positive result



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Cdiff cases	2	3	7	5	6	8	3	4	6	5	1	4
Total to date	2	5	12	17	23	31	34	38	44	49	50	54
Lapse in care by month	1	2	2	3	2	4	2	2	5			
Running Trajectory Total	4	8	11	15	18	22	25	29	32	36	39	43

Clostridium difficile Action Plan

Work continues to reduce the cases of C difficile. This relies upon appropriate antibiotic prescribing and advice, the earliest detection of possible C.difficile case and prompt isolation of patients with diarrhoea. All positive C. difficile stool samples are telephoned to the ward as soon as they are available with advice on the most appropriate antibiotic based on the clinical scenario. These measures taken into account with environmental cleaning, and good hand hygiene technique and practice will help in reduce cases overall and cross infection. Introduction of Hydrogen Peroxide Vapour and Ultra violet light deep cleaning will also reduce cases.

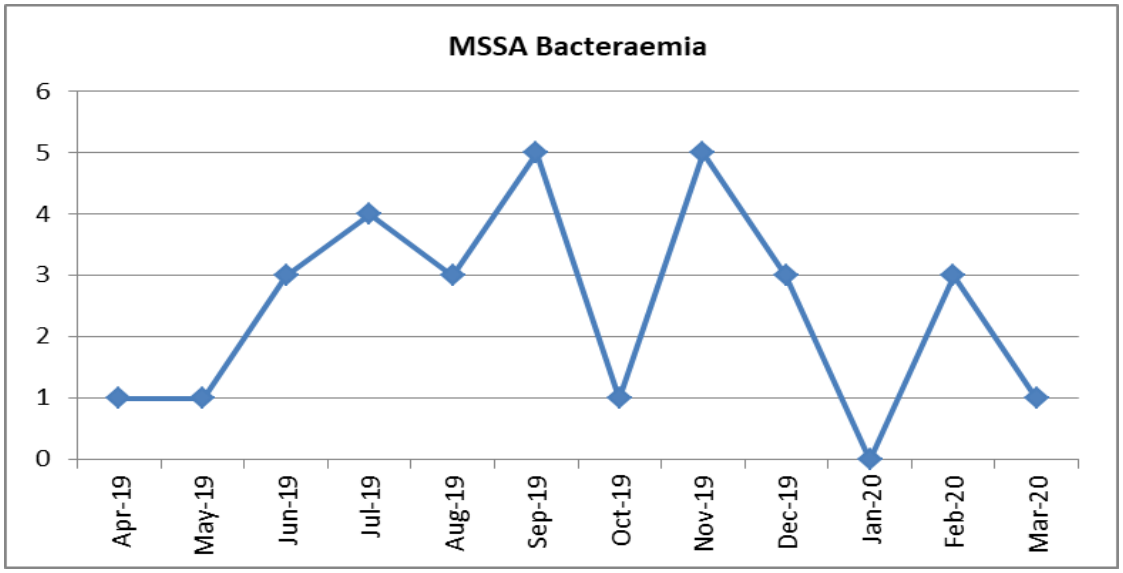
As from April 2020/21 financial sanctions have been removed from the NHS contract. Thereby, the CDI Panel will not be reviewing 2020/21 cases. The Trust however, is still expected to undertake a review of each case to identify whether there is any learning to be shared.

MRSA Bacteraemia

In 2019/20 there was one trust apportioned MRSA bacteraemia case (this is against a target of zero). The source was identified as arising from skin/soft tissue infection. Two further cases of MRSA bacteraemia were identified and apportioned to the community. Last year we had five cases of which four were contaminants. The trust has a MRSA recovery action plan in place which focuses on ensuring staff are competent in taking blood cultures. This is monitored monthly at the IPCC meeting.

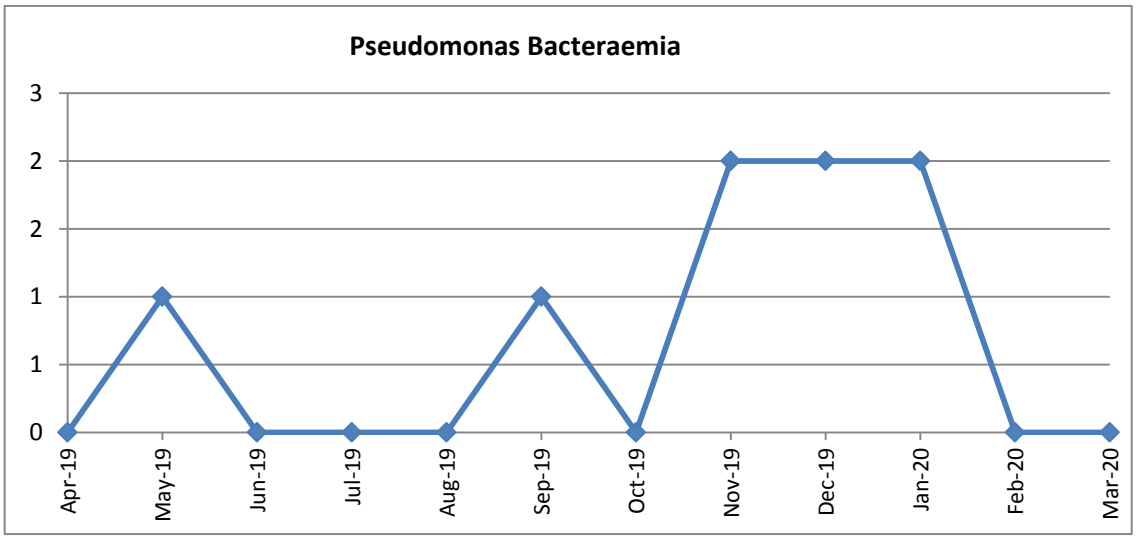
MSSA Bacteraemia

Thirty MSSA bacteraemia cases were apportioned to the trust for the period 2019/2020. Last year 2018/2019 there were 23 trust apportioned cases of MSSA. This is an increase of seven. We do not have a formal target for reduction of MSSA bacteraemia cases. The cases of bacteraemia were associated with the following sources of infection. Infected peripheral lines, infected pacemakers, skin and soft tissue infections and septic arthritis.



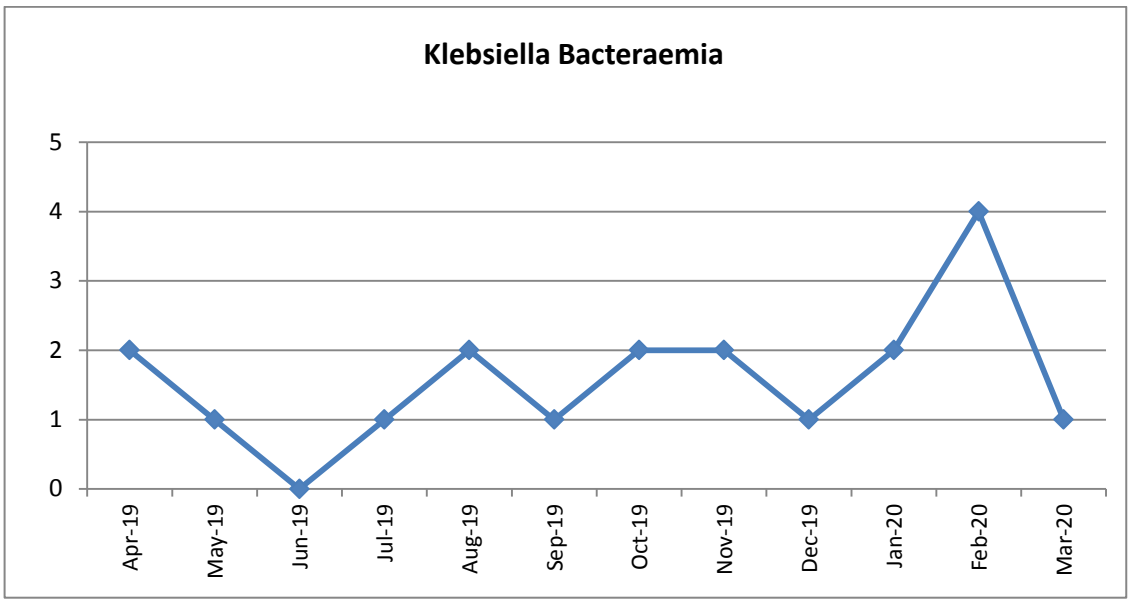
Gram Negative Blood Stream Infections

In 2019/20 the Trust had 8 trust apportioned pseudomonas cases, compared to 4 cases in 2018/19. The bacteraemia cases were associated with the following sources; 1) Pneumonia 2) lower respiratory tract infection 3) Upper UTI- urine catheter associated. 4) Acute lymphoblastic leukaemia 5). There were 2 cases were the source of infection could not be established.

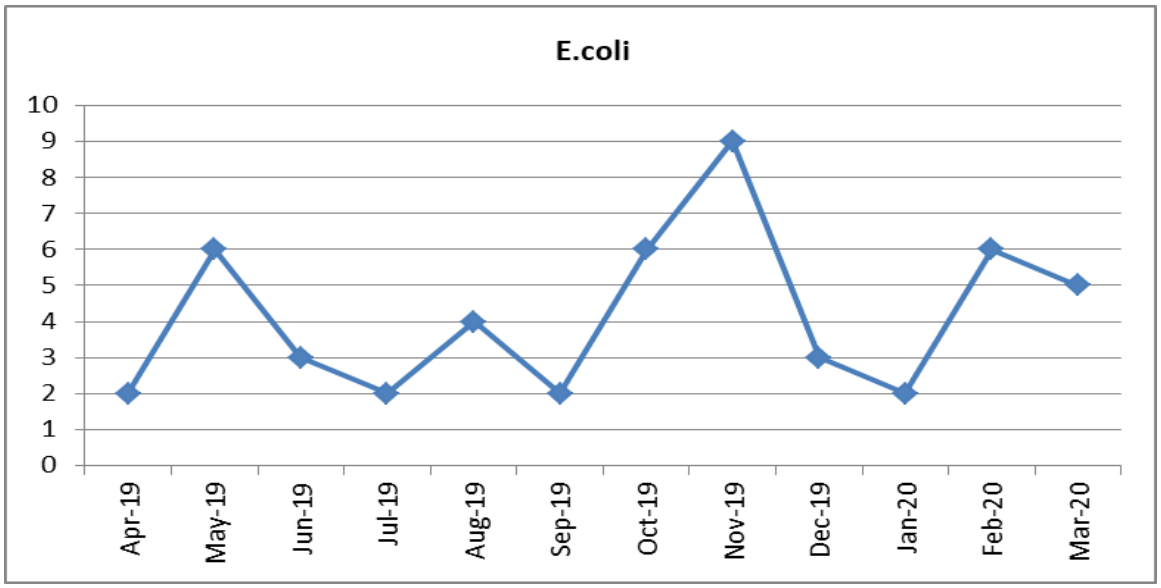


In 2019/20 we had 19 trust apportioned Klebsiella bacteraemia cases, compared to 14 cases in 2018/19. The cases were associated with the following sources of infection; 1) Urinary tract

infections 2) Catheter associated urinary infection 3) Skin and soft tissue infection 4) Line infection 5) Post ERCP.



In 2019/20 we had 50 trust apportioned Escherichia coli bacteraemia cases, compared to 52 in 2018/19. This is a reduction of 2 cases on last year.



Since 2018/19 there has been a continued focus on using the Health Economy approach to reduce *Escherichia coli* bloodstream infections as they represented 55% of all Gram-negative bloodstream infections nationally.

The Secretary of State for Health launched an important ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021 and reduce inappropriate antimicrobial prescribing by 50% by 2021. Gram-negative bloodstream infections are believed to have contributed to approximately 5,500 NHS patient deaths in 2015. We know GNBSI cases can occur in hospitals however, half of all community onset cases have had some healthcare interventions either from Acute, Primary or Community Care. Therefore, a Health economy approach is required to achieve the reductions

Research evidence has established that the most important risk factors for healthcare associated Gram Negative infections are:

- Indwelling vascular access devices (insertion, in situ, or removal)
- Urinary catheterisation (insertion, in situ with or without manipulation, or removal)
- Other devices (insertion, in situ with or without manipulation, or removal)
- Invasive procedures (e.g. endoscopic retrograde cholangio-pancreatography, prostate biopsy, surgery including, but not restricted to, gastrointestinal tract surgery)
- Neutropenia (low white cell count – usually from chemotherapy)
- Antimicrobial therapy within the previous 28 days
- Hospital admission within the previous 28 days.

The local Health Economy group of which SaTH is a member, met quarterly throughout this period to further expand the work and raise awareness required to prevent Gram negative infections. Most of the work has been to reduce urinary catheter related infection in the hospital and the community by the introduction of the Catheter Card, carried by the patient. The card is given to every patient who is catheterised as a way of communication to all healthcare providers of the reason for catheterisation and when to change or remove it. This card has been well received and discussed regionally.

An awareness initiative to promote the Antimicrobial Resistance and Lower Urinary Tract Infections in older people was undertaken by developing a poster and discussing it with medical and nursing staff in clinical areas. This was to highlight the NICE guidance about diagnosis, treatment and antibiotic management of UTI in older patients. The poster featured the “Dip-No dip“ campaign slogan to remind staff not to use a dipstick to diagnose UTIs in the older person.

IPC staff designed posters called “WEE NEED YOU” which were given to the wards alongside background education regarding the timely review and documentation that is required in monitoring use of urinary catheters. This was shared in the trust media page “Chatterbox” and was approved by the IPC NHSEI Lead during their visit. The urology specialist nurse is now using these items for teaching clinical staff.

Within the group there is also a focus on Antimicrobial Stewardship and the effective systems and processes for monitoring compliance with antimicrobials. This is reported through pharmacy and through IPCC.

National Hydration Week was celebrated within the trust focusing on areas such as dementia care and Speech/Language therapy where patients’ ability to undertake hydration is of a paramount importance. We also highlighted hydrating fruit options and physical aids that can be used to help dementia patients.

Carbapenemase–Producing Enterobacteriaceae cases (CPE)

CPE are gram negative bacteria which are so resistant to antibiotics that even our last line of defence – carbapenem antibiotics – are ineffective. So it is extremely important to detect patients with these bacteria and prevent spread through isolation and cleaning. Public Health England published a toolkit for the early detection, management and control of CPE in December 2013. The toolkit provides expert advice on the management of CPE to prevent or reduce the spread of these bacteria into (and within) health care settings, and between health and residential care settings. The Trust has a CPE policy in place. This reflects screening guidance recommended by Public Health England.

2018-19 the trust had nine Cases of CPE. Five of those cases were attributed to the Trust. During the period 2019/20 the trust had six Cases of CPE attributed to the trust.

Audit Programme to Ensure Key Policies are Implemented

SaTH have a programme of audits in place, undertaken by both clinical areas and the IPT, to ensure that areas are consistently complying with evidence based practice and policies. Action plans which were devised by clinical areas where issues are highlighted were fed back to the IPCC via the Matron/ Head of nursing for the area.

Audit title	Completed	Key Findings
Commode Audit	Sept 2019	74% commodes were noted as clean and stored correctly- IPC to audit regularly on quality ward walks 23% of areas used green decontamination bands on commodes and bed pans- standard decontamination label to be rolled out by procurement team
Isolation/side room availability and utilisation audit, including placement and management of diarrhoea patients (twice yearly July and Nov)	Aug 2019	The average availability of single rooms with en-suite in UK was 20.7%, in SaTH is 7.5%. Inadequate side rooms to isolate all patients with a history of a significant organism according to national guidelines Inadequate side rooms to isolate all patients with diarrhoea (T5-7) There is a trend of non-compliance with isolation etiquette trust wide, side room doors left open without documented evidence of risk assessment Action IPC Roadshow, focus on isolation, regular audit on isolation etiquette as part of quality ward walk
Sluice Audit	Sept 2019	246 estate issues identified across both sites, some of which were still outstanding from 2017's audit. This is a 9% improvement from 2017. Action-Estates and cleanliness team to update IPCC on progress
Audit of IPC Care Plan 'H' and documentation	Sept 2019	All patients that required isolation were isolated. All patients with a current infection risk had an infection status sheet, however in all cases these had been put in place by the IPC nurses not the ward nurses. If side room doors were unable to be kept closed, a reason was not always documented in the notes. Whilst MRSA screening was always documented on the front of the nursing admission document, the CPE risk assessment was not done at all. Action- Infection status sheet discontinued, new IPC care plan in place to be ordered and completed by the ward. Launched at IPC roadshow Nov 2019. Nursing documentation being reviewed by the trust as a whole.
Use of PPE (Gloves and Aprons) Link Nurses	Feb 2020	Postponed due to COVID. Completed in May 2020 through clinical audit, awaiting results.
Segregation of Linen (review audit first & invite facilities to complete)	Dec 2019	Linen was found to be clean at the point of delivery to the ward. Linen was not always found to be disposed of at the bedside. Linen rooms were found to house inappropriate items Action- linen segregation posters available in all sluices, Ward managers aware that linen should be kept in a designated area to reduce risk of cross contamination.

Infection Prevention and Control Quality Ward Walks

As of April 2019, the Quality Ward Walk process changed to assess an area of IPC each month rather than all aspects each quarter, this has increased our visibility on the ward and has been well received by department managers. Remedial actions are being put into place in a timelier manner. The following 3 categories are assessed monthly

- Environment and Equipment
- Isolation/Management of Infective Patients
- Invasive devices

The IPCT also record any other observations of IPC concern. These will be marked as a percentage and if the ward/department falls under the 80% pass rate the IPCT will then add that particular category into the following month and complete it again. Any areas that fail a consecutive assessment will be required to provide a robust action plan that gives assurances on the areas that require improvement.

Reoccurring non-compliance noted during the QWW was utilised during the IPC roadshow, such as “It’s in your hands” provided focused themes around hand hygiene and glove awareness, this also provided educational opportunities to reinforce good practice and to discuss key points.

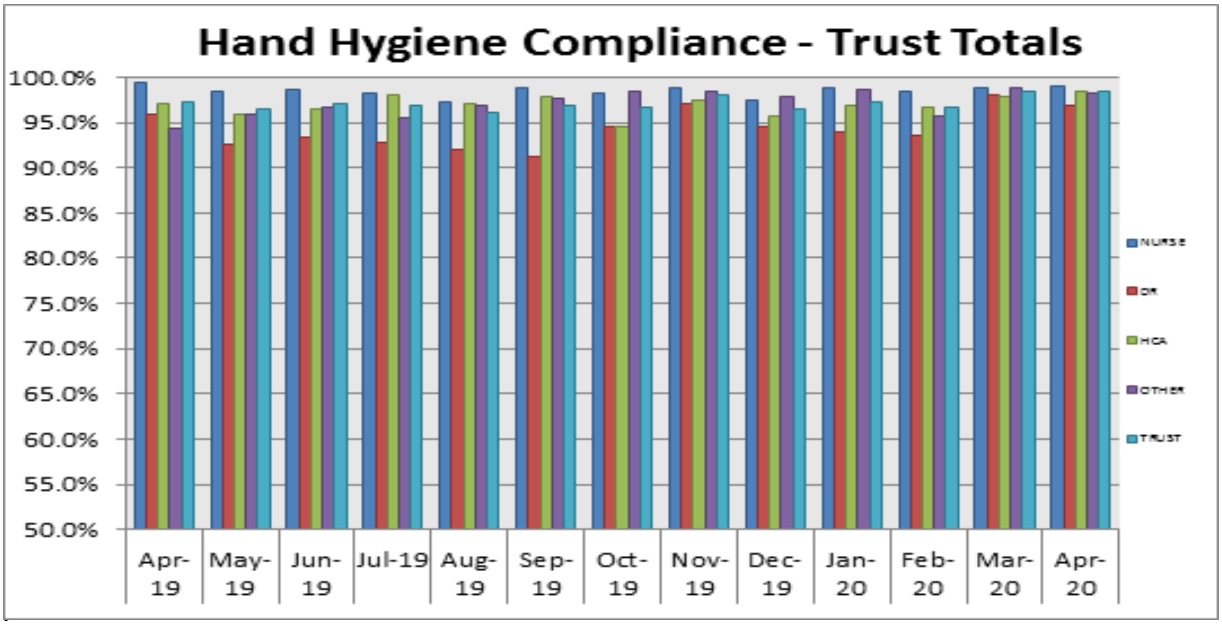
During the year, IPC worked closely with the cleanliness team to review and produce new robust cleaning checklists. Ongoing monitoring in ED has meant the introduction of extended evening cleaning is now implemented. The trust has also implemented evening cleaning hours for every ward across both sites.

The IPC Team work closely with the Estates Department. Monitoring, reviewing and reporting any outstanding work to be completed. A prioritised list of work was produced and reviewed monthly at IPCC.

The IPC team have been supporting and monitoring both Emergency departments over the past 12 months. Both areas have received daily visits and weekly Quality ward walks, concentrating on PPE, Hand hygiene and the department environment. Any issues are immediately escalated to the department manager, Matron and Head of nursing. The IPC team and Estates department have collaboratively reviewed the area; this has resulted in increased hand washing facilities in the department & improved decoration. Throughout the Covid 19 pandemic the IPC team have supported both sites with advice for clinical placement of patients and staff training with enhanced PPE.

Audits of Hand Hygiene Practice

All wards audit their compliance with hand hygiene at least monthly. Results are shown in the table below. Overall compliance remains over 95%. However, whilst the overall average for nurse and HCA compliance was consistently over 95%, the doctors’ overall hand hygiene compliance fell below 95% on nine occasions throughout the year.

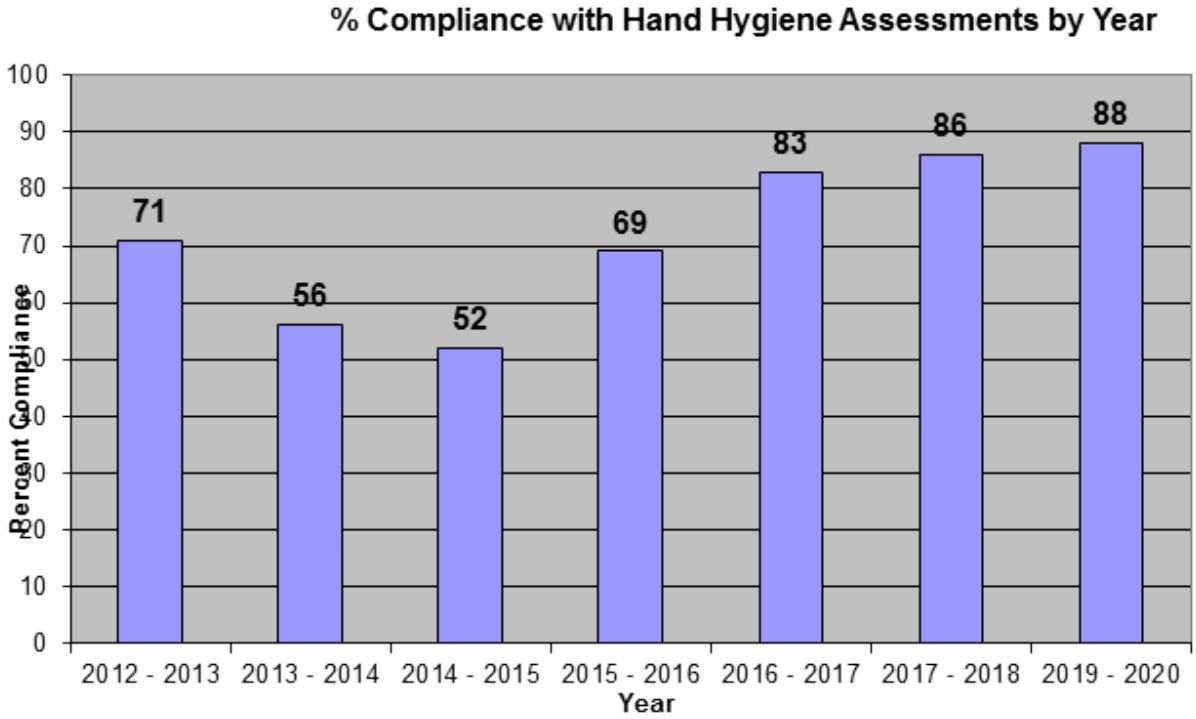


Hand hygiene technique assessments

The Trust Hand Hygiene Policy stipulated that staff have their hand hygiene technique assessed within one month of starting their employment and reviewed 3 yearly It is the responsibility of the Ward Manager and the IPC link nurse to ensure these assessments are carried out.

The overall compliance rate for 2019/20 was 88%. This is a marginal improvement on last year's 86%. It should be noted that these figures do not take into account medical staffing as listed below. From April 2020 this review will be required every year.

Historically not all doctors were included in the assessment of hand hygiene technique. Now all junior doctors are assessed when they start in August and senior doctors are required to have a 3 yearly hand hygiene assessment. This will be changed to yearly from April 2020. For 2019/21 compliance for doctors was 77%. This is an improvement of 7% when compared to last year's results.



Criterion 2:

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Cleanliness Team

The cleaning provided at SaTH for all clinical and non-clinical areas is completed by the in-house Cleanliness Team. Cleanliness Technicians are responsible for ensuring that cleaning methodologies are rigorously applied and the frequencies are maintained. All cleaning staff play an essential role in ensuring that the Trust reduces hospital acquired infections which helps to promote confidence in patients and visitors.

Monitoring Processes for In-house Cleaning

The Cleanliness Team are committed to ensuring high standards of cleanliness and that these standards are maintained by promptly addressing any shortfalls. The Team work to national targets and local standards which are reflected in the Environmental Audit scores and our Patient-Led assessments of the care environment (PLACE) results. The Trust monitoring team use a the MiC4C (credits for cleaning) software which is widely used across the NHS, visible checks of all elements are carried out, the system then generates a report and percentage score, the reports are sent to the Cleanliness Management team, Estates Team, Ward Managers and Matrons for action.

The Senior Cleanliness Manager or Site Cleanliness Managers also participate in any outbreak or periods of increased incidents (PII) meetings, when issues are identified on site.

Scheduled and ad hoc meetings with Infection Prevention, Matrons and clinical colleagues to regularly monitor, review progress and address/resolve any issues are held to ensure that standards and performance target and compliance is met, whilst empowering Nurse Managers to be involved in the monitoring of cleanliness standards.

PLACE Inspection

SaTH PLACE assessment took place during September 2019. The annual assessments involve local people (known as patient assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia and disability.

Audit Cleanliness scores at SaTH for PLACE 2019 are as follows,

RSH 99.57%, PRH 100%, Overall Score 99.60% against the National Average of 98.60%.

Terminal Cleans

All terminal cleans at SaTH are requested via the internal bleep system during Cleanliness Working hours. Any terminal cleans outside of these times are requested via switchboard to an external company. Hydrogen Peroxide decontamination of infected side rooms is requested as per the Cleanliness Team RAG poster

Radiator Cleaning

SaTH has a planned annual programme of radiator cover removal to allow for cleaning.

Criterion 3:

Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Antimicrobial Stewardship (AMS)

The trust antimicrobial management group (AMG) includes representatives from pharmacy, microbiology, nursing and medical staff. This group manages policy with regard to antimicrobial stewardship, formulates policy with regard to antimicrobial stewardship and responds to concerns in this area. The group feeds back actions and concerns to the executive board via the drug and therapeutic committee and reports in to the Infection Prevention and Control Committee.

The action of AMG continues to be hampered by the lack of attendance of the medical and nursing representatives. This means that the group meetings are often non-quorate. Actions by the group can therefore be difficult to implement.

The group undertakes the following actions

- Production of the antibiotic guidelines publishing them both on the trust intranet and the micro guide app
- Yearly update of the antibiotic guidelines
- A regular update of the Trust Antimicrobial Stewardship Policy.
- A rolling Antimicrobial Audit Programme in line with Start Smart then Focus has been in place across the Trust for a number of years.
- The Trust's Antimicrobial Guidelines were reviewed and temporary alternative guidance issued when certain key antibiotics were unavailable due to global and national shortages.
- The Antimicrobial Guideline App (Microguide) for mobile devices continues to be popular with prescribers, facilitating easy access of antimicrobial guidelines at the point of prescribing. The web-based app allows more efficient updating of guidelines following review by AMG members. A paediatric version of the guideline was introduced for the first time this year.

Undertaking of audits has been difficult to achieve without the facility of electronic prescribing and the loss of one Antimicrobial Pharmacist has meant that feedback to clinical governance leads has not been possible. However there continues to be regular monitoring of prescribing at ward level and pharmacist antibiotic related interventions are reviewed each month.

The antibiotic pharmacist continues to undertake FY1 teaching in August/September for the new intake and attends medical and surgical clinical governance meetings to communicate information where necessary.

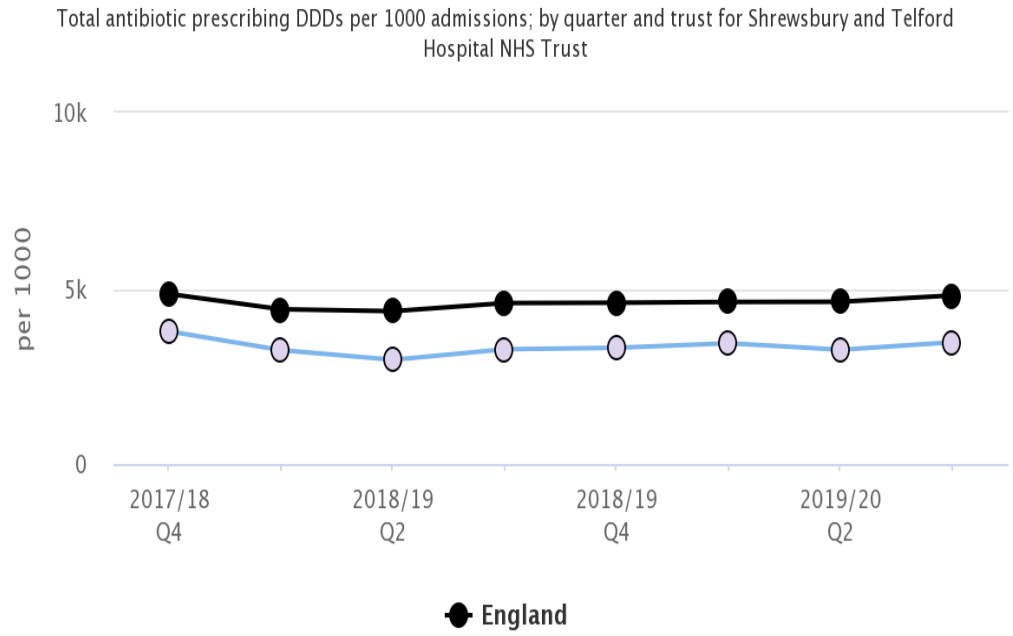
The appointment of a sepsis nurse has led to positive work surrounding sepsis and areas now have sepsis boxes and drawers or a sepsis trolley to assist in the prompt treatment of those patients suspected of having sepsis.

In common with other Trusts in the UK, SaTH faced challenges as a result of ongoing shortages of a number of key antimicrobials due to manufacturer's supply problems. Aztreonam injection continues to be intermittently available; there have also been issues with piperacillin/tazobactam and benzylpenicillin. This is expected to worsen with the situation surrounding COVID-19. The AMG, Microbiology and Pharmacy Departments worked collectively to ensure that alternative agents were available for patients in a timely manner.

- Antimicrobial guidelines were reviewed and alternative agents chosen taking into account antimicrobial stewardship and local resistance patterns, benefits and risks of proposed substitute agents, including cost pressure to the Trust as a result of using more expensive alternatives.
- Alternative medicines were sourced, purchased and made available in key areas via review of stock lists.
- Information on dosing, administration and side effects of the new alternative was communicated to prescribers, nursing staff and pharmacists.
- Antibiotics that are in short supply are restricted to those conditions considered highest priority or were an appropriate alternative is not available.

CQUIN Summary 2019-20

- Total consumption of antibiotics has been moved from a CQUIN target to national contracting, there is a requirement to reduce this by 1% each year.
- SaTH continues to be a lower than average user of antibiotics.
- There were two antimicrobial resistance CQUINs this year; lower urinary tract infections in older people and antibiotic prophylaxis in colorectal surgery.
- CQUIN completion has been challenging due to situation relating to COVID-19 therefore it was agreed nationally that results would be based on quarters 1-3 only.
- The lower urinary tract infections CQUIN has not been achieved and requires considerable input from both medical and clinical colleagues for next year in which it has been expanded.
- The colorectal surgery CQUIN is in the range of achievement and there has been engagement with clinicians to maintain and improve results.



Criterion 4:

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

Communication Programme

The Trust has a dedicated Communication Team. The IPC team informs the Communications Team, via email, of all outbreaks. Where these may result in media interest because of the nature or impact of the outbreak, the Communications Team is invited to meetings to provide support and guidance and to prepare proactive and reactive media statements.

The IPC and Communications Teams work together to:

- Promote IPC events.
- Communicate campaign to inform GPs and the public around management of Influenza and Norovirus, through the Trust's GP Liaison.
- Update the Trust website and intranet.
- Issue media statements during outbreaks.
- Support the annual flu vaccination campaign

Trust Website and Information Leaflets

The Trust website promotes infection prevention issues and guides people to performance information on MRSA, Clostridium *difficile* and other organisms.
The IPT have produced a range of information leaflets on various organisms.
The Trust has a policy on the transfer of patients between wards and departments.
A large number of documents relating to COVID 19 were added in February and March 2020, including information for patients, visitors and staff. This included topics such as volunteering, symptoms of COVID 19, how to keep healthy and avoid infection, how to get tested and visiting. This continues to be updated by the Communications Team with advice from IPC as new information becomes available.

Criterion 5:

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Infection Prevention Nurses are alerted of daily laboratory alert organisms.

The Trust has a policy for screening both elective and emergency patients for MRSA and a system is in place for monitoring compliance.

Clinical Portal System / SEMA

The microbiologists work with IPC Team regarding patient alerts. The SEMA system includes alerts for patients with a history or current MRSA, CDI, PVL-toxin producing *S. aureus*, ESBL, VRE or Carbapenemase producing multi-resistant Gram Negative Bacilli, Flu, blood borne viruses and COVID-19 was added at the start of the pandemic in 2020. These alerts enable staff on wards and departments to promptly identify patients who have recently had an alert organism identified, allowing wards/departments to isolate in a timely manner, follow-up patients appropriately and to prescribe appropriate empiric antibiotics if antibiotic treatment is indicated. Alerts are automatically added to clinical portal from SEMA to ensure the information is available on all systems used.

Surgical Site Infection Surveillance (SSISS)

SaTH continues to participate in the Public Health England (PHE) National Surveillance Programme. It is a mandatory requirement for acute trusts to participate in the collection of surgical site infections for a minimum of one orthopaedic category over one surveillance period each financial year. SaTH also collects data on other categories of surgery. Following submission to PHE for analysis & reporting the data is used as a benchmark allowing individual trusts to compare their infection rates with other participating hospitals.

The aim of SSIS is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance to compare their rates of surgical site infections over time and against a national benchmark rate, this information is used to review and guide clinical practice.

A rolling programme of surgical site surveillance was developed to cover as many surgical procedures as possible. This can be adapted if there are any concerns in a particular area. SaTH carries out continuous surveillance in total hip replacement and total knee replacement the Gynaecology ward staff collects continuous surveillance in abdominal hysterectomy including post discharge.
The team collect local evidence of surgical site wound infections, which develop whilst the patient is in hospital and once discharged home. This continues for 30 days postoperatively (if an implant is present this can continue up to one year) and is followed up with a Patient self-reported feedback questionnaire, although this is helpful it can be seen as less reliable. Cases of identified surgical site infections are reviewed through a Root Cause Analysis (RCA), the definitions for a deep, superficial and organ space infection are described in the SSISS guidelines via PHE. An RCA ensures that a robust process is in place for the identification of any surgical site infection and identifies where improvements can be made in clinical practice. This aids effective and thorough reporting to PHE as often just one infection can take us above the National Benchmark due to low numbers of surgeries per category.

Surveillance carried out at SaTH 2019-2020

Type of Surgery	Qtr	No. of Cases	No. Inpatient Readmission Infections (%)	National infection Rate	No. Eligible for post discharge	Return rate %	Post Discharge infections
Neck of Femur RSH	1	94	0 (0%)	1%	86	64%	0
Neck of Femur PRH	1	71	1 (1.4%)	1%	57	42.1%	0
Vascular RSH	1	65	1 (1.5%)	2.5%	39	64.1%	2
Total Hip Replacement PRH	1	54	1 (1.9%)	0.4%	49	77.6%	2
Total Knee Replacement PRH	1	38	0 (0%)	0.3%	37	86.5%	0
Neck of Femur RSH	2	84	2 (2.4%)	1%	74	74.3%	0
Neck of Femur PRH	2	61	0 (0%)	1%	55	65.5%	0
Total Hip Replacement PRH	2	78	2 (2.6%)	0.4%	75	78.7%	3
Total Knee replacement PRH	2	62	0 (0%)	0.3%	62	87.1%	2
Abdominal Hysterectomy	2	17	0 (0%)	1.2%	16	18.8%	0
Total Hip Replacement PRH	3	60	0 (0%)	0.4%	60	85%	1
Total Knee Replacement PRH	3	48	0 (0%)	0.3%	48	85.4%	0
Vascular RSH	3	64	0 (0%)	2.6%	60	71.1%	0
Abdominal Hysterectomy	3	54	0 (0%)	1.2%	54	9 PD 45 reviewed	0
Neck of Femur RSH	4	89	0 (0%)	0.9%	82	29 PD 53 reviewed	1
Neck of Femur PRH	4	62	0 (0%)	0.9%	55	17 PD 38 reviewed	0
Total Hip Replacement PRH	4	34	0 (0%)	0.4%	34	34 reviewed	0
Total Knee Replacement PRH	4	33	0 (0%)	0.3%	33	33 reviewed	0
Reduction of long Bone PRH	4	52	0 (0%)	0.9%	51	51 reviewed	0
Reduction of long Bone RSH	4	65	1(1.5%)	0.9%	65	15 PD 50 reviewed	1
Abdominal Hysterectomy	4	34	0 (0%)	1.2%	34	20/PD 14 reviewed	2

Quarter 1 April-June
Quarter 2 July-September
Quarter 3 October-December
Quarter 4 January-March

During January-March (quarter 4) limited post discharge was carried out, all patients during this quarter were reviewed using positive microbiology swab results, patient's readmissions due to wound healing problems and the review of hospital follow up appointments.
During this quarter we had 1 infection in 65 operations in reduction of long bone at RSH, due to small numbers we look at the last 4 quarters in which we participated and we have had 1 infection in 160 operations which gives us an infection rate of 0.6% which is below the national infection rate for this category of surgery.

Over the year we received two high outlier letters from PHE, one for Repair of neck of femur (RSH) 2 infections in 84 operations (2.4%) and the other for Total Hip Replacement (THR), 2 infections in 78 operations (2.6%) both occurring during July-September quarter.

Relatively low numbers of operations are performed per quarter and 2 infections will take SaTH over the national infection rate, therefore the last 4 periods are considered. Repair of neck of femur (0.6%) with the national being 1% and THR (1.6%) which is higher than the national rate of 0.4%.

A root cause analysis was carried out on the four infections; the consultants were involved in this process. On analysis of the RCAs, the two neck of femur infections were readmission infections, both requiring theatre intervention for debridement and washout, both of these patients were considered high risk with several co-morbidities. An ASA recorded score of 3 and 4 with onset of symptoms occurring at days 16 and 32. There was documentation to suggest that both of these patients had been removing their dressing post-operatively. The previous quarter we received a low outlier letter in this category of surgery.

The THR infections occurred 15 and 27 days postoperatively, both were readmission, deep infections requiring further surgical intervention, both had high BMI's of over 37.
Similarities between the four cases have found temperature documentation intra operatively and type of dressing used are not consistent. All patients received appropriate antibiotic prophylaxis and skin preparation prior to incision, microbiology specimens taken from each patient grew different organisms. Pico dressings are now the dressings recommended for all orthopaedic joint replacements across SaTH.

Infection prevention and control quality ward walks have been carried out on the elective orthopaedic ward and trauma wards, both areas have maintained above the acceptable standard. The matron's for these areas are involved in improving compliance in hand hygiene audit scores and have been 100%.

Responses to these high outlier letters have been sent to PHE by the infection prevention and control team in conjunction with the Lead Consultant Microbiologist.

Managing Outbreaks of Infection - Responses to Incidents and Outbreaks

The IPC Team are involved in the management of outbreaks, periods of increased incidence and incidents.

The IPC team monitors all alert organisms to identify trends and potential links between cases based on their location. If links are identified, a Period of Increased Incidence (PII) investigation is commenced and a meeting to discuss potential cases is held within 3 working days wherever possible.

In 2019/20 8 PIIs were declared as outbreaks out of a total 26 clusters investigated.

All outbreaks are discussed for the purpose of shared learning and service development through care group governance meetings. Recurring themes from investigations are disseminated through the IPC committee.

Action plans that are put in place by the ward manager and/or matron are monitored by the IPC team for compliance, once compliance has been demonstrated the action plans are signed off by the lead nurse for Infection Prevention and Control and the Matron or Head of Nursing for the area.

If further PIIs are linked to the same area, previous action plans are revisited.

Month	Ward	Organism	No. of cases	Typing results
June 19	26	Gent R ESBL Klebsiella	6	5 of 6 same type
August 19	16	Gent R ESBL E.coli	2	2 of 2 Same
Sept 19	22RE	VRE	2	2 of 2 Same
Sept 19	17	Gent R ESBL E.coli	3	3 of 3 Same
Oct 19	26	MRSA	3	3 of 3 Same
Dec 19	22TO	MRSA	2	2 of 2 same
Dec 19	32SS	C.diff	3	2 different to each other, unable to type third
Jan 19	26	Gent R ESBL Klebsiella	3	2 of 3 same
Feb 19	22TO	Norovirus	12 patients and 3 staff	N/A

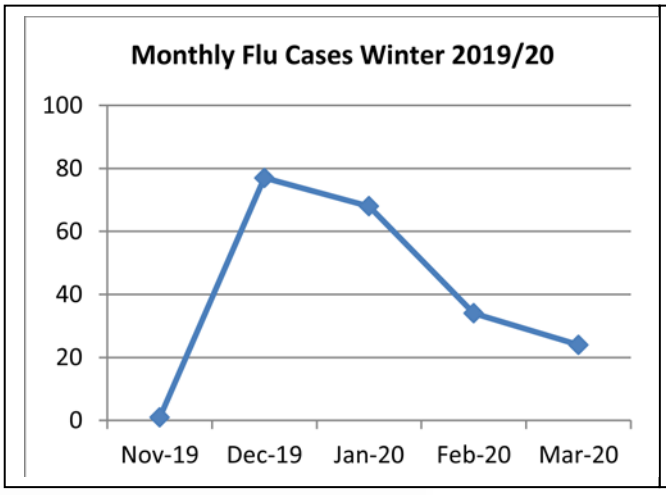
Seasonal Influenza

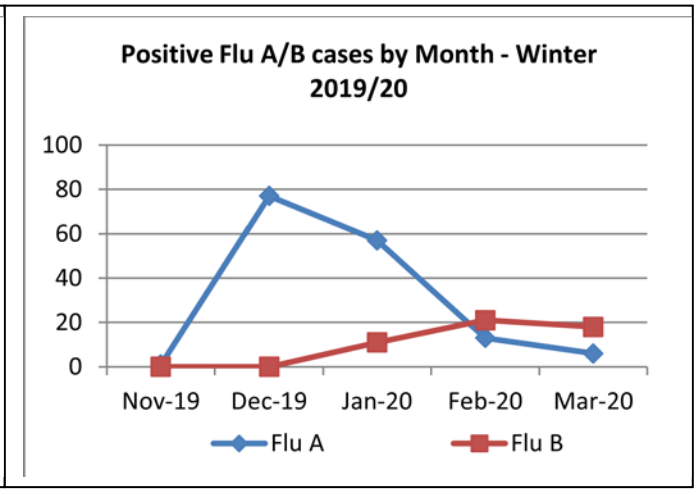
The UK saw a significant number of influenza cases during this winter, and SaTH was no exception with an unprecedented number of cases presenting to the emergency portals, which was on top of other pressures the Trust saw from acutely unwell patients. From November 2019 to March 2020, the Trust introduced Point of Care Flu testing at both sites in AMU. This allowed influenza patients to be isolated promptly and reduce cross infection.

SaTH had several wards affected, which was in line with other Acute Hospitals in the region. However, with good control measures these were mainly restricted to bay closures SaTH had no whole ward closures.

For each case immediate control measures were instituted, following the latest PHE guidance, including the use of antivirals. Affected areas were visited and assessed by an Infection Prevention Nurse at least once daily. Infection Prevention nurse also attended Clinical site bed meetings at least once daily

Overcrowding and pressures in the emergency unit and lack of side rooms across the trust exacerbated the situation and prevented early isolation in a number of cases. Nevertheless, the staff did a magnificent job in preventing further spread as best as they could, given the pressures, implementing antiviral medication as per PHE guidance to those exposed patients.





Criterion 6:

Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

At SaTH infection prevention is included in all job descriptions**.** All clinical staff receive induction and update training and education in optimum infection prevention practices. This includes volunteers. There are leaflets for contractors explaining their responsibilities and external work must be signed off by the IPC team with Estates to ensure appropriate cross infection measures such as dust control are in place.

Staff Training & Education

The IPC team deliver numerous training sessions year round, these have included programme of mandatory sessions and corporate induction days. The team have also provided bespoke training sessions on wards and in departments so staff do not have to leave the ward.

Staff Group	Infection Prevention & Control	Hand Hygiene Competence
Add Prof Scientific and Technic	96%	82%
Additional Clinical Services	86%	93%
Administrative and Clerical	100%	88%
Allied Health Professionals	81%	91%
Estates and Ancillary	81%	75%
Healthcare Scientists	100%	85%
Nursing and Midwifery Registered	85%	92%
Medical and Dental	78%	75%
Subject Total	**84%**	**88%**

Road Show 2019

The IPC team carried out a roadshow in May 2019 and November 2019. The roadshow themes were "*It's in your hands*" focusing on hand hygiene and glove awareness and MRSA and Norovirus. The IPC team visited every ward on both hospital sites. The purpose was to provide an educational opportunity to reinforce good practice and to discuss key points. We make it fun to take part by having a quiz to try and the potential to win a small prize.

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Infection Prevention and Control Team/Team Development

The Infection Prevention and Control Team have also attended several study days on different aspects of Infection Prevention & Control throughout the year, including regional and local IPS conferences and Surgical Site Surveillance Conferences.

One Infection Prevention Nurse has completed the Infection Prevention Course at Birmingham City University.

One Infection Prevention Nurses have completed the Marian Reed Development Programme Infection Prevention & Control Secretary is planning to visit local hospital (Stoke) to develop knowledge in regards to data analysis and share good practice.

All new staff to the Infection Prevention Nurses has a local induction programme to Infection Prevention.

Criterion 7:

Provide or secure adequate isolation facilities.

The average proportion of single rooms available in NHS acute trusts in England in 2016/17 was 30.2%. The average for single rooms with en-suite was 20.7% (Public Health England).

SaTH are significantly below the national average at 19.1% overall (*including* Women's and Children's) and with only 7.5% en-suite. This significantly impacts the ability to isolate all patients who should be isolated according to national guidelines, therefore when side room capacity is low; a risk assessment is completed for the appropriate allocation.

A risk assessment tool is available to help staff in making these decisions and ensuring that practice is consistent. The IPC team work closely with ward staff and Clinical Site Managers to ensure the most effective use of side rooms according to risk

The trust also has no negative pressure side rooms; the provision of these impedes the Trust's ability to care for patients with certain infections such as multidrug resistant TB.
Isolation capacity and usage of side rooms is audited twice a year by the IPC team.

	PRH		RSH		Total	
	All in-pt beds	In-pt beds excl Specialist & W&C (±)	All in-pt beds	In-pt beds excl Specialist & W&C (±)	All in-pt beds	In-pt beds excl Specialist & W&C (±)
Total In-pt beds	**434**	**313**	**431**	**431**	**865**	**744**
Side Rooms (S/R)	104	51	59	59	163	110
S/R with En-suite	64	12	19	19	83	31
Double occupancy rooms*	5 double rooms	5 double rooms	0	0	10 total beds	5 double rooms=10 beds

The COVID 19 pandemic has brought the lack of side rooms and other isolation facilities into sharp relief and we will be working with trust management to increase isolation capacity in 2020/21.

Criterion 8:

Secure adequate access to laboratory support as appropriate

Laboratory services for SaTH are located in the purpose built Pathology Laboratory on-site at both sites (Royal Shrewsbury Hospital & Princess Royal Hospital). The Microbiology Laboratory has full Clinical Pathology Accreditation (CPA)

The Infection Prevention Nurses work closely with all Consultant Microbiologists and the Clinical Scientists. Two of the consultant microbiologists have retired this year. The trust has managed to appoint a consultant clinical scientist to one of these posts and she has been heavily involved in developing the COVID 19 testing in the laboratory. The retired microbiologists are doing some part time work but we are still one WTE consultant microbiologist short. Attempts to appoint to this post have so far been unsuccessful. This reflects a shortage of consultant microbiologists UK wide. This impacts on the IPC team because the microbiologists are extremely busy and have less time available to assist with IPC.

Criterion 9:

Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections

The overarching policies are written in line with the Trust Governance policy which outlines requirements for responsibility, audit and monitoring of policies to provide assurance that policies are being adhered to. Both policy and manual are available for staff to view on the Trust intranet.

The IPC have a rolling programme of policies which require updating each year. In addition policies are updated prior to review date if national guidance changes.

In 2019/20 the team updated the following IPC polices:

Avian Influenza
MERS CoV
C difficile
CPE
ESBL
Seasonal Influenza
MRSA
Norovirus
Major Outbreak Policy
Patient Placement and Movement Policy
Pseudomonas Policy
Streptococcal Infection Group A C and G
Streptococcal Infection Group B
Viral Haemorrhagic Fever

An Infection Prevention & Control A-Z of Common Infections is available on the trust's intranet. This significantly enhances the quick location of key infection prevention guidance by our front line staff in regards to infection control common infections. Staff also have a direct link from the intranet to the Royal Marsden polices on nursing procedures. The team also produced a new policy on COVID 19.

Criterion 10:

Providers have a system in place to manage the occupational health needs of staff in relation to infection.

Occupational Health services are provided by Team Prevent who carry out pre-placement health assessments including assessment of Immunisation needs and delivery of the Immunisation programme.

Seasonal Staff Influenza Vaccination Campaign

All front line staff are offered influenza vaccination to protect themselves and the patients they look after.

The annual seasonal influenza vaccination campaign for staff launched at the beginning of October 2019 and finished at the end of March 2020. This year's theme was Flu DJ (designated "jabber").The executive team received their flu jabs to encourage others and to enforce the importance of protecting ourselves, patients, friends and family from the flu.

The seasonal influenza campaign was led by IPC Team and supported by Workforce representatives, the Communication and Web Development Team, Occupational Health, Pharmacy representatives and members of the specialist nursing team.

Peer vaccinators within the Trust worked together to vaccinate both hospital sites as well as the community maternity units and the business parks. The Occupational Health department (Team Prevent) hosted some flu clinics at the start of the campaign, along with the Trust's peer vaccinators to start the Flu Season. The peer vaccinators hosted a large number of walkabouts and static clinics, engaging with lots of staff, providing information and dismissing myths around the Flu Vaccine.

A '24 Hour Jabathon" was held at both sites to ensure we captured all staff during all shift patterns. A flu hotline was also set up to capture any remaining staff.

The Communications and Web Development Team helped with communicating the important messages around Flu to staff, including myth busting. The Flu dates were published via email and the intranet, along with flyers and posters being handed around to staff. In addition to promoting, the Trust introduced an incentivised approach whereby staff received a flu jab voucher. The voucher was a £3 Café Bistro voucher.

The Flu Campaign for 2019/20 resulted in 83% of frontline health care workers getting the vaccine. The national target was 80%.

SECTION 5: IPC FOCUS FOR 2020 - 2021

- Continuing work related to the COVID19 pandemic. We will use the newly published NHS IPC Board Assurance Framework to ensure that all guidance and risks relating to this complex problem are addressed and that gaps in compliance are promptly acted on. This will be presented at IPCC and to Trust Board.
- IPC guidelines for COVID 19 will be updated continuously in line with new guidance from PHE.
- Ongoing training in appropriate use of PPE for COVID 19 continues
- Advising on decontamination of environment and equipment used for COVID 19 patients
- We are developing continuous monitoring of possible health care acquired cases of COVID 19 with rapid action to control possible clusters
- Purchasing an automated surveillance system ICNet which will assist us in identifying and acting on clusters of infections including COVID 19, MRSA, ESBL, C diff and other infections
- We will also be working with trust management to increase social distancing for staff and patients and enhance isolation capacity for patients both for patients with infection and those that need to shield against infection.
- We will take part in developing safe systems for restoration of elective activity, to allow this to continue safely while protecting patients from acquiring COVID 19
- We will be involved in planning for possible second or later waves of COVID 19 and also controlling possible simultaneous influenza and COVID 19 outbreaks over the winter months
- This will include ensuring a high level of immunisation of staff with influenza vaccine before winter. If a COVID 19 vaccine becomes available we will assist in prioritising staff and/or patients for vaccination
- Antimicrobial Resistance – Lower Urinary Tract Infections in Older People
- Achieve 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines
- Continue to address and monitor outstanding estates maintenance work across the Trust
- Reduce the incidence of Clostridium difficile infection in SaTH based on a strong health economy partnership approach including surveillance, implementation of best practice, audit and root cause analysis
- Reduce Blood culture contamination rates

SECTION 6: CONCLUSION

Overall, our success is measured by our compliance with the Health Act, which encompasses all aspects of infection prevention and control, including management systems, environment, cleaning, training and policies to protect patients and staff. Our current compliance (as of 13/5/20) is very high at 95.9%. Outstanding issues include lack of an automated surveillance system, which we hope to get in 2020/21, levels of IPC training at 84%, and low levels of isolation facilities.

We have also completed 97% of our IPC program from last year. Outstanding work includes planned items from February and March which were pushed back because of pressure from the COVID pandemic. This included audits of PPE use, audits of job plans and two policies. However in response to COVID we have been undertaking a huge amount of PPE and other practice audit and training on the wards. Incomplete tasks will be addressed in the first three months of the 2020/21 programme.

The COVID pandemic has proved a huge challenge for the NHS but has also shown how well our staff are able to rise to that challenge, with all departments working together flexibly to provide a safe environment for patients and staff while dealing with many more ventilated patients than normal. Restoration of normal services will provide new hurdles and we must also be prepared for a possible second wave. While this will make up a large part of our workload for 2020/21 we also need to ensure that we keep a grip on other infections and that our staff maintain a high level of compliance with training.

SECTION 7: REFERENCE

Department of Health: The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

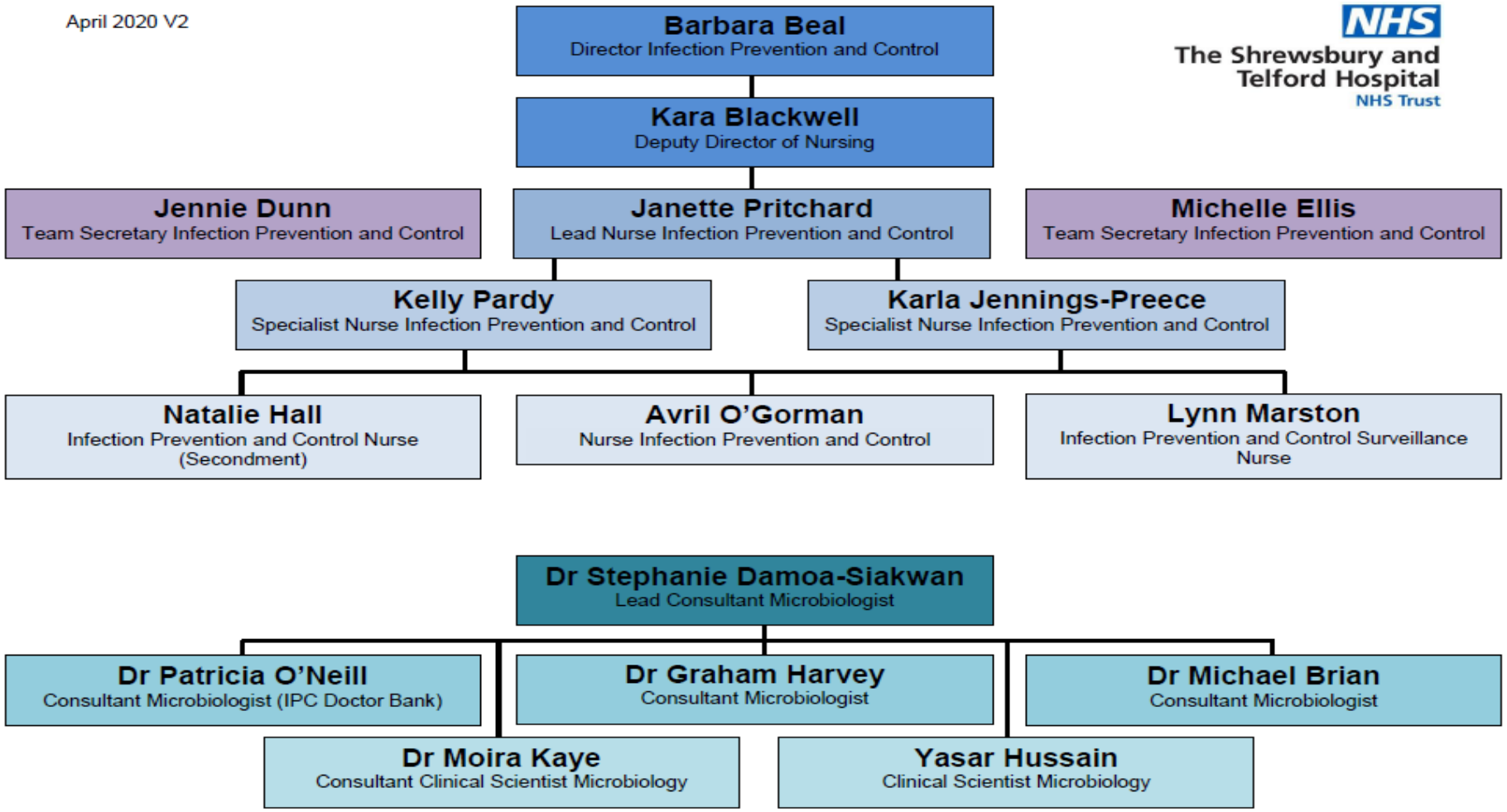
https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Department of Health: Improving outcomes and supporting transparency

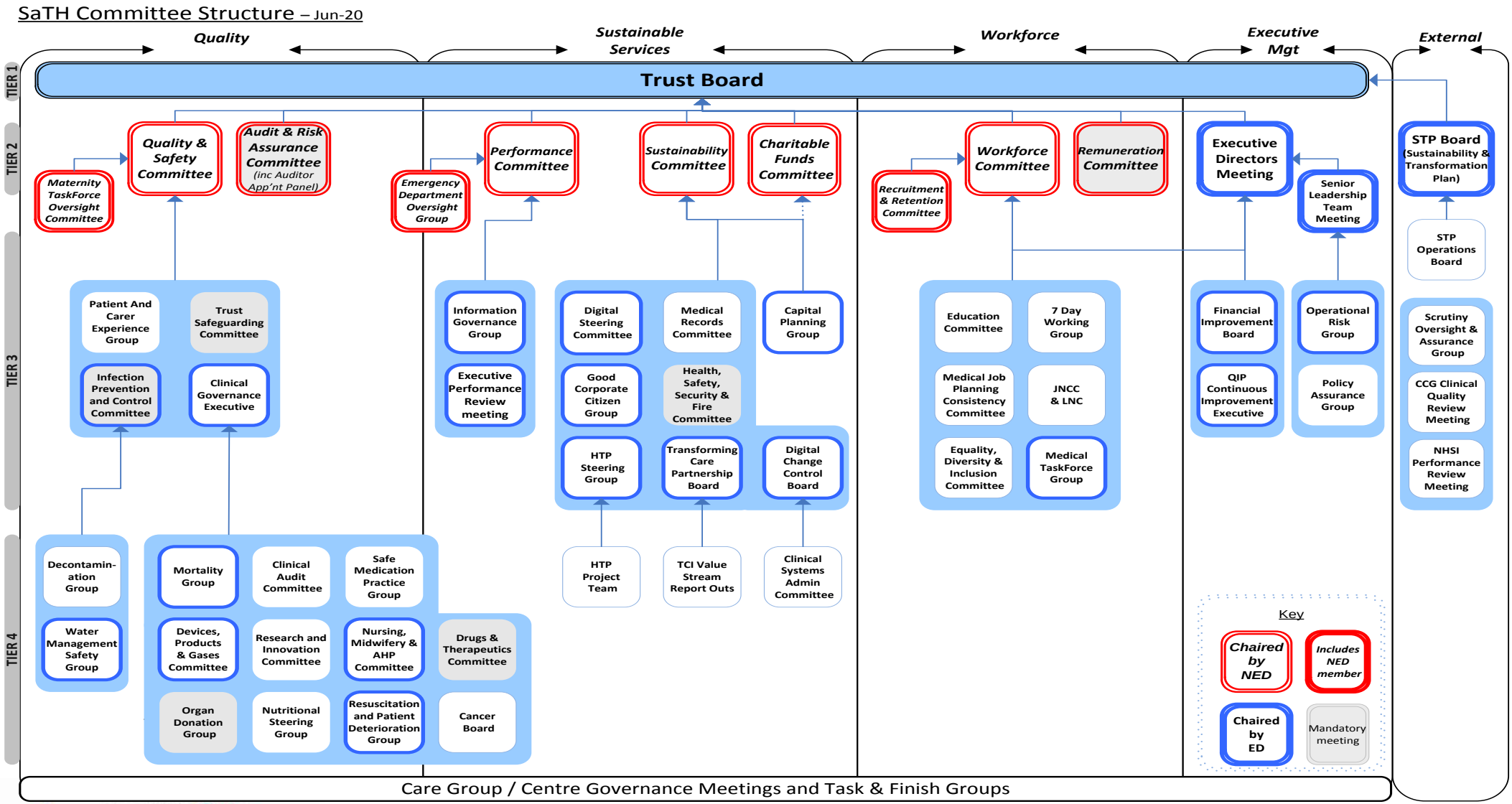
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/545605/PHOF_Part_2.pdf

Infection Prevention Society Audit tools. http://www.ips.uk.net/professional-practice/quality-improvement-tools/quality-improvement-tools/

Appendix 1: Infection Prevention and Control Structure



Appendix 2: Infection Prevention and Control Committee (IPCC) Strategic Links



NHS
The Shrewsbury and Telford Hospital
NHS Trust

Cover page	
Meeting	Board of Direcxtors
Paper Title	Complaints Annual Report 2019/20
Date of meeting	30 July 2020
Date paper was written	27 April 2020
Responsible Director	Bev Tabernacle, Director of Strategy & Transformation
Author	Julia Palmer, Head of PALS and Complaints

Executive Summary

This report provides an overview of complaints, PALS contacts and bereavement activity during 2019/20. Numbers of complaints and PALS contacts continued to be in line with expected activity, and learning is a key focus for complaints investigations.

Previously considered by	Quality Operational Quality Committee Quality and Safety Assurance Commitee

The Board is asked to:			
☐ Approve	☐ Receive	☑ Note	☑ Take Assurance
To formally receive and discuss a report and approve its recommendations or a particular course of action	To discuss, in depth, noting the implications for the Board or Trust without formally approving it	For the intelligence of the Board without in-depth discussion required	To assure the Board that effective systems of control are in place

Link to CQC domain:				
☐ Safe	☐ Effective	☐ Caring	☑ Responsive	☐ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare

	☑ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☐ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	We need real engagement with our community to ensure that patients are at the centre of everything we do (CRR 1186) We need positive staff engagement to create a culture of continuous improvement (CRR 423)

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	*Is there a financial impact associated with the paper?*

Main Paper
Situation
The purpose of this report is to provide the Trust Board with an overview of the formal complaints and PALS concerns received by the Trust during 2019/20 and to provide the Board with assurance that the Trust is handling complaints in line with national regulations.
Background
During 2019/20, the Trust received 762 formal complaints. Although an increase on the previous year, this still represents just under one in every 1000 patients seen at this Trust making a formal complaint (0.78). The SPC chart in the report confirms that this is in line with expected figures, with the exception of one breach of the upper control limit in October 2019, and one breach of the upper warning limit in November 2019, which corresponded with an increase in adverse publicity during that time. The Trust received 1951 PALS contacts during 2019/20, with the majority relating to appointments and communication. The Trust has continued to develop bereavement services during 2019/20, introducing the Medical Examiner Service at the RSH site.
Assessment
Complaints and PALS contacts continue to be seen as an opportunity to learn and make improvements based on what patients and their relatives are telling us about their experiences. Data is shared with care groups on a monthly basis so that any problem areas identified can be addressed promptly, and learning is shared across all care groups.
Recommendation
The Board is asked to note the details included in this report.

Annual Complaints and PALS Report 2019/20

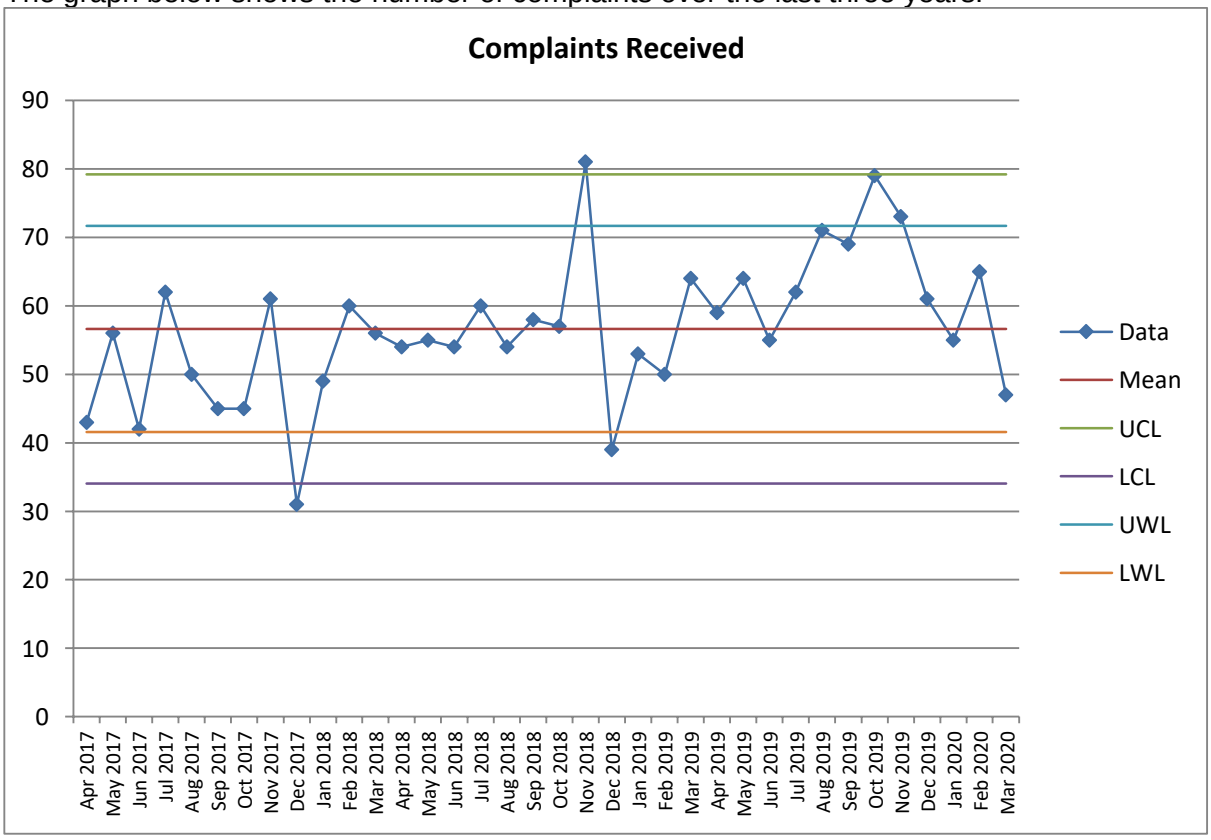
1.0 Introduction

The purpose of this report is to provide the Trust Board with an overview of the formal complaints and PALS concerns received by the Trust during 2019/20 and to provide the Board with assurance that the Trust is handling complaints in line with national regulations.

2.0 Formal complaints

During 2019/20, the Trust received 762 formal complaints. This represents just under one in every 1000 patients seen at this Trust making a formal complaint (0.78).

The graph below shows the number of complaints over the last three years:



The number of complaints has remained overall in line with average numbers for a Trust this size, with some in-month variation, and only one breach of the upper control limit in October 2019, and one breach of the upper warning limit in November 2019, which corresponded with an increase in adverse publicity during that time, relating to Maternity and the CQC inspection.

Of the 661 complaints closed in 2019/20, 22% (144) were upheld, 58% (385) were partially upheld and 20% (132) were not upheld. A complaint is deemed to partially upheld if any aspect of it is upheld in the response and fully upheld if the main aspects of the complaint are deemed to be upheld.

3.0 Performance

3.1 Acknowledgement

The Trust is required to acknowledge all complaints either verbally or in writing within three working days of receipt. This was achieved in 99% of cases in 2019/20; breaches were due to a combination of higher workload and lower staffing levels in the department due to sickness and leave. From October 2018, the Complaints Team set a stretch target of two working days, and 84% of complaints were acknowledged within two working days in 2019/20.

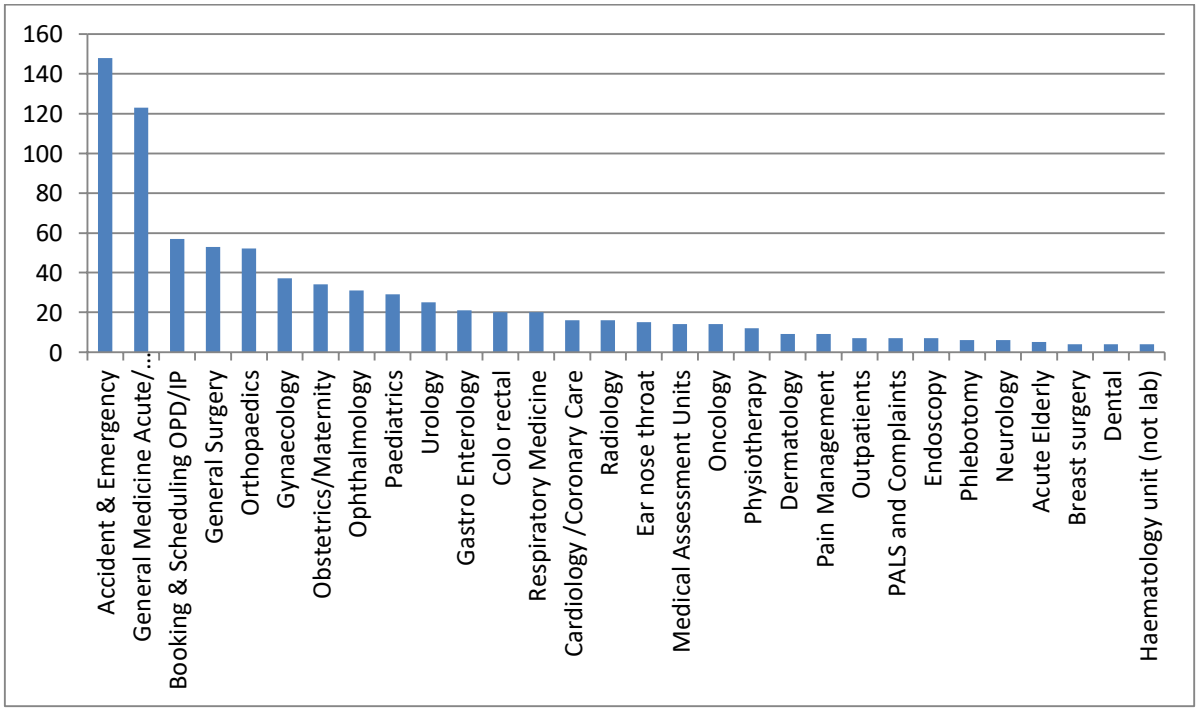
The Case Manager handling the complaint will phone the complainant where possible to clarify the issues for investigation and the complainant's expectations and to act as a contact point throughout the complaint.

3.2 Response Times

Each complainant is given a timescale for response, which will vary depending on the complexity of the complaint and the level of investigation required. Where it is not possible to respond within the initial timescale agreed, the complainant is contacted and advised of the delay and given a new timescale. In 2019/20, 59% of complaints were responded to within the initial agreed timescales, which is a decrease from the previous year. Delays were due to staff within Care Groups not responding to the Complaints Team in time, or further information being required; this was due to a variety of reasons, including key staff being off sick and difficulties obtaining notes to be able to respond. Work is ongoing to increase this further, with training available to managers on investigating complaints, and further refinements to the complaints processes.

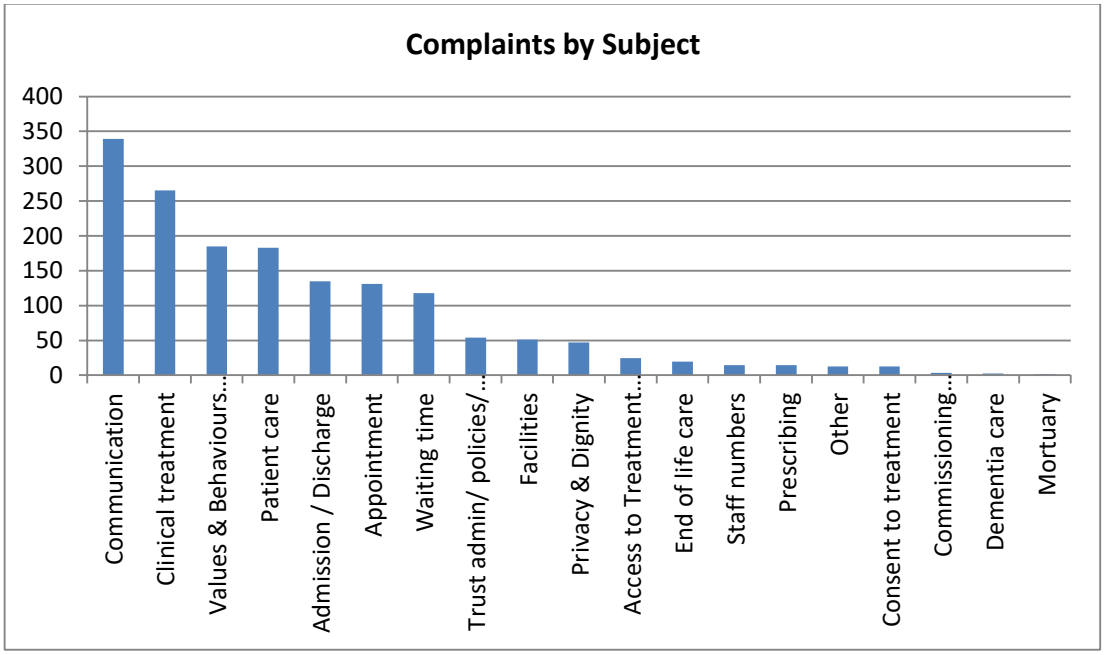
4.0 Breakdown of Formal complaints

The graph below shows the number of complaints by specialty for the top 30 specialties in 2019/20. Due to the high volume of patients seen and the nature of the specialty, some areas consistently receive a higher number of complaints than others.



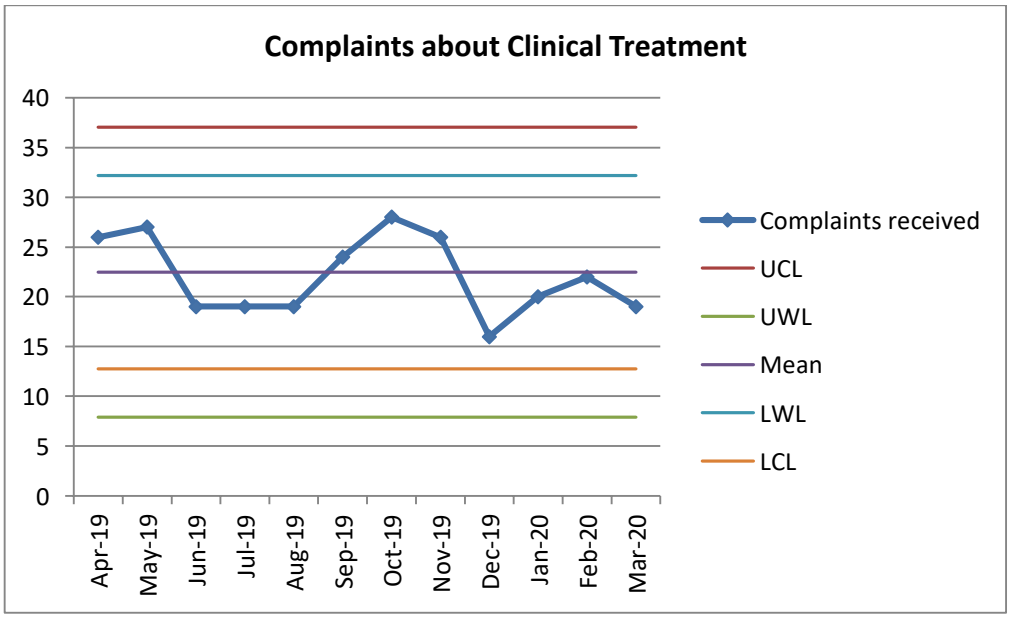
4.1 Key themes

The graph below shows the number of complaints by subject. Because a complaint may be multi-faceted and cover more than one subject, which means that the total number of issues raised will exceed the total number of formal complaints.



a) Clinical Treatment

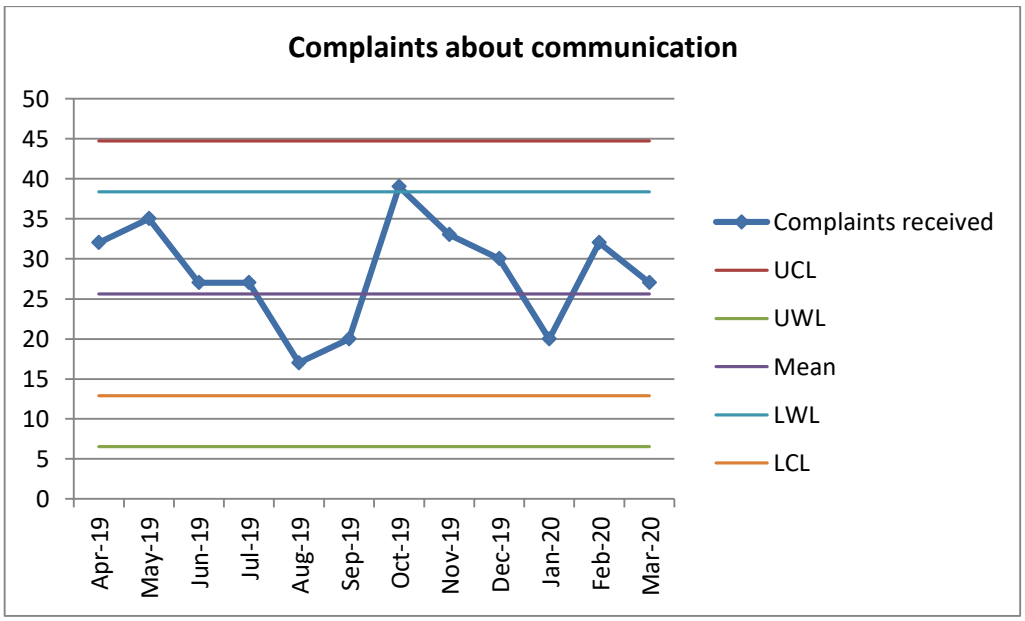
Complaints within this category may involve aspects of the clinical care provided by health professions, as well as complaints about the patient's diagnosis and treatment, any complications, and pain management. During 2019/20, there were 265 complaints that fell into this category; there were no breaches of the upper warning or control limits. The majority of these related to delays in diagnosis and misdiagnosis (including missed fractures) and delays in treatment.



b) Communication

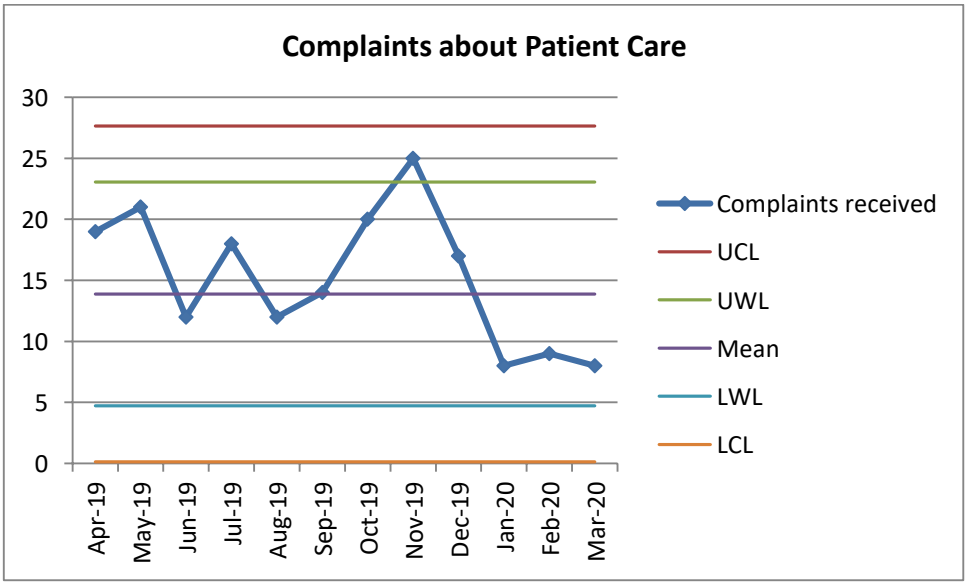
This category covers all aspects of communication, written and verbal, with the patient, relatives, between staff, with the GP and in relation to test results. During 2019/20, the Trust received 339 complaints where

communication featured; there was one breach of the upper warning limit in October 2019, corresponding with an increased number of complaints in the Trust as a whole. These cover a range of specialties, with the main issues being communication with relatives and patients receiving conflicting information.



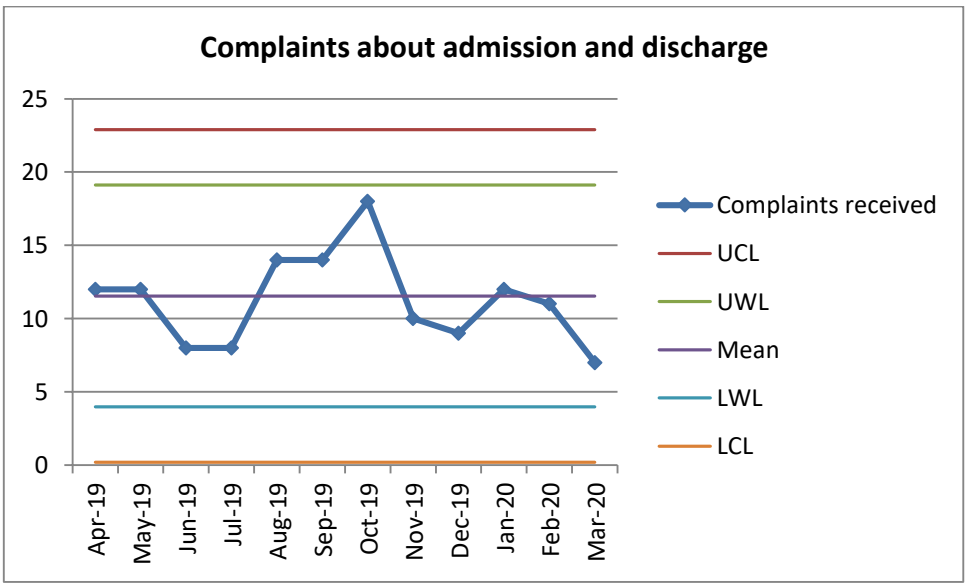
c) Patient care

Complaints within this category include complaints about patient falls, nutrition and hydration, infection control and pressure area care. The Trust received 135 complaints in 2019/20 about this aspect of care; there was one breach of the upper warning limit in November 2019, corresponding with an increased number of complaints in the Trust as a whole. The majority of these complaints related to patients not having their care needs adequately met.



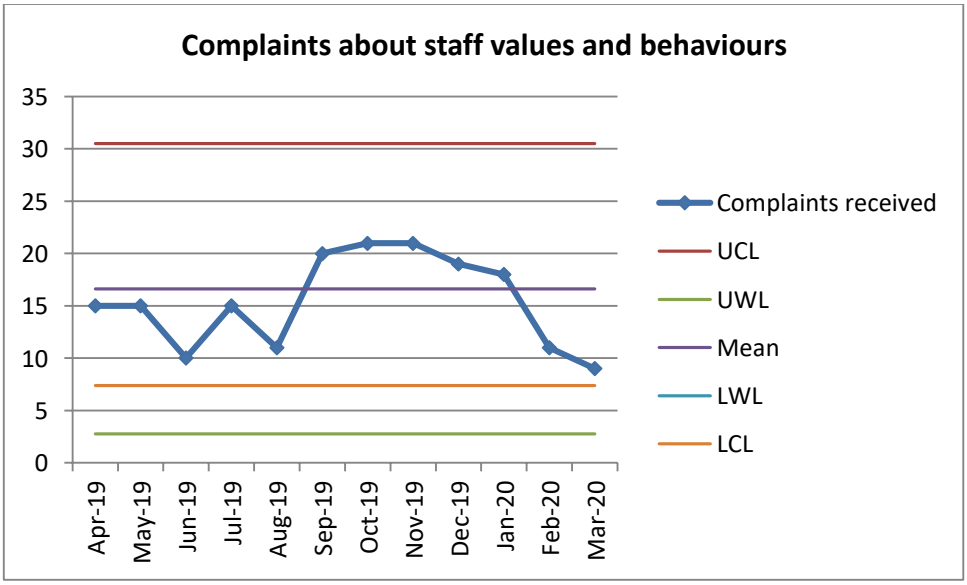
d) Admission Arrangements

Complaints within this category relate to the patient's admission and subsequent discharge, as well as any transfers. During 2019/20, there were 135 complaints within this category; there were no breaches of the upper warning and control limits.



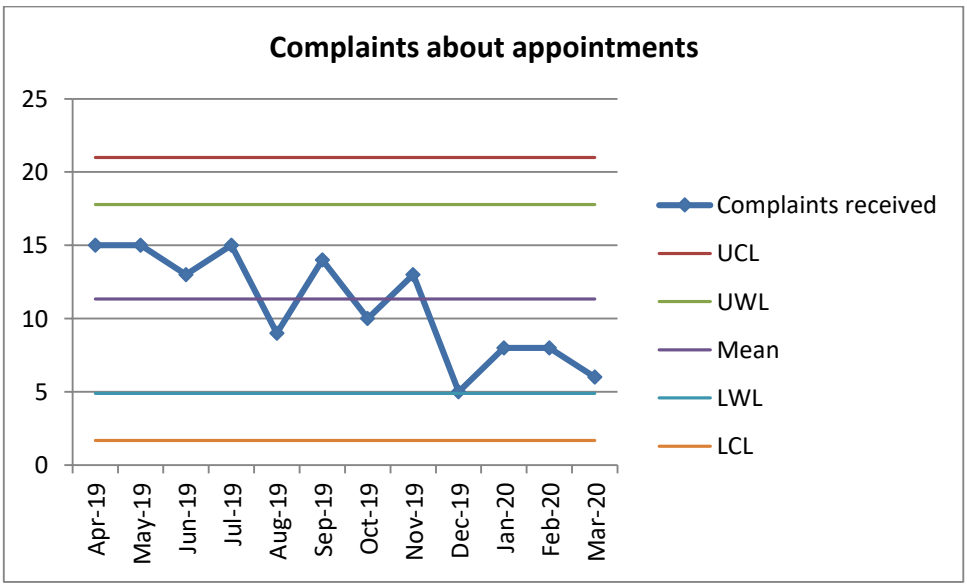
e) Values and behaviours

This category includes complaints about staff attitude, professional behaviour and breaches of confidentiality. There were 185 complaints within this category during 2019/20, with no breaches of the upper warning or control limit.



f) Appointments

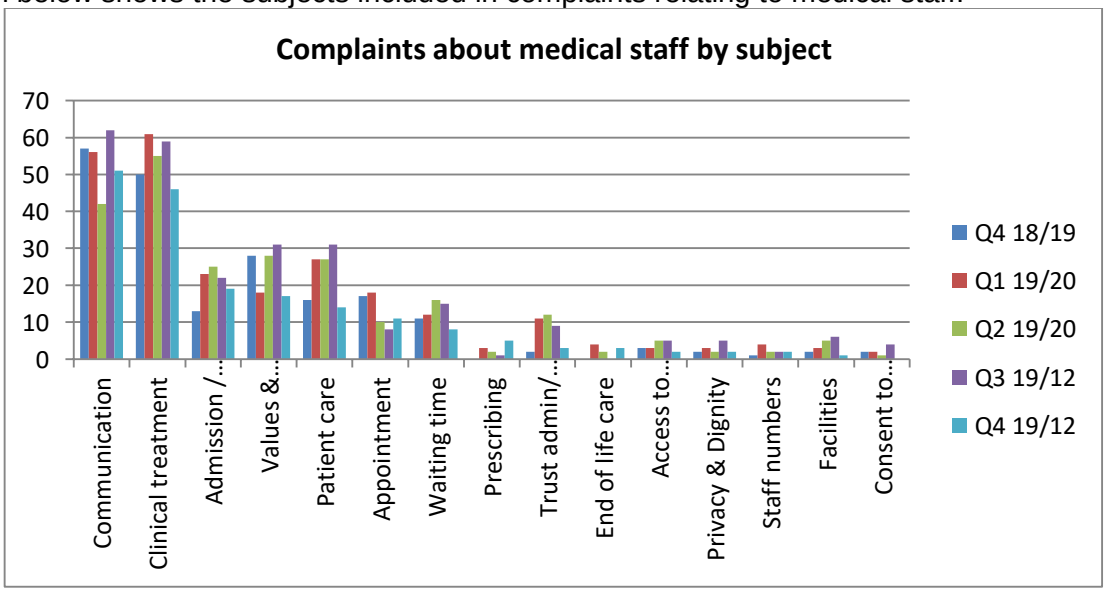
Complaints within this category include waiting times to receive an appointment and cancellations of appointments. During 2019/20, the Trust received 131 complaints; there were no breaches of the upper warning and control limits.



4.2 Staff Groups

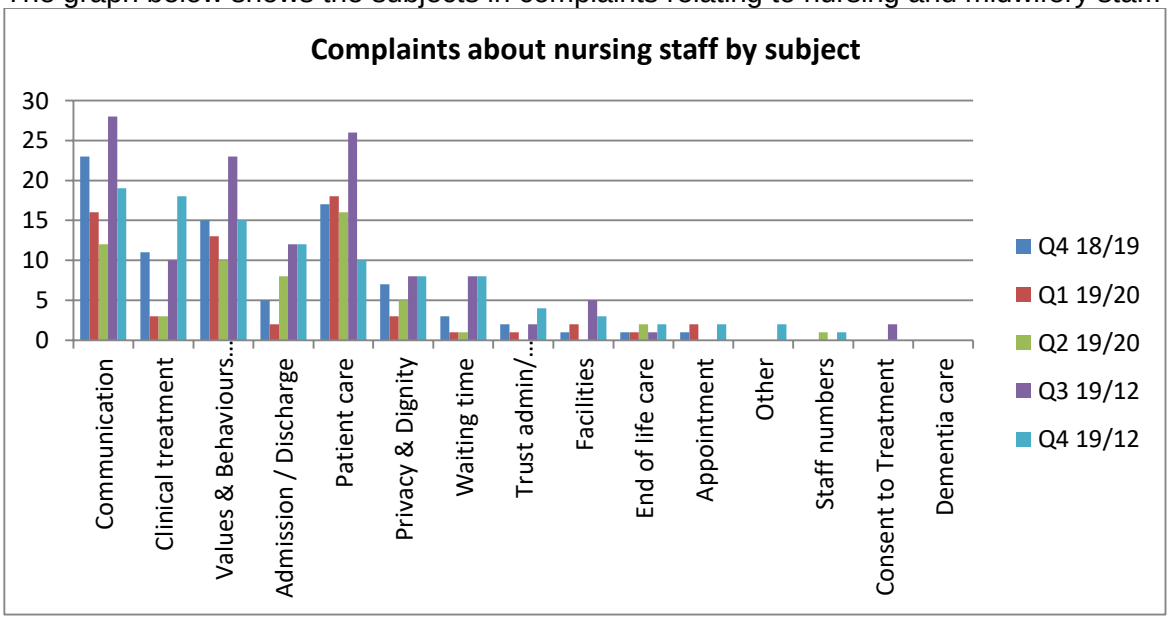
459 complaints raised issues relating to medical staff. Of these 221 were about clinical treatment, 211 were about communication, and 94 were about values and behaviours.

The graph below shows the subjects included in complaints relating to medical staff:



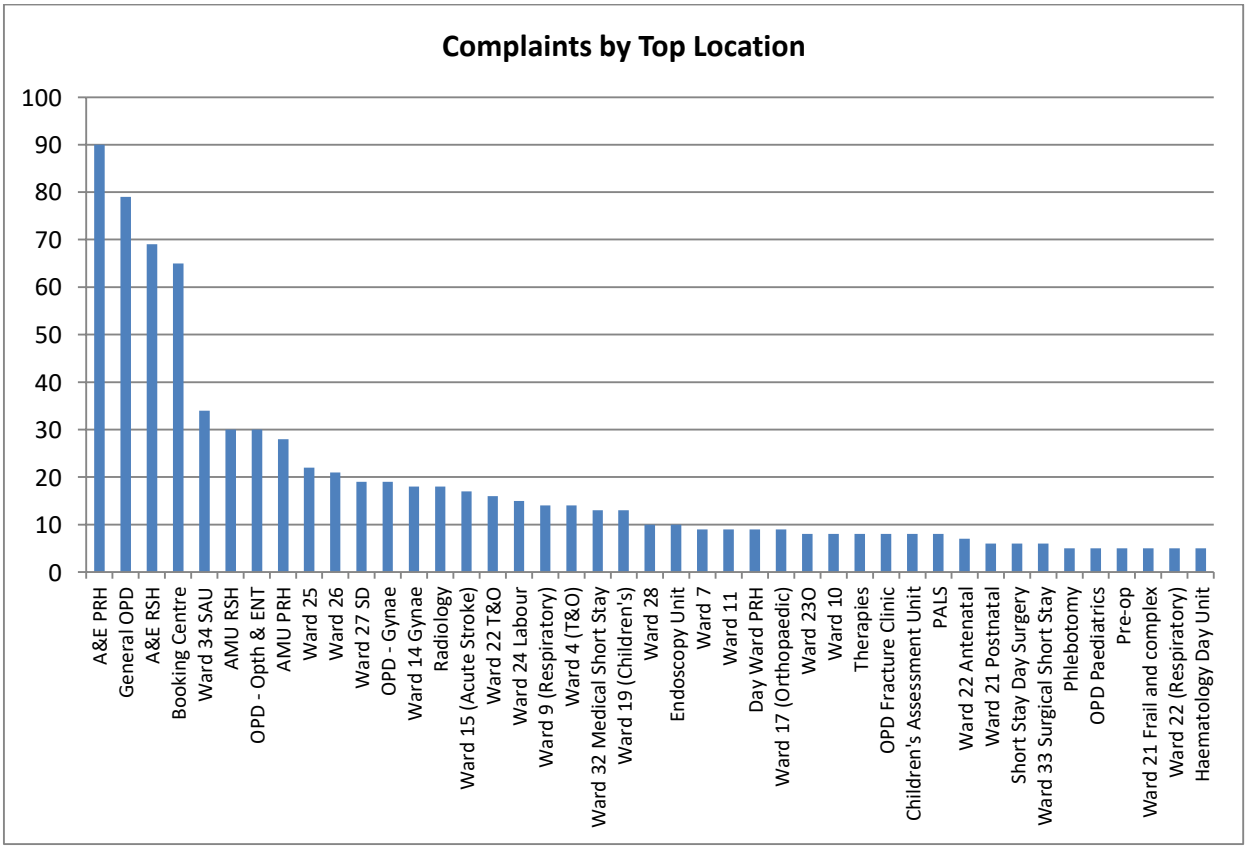
194 complaints raised issues relating to nursing and midwifery staff. Of these, 75 related to Communication, 70 related to Patient Care, and 61 related to values and behaviours.

The graph below shows the subjects in complaints relating to nursing and midwifery staff:



4.3 By location

The graph below shows the number of complaints by top location:



5.0 Actions and Learning from Complaints

The Trust is committed to becoming the safest and kindest Trust and as part of that, it is important that each complaint is seen as an opportunity to reflect, learn and make improvements in the areas that matter most to our patients and their carers and families. Some examples of learning and changes in practice that have arisen from complaints are set out below:

- Following a complaint in which a number of concerns were raised about antenatal care, a three-minute brief was produced in relating to self-medication and documentation. The complaint was shared at the daily safety huddles to ensure wider learning, and the pro-formal for recording blood glucose levels has been reviewed.

- As a result of a complaint which raised multiple concerns about end of life care and nursing care, there has been further training and support given to the ward staff in relation to pressure care and end of life care. Staff have also been reminded of the referral process to Speech and Language Therapy.

- A patient shared her experience of attending an appointment where she expected to have her coil fitted. A number of contributory factors were identified and addressed, including liaising with GPs to ensure that they are aware that they must issue coils when referring women in, ensuring that there is a supply of copper coils in GATU as a back-up and introducing a process to ensure that referrals are triaged by a senior doctor.

- A patient's wife shared how a very good experience of care in this Trust was marred by a ward transfer overnight just prior to discharge, in which clear instructions were not handed over properly, and, as a result, the discharge was nearly delayed. Following on from this, both wards reviewed their discharge documentation and handover of patients, to help ensure safe transfer of patients, with full handover of information.

- Parents raised concerns that their expectations were not met when they brought their child in for allergy testing. The complaint was reviewed at the governance meeting, to discuss changes to appointment letters to ensure patients and their relatives know what to expect, looking at how dignity can be better protected during skin examinations, and ensure that out of area referrals are managed appropriately.
- A patient raised concerns that drinks were left out of reach of patients, that her property was lost, she was not given the right equipment on discharge, communication was poor, and that, despite regular requests, she was never able to speak to the matron for the ward. The complaint has been shared with ward staff, and discussion had about the importance of ensuring that patients are able to easily reach their drink, and checking for patient belongings before sending linen to the laundry. In addition, the Ward Manager implemented a weekly 'open door' and she and the Matron commenced weekly rounds to visit patients. The Therapies team have reviewed processes for escalating any equipment stock issues.

- A patient was admitted following results from a routine blood test; however it was subsequently identified that the results were incorrect and the patient had been admitted unnecessarily. It appears that the sample became contaminated during the process of manually transferring it to a second tube. As a result the incident has been discussed, and a number of corrective measures have been put in place, including ensuring that any bottles requiring transfer will be handled one tube at time, as well as printing labels for each tube rather than using pre-labelled tubes and putting in place steps to allow auditing.

- A patient's husband raised significant concerns about the way in which the patient's discharge was managed. The investigation identified a number of failings in communication both internally and with external organisations, and the systems are being reviewed as part of the wider improvement work on stroke pathways.

- A patient raised concerns about the attitude of the doctor and the manner in which an internal examination was carried out. The doctor used the complaint as an opportunity to reflect and identified a number of areas where changes were needed, including recognising that the busyness of the shift impacted on the way she managed the consultant, and the need to take a few minutes to collect her thoughts before proceeding with the consultant, taking a step back when it becomes apparent a consultant is not going well, and ensuring she takes time to explain her approach. She has also changed her approach to history-taking and has carried out research to understand better the various conditions that increase pain during internal examination.

Individual staff are asked to reflect on complaints that they have been involved on, and learning from complaints is also discussed at Care Board meetings, and at ward and departmental meetings.

6.0 Parliamentary and Health Services Ombudsman (PHSO)

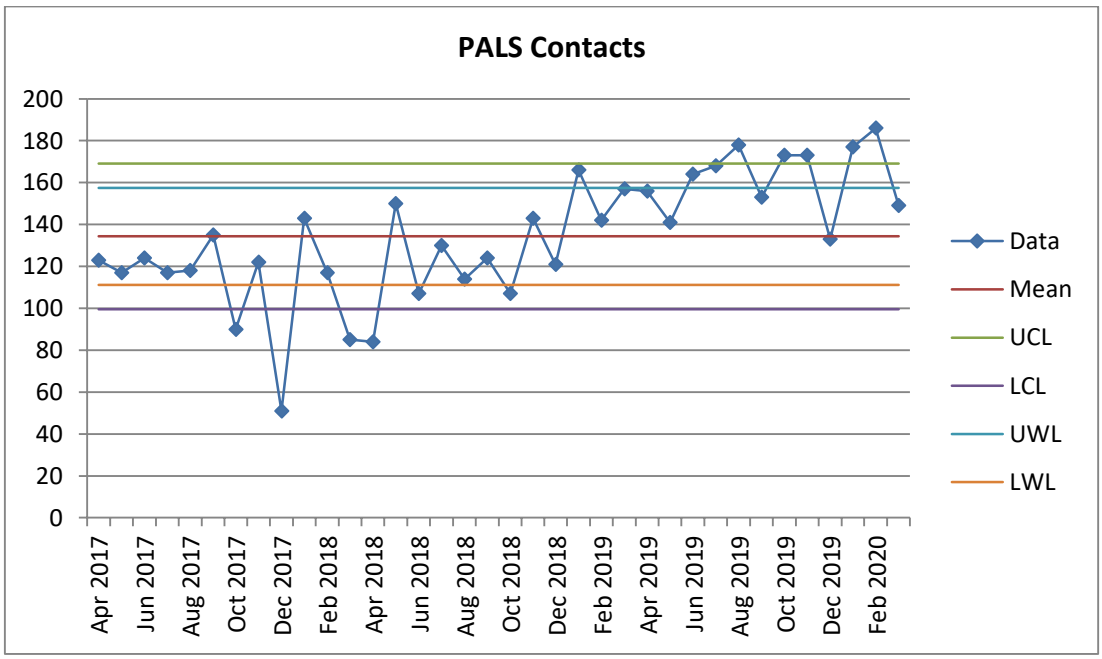
During 2019/20, six cases were referred to the PHSO.

During 2019/20, the PHSO concluded four investigations. One of these was not upheld and three were partially upheld; details of these cases are below:

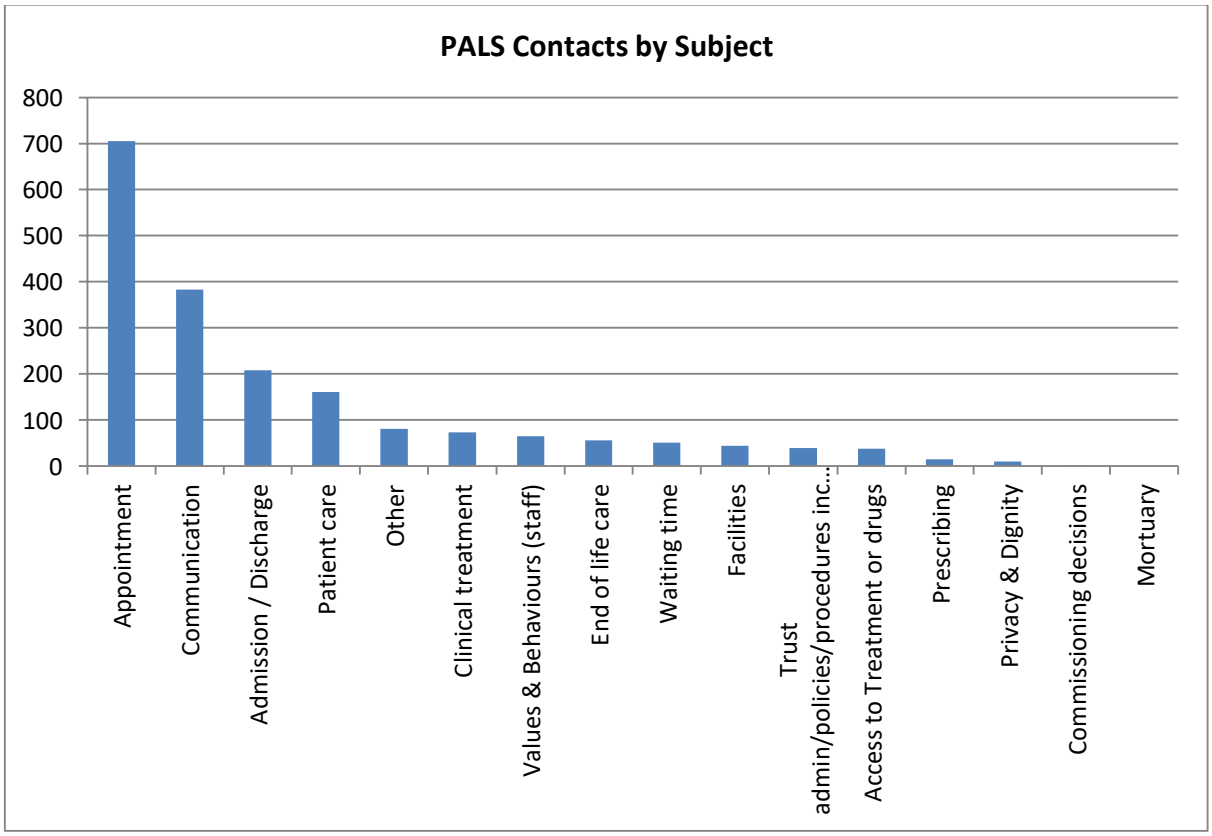
- Concerns raised about a delay in cancer diagnosis and subsequent treatment. The PHSO found that, although the box on the DNAR form had been ticked to confirm that the decision had been discussed with the family, there was no documentation to support this discussion having taken place. They recommended that a further letter of apology to be sent to the complainant, which was done, and the learning was shared.
- Concerns were raised about pain management; the PHSO found that care had been appropriate, but that there had been a missed opportunity to identify the impact of the pain on the patient's mental wellbeing on one occasion, and recommended that the Trust write to the patient to apologise. This was done, and the learning was shared with the relevant specialty.
- Concerns were raised about a delaying in investigating and treating high cholesterol. The PHSO found that, although the investigation and treatment were appropriate, there should have been a referral to cardiology, but that this would not have changed the outcome. They therefore made no recommendations, however their report and findings were considered by the specialty.

7.0 Patient Advice and Liaison Service (PALS)

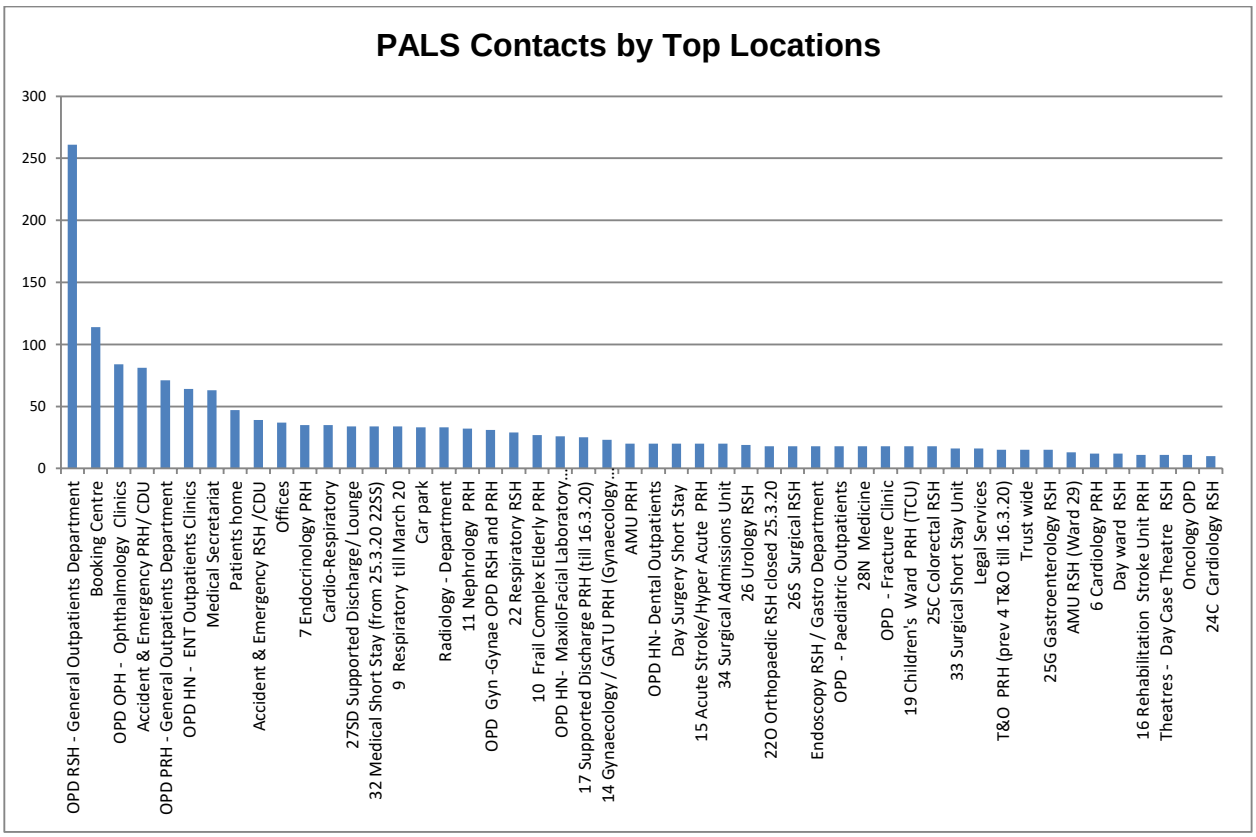
During 2019/20, the Trust dealt with 1951 patient contacts. Work has been ongoing during 2019/20 to publicise the service to patients and their families to ensure that they feel confident to access the service should they need it.



The majority of contacts relate to problems with appointments and waiting times. The graph below shows the subjects for PALS contacts:



The majority of PALS contacts received relate to outpatient locations and the emergency departments, in line with levels of activity; the graph below shows the top locations for PALS contacts:


PALS Contacts by Top Locations
300
250
200
150
100
50
0
OPD RSH - General Outpatients Department
Booking Centre
OPD OPH - Ophthalmology Clinics
Accident & Emergency PRH/ CDU
OPD PRH - General Outpatients Department
OPD HN - ENT Outpatients Clinics
Medical Secretariat
Patients home
Accident & Emergency RSH /CDU
Offices
7 Endocrinology PRH
Cardio-Respiratory
27SD Supported Discharge/ Lounge
32 Medical Short Stay (from 25.3.20 22SS)
9 Respiratory till March 20
Car park
Radiology - Department
11 Nephrology PRH
OPD Gyn -Gynae OPD RSH and PRH
22 Respiratory RSH
10 Frail Complex Elderly PRH
OPD HN- MaxiloFacial Laboratory...
17 Supported Discharge PRH (till 16.3.20)
14 Gynaecology / GATU PRH (Gynaecology...
AMU PRH
OPD HN- Dental Outpatients
Day Surgery Short Stay
15 Acute Stroke/Hyper Acute PRH
34 Surgical Admissions Unit
26 Urology RSH
22O Orthopaedic RSH closed 25.3.20
26S Surgical RSH
Endoscopy RSH / Gastro Department
OPD - Paediatric Outpatients
28N Medicine
OPD - Fracture Clinic
19 Children's Ward PRH (TCU)
25C Colorectal RSH
33 Surgical Short Stay Unit
Legal Services
T&O PRH (prev 4 T&O till 16.3.20)
Trust wide
25G Gastroenterology RSH
AMU RSH (Ward 29)
6 Cardiology PRH
Day ward RSH
16 Rehabilitation Stroke Unit PRH
Theatres - Day Case Theatre RSH
Oncology OPD
24C Cardiology RSH

8.0 Patient feedback

In addition to the feedback received directly via PALS, members of the public are able to leave feedback on the NHS Choices website and the PALS team will respond to these and share them with the relevant areas. All comments are posted anonymously and so individual comments are advised to contact the PALS department if they would like to discuss the matters further.

54 patient comments were published on the NHS Choices Website in 2019/20. Of these, 65% (35) were positive, 32% (11) were negative and 23% (8) were a mixture of positive and negative.

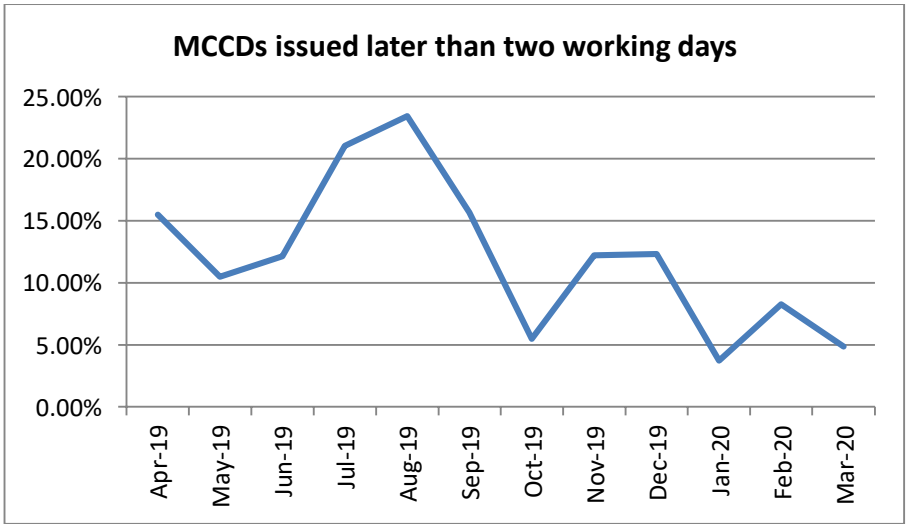
In addition to the comments left on the NHS Choices Website, the Trust received 148 letters of thanks.

9.0 Bereavement

In addition to supporting patients and their families with on the spot concerns, the PALS & Bereavement team meet with bereaved families to issue the medical certificate of cause death (MCCD) and provide advice on registering deaths. In 2019/20, the PALS & Bereavement team issued 1723 death certificates, and arranged 857 appointments for families to register their loved ones death at the Royal Shrewsbury site.

From 01 April 2019 the Trust successfully implemented the Medical Examiner (ME) Service from RSH. Nationally SaTH are early implementers of the Medical Examiner Service, and have actively proceeded with implementing a service during the non-mandatory phase. The Trust has recruited seven Medical Examiners from a range of sub-specialisms and has built the Bereavement Service up around this, with introducing new roles such as Lead Medical Examiner Officer and two Medical Examiner Officers. One of the most significant outcomes of introducing the ME system is the level of support offered to our bereaved relatives. Families are now contacted by the Medical Examiner to discuss the care their loved one received and to offer them the opportunity to raise and discuss any concerns that they may have had with their care. The ME also explains the cause of death that has been established, so that they are aware of this before being handed the MCCD. The ME service has been received very positively by our bereaved relatives. Our next step is to introduce the ME service to PRH. Plans have been worked up over the last few months, with recruitment of additional Medical Examiners taking place and accommodation to host the service identified. The end of the financial year for PALS, Bereavement & the Medical Examiner Service hasn't taken shape as had anticipated due to the global pandemic, however all three services have embraced the necessary changes in the way they work, whilst maintaining support for our bereaved relatives and service users and keeping this as our main priority. During 2019/20, the Medical Examiners reviewed 966 deaths.

The time taken to complete MCCDs is monitored and for all cases where there is no coronial involvement, the MCCD should be issued within two working days. As can be seen from the graph below, this has improved during the year.



Each family is given a bereavement survey and findings from this are monitored each month. During 2019/20, 277 surveys were returned. Key findings from these surveys include the following:

- 89% found that the support they had received from the Bereavement team was enough or more than enough
- 91% were given the death certificate and any belongings in an appropriate environment
- 98% were given a bereavement booklet
- 78% were given enough opportunity to discuss their concerns

These findings are similar to previous years, with the exception of families being given enough opportunity to discuss their concerns, which has increased from 68% last year; this is thought to be a reflection on the introduction of the Medical examiner service at RSH, which now allows families the opportunity to talk to an independent clinician.

10.0 Key achievements in 2019/20

- Implementation and embedding of the ME service at RSH
- Use of ThinkOn Methodology to improve processes for complaints, PALS and bereavement services
- Complaints statement forms updated to include more robust learning section, including use of high quality questions to prompt better thinking, and addition of audit section, to encourage auditing of actions
- Trial of paperless complaints, with full implementation at the end of March 2020; it is estimated that this will save the Trust approximately £550 a year and 351.2 hours (46.8 working days) of time.

11.0 Plans for 2020/21

- Introduction of the ME service at PRH.
- Implement agile PALS service within the Women & Children's Care Group
- Develop a system for tracking the implementation and embedding of changes as a result of learning from complaints.

12.0 Conclusion

The Trust has continued to handle complaints in line with national regulations, and has used both formal complaints and PALS contacts as an opportunity to drive improvements in patient care. The Trust is also continuing to support bereaved families, with the introduction of the ME system at the RSH as a key improvement in this.

The Board is asked to consider the report and note its findings

Julia Palmer
Head of PALS and Complaints
April 2020

Cover page	
Meeting	Board of Directors
Paper Title	National Inpatient Survey 2019 / 20
Agenda No	
Date of meeting	30 July 2020
Date paper was written	2 July 2020
Responsible Director	Maggie Bayley, Chief Nurse (Interim)
Author	Ruth Smith, Lead for Patient Experience Lucy McGuinness, Clinical Governance Lead
Presenter	Kara Blackwell, Deputy Chief Nurse

Executive Summary

The following report summarises the National Inpatient Survey 2019 results which were published by the CQC on 2nd July 2020.

The National Inpatient Survey 2019 was undertaken between September and December 2019, and included patients treated at the Trust during July 2019. The survey explores a number of domains which impact upon patient experience. A report is provided for the organisation to benchmark performance against the previous year and with other acute Trusts however this is presently based upon the national data for 2018.

Key Points:

- SaTH had a response rate of 51.16%, which was 6.16% above the national average.
- In 59 questions saw SaTH perform 'About the Same' as other trusts.
- In addition to this of the questions which were comparable to those used the previous year the vast majority (57) did not demonstrate a statistically significant difference in score. This suggests that patients report a similar level of satisfaction as the previous year and in comparison to other Trusts.
- SaTH performed 'Worse' than other trusts in 4 questions
- SaTH demonstrated a 5% or more deterioration in scores in 10 questions when compared to the 2018 survey and a statistically significant decline in 4 questions.
- The Trust scored in the bottom 20% of Trusts for 45 questions.

Previously considered by	

The Committee is asked to:			
☐ Approve	☐ Receive	☑ Note	☐ Take Assurance
To formally receive and discuss a report and approve its recommendations or a	To discuss, in depth, noting the implications for the Board or Trust without formally	For the intelligence of the Committee without in-depth discussion required	To assure the Committee that effective systems of control are in place

particular course of action	approving it		

Link to CQC domain:				
☐ Safe	☐ Effective	☑ Caring	☑ Responsive	☑ Well-led

Link to strategic objective(s)	*Select the strategic objective which this paper supports* ☑ PATIENT AND FAMILY Listening to and working with our patients and families to improve healthcare ☐ SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care ☐ HEALTHIEST HALF MILLION Working with our partners to promote 'Healthy Choices' for all our communities ☑ LEADERSHIP Innovative and Inspiration Leadership to deliver our ambitions ☐ OUR PEOPLE Creating a great place to work
Link to Board Assurance Framework risk(s)	We need real engagement with our community to ensure that patients are at the centre of everything we do (CRR 1186)

Equality Impact Assessment	◉ Stage 1 only (no negative impact identified) ○ Stage 2 recommended (negative impact identified and equality impact assessment attached for Board approval)
Freedom of Information Act (2000) status	◉ This document is for full publication ○ This document includes FOIA exempt information ○ This whole document is exempt under the FOIA
Financial assessment	

Main Paper

Situation

The NHS National Inpatient Survey is conducted annually. Information drawn from the core questions in the Inpatient Surveys are used by the Care Quality Commission (CQC) as part of its new Hospital Intelligent Monitoring. NHS England will use the results to check progress and improvement against the objectives set out in the NHS mandate, and the Department of Health will hold Trusts to account for the outcomes achieved. The results will also be used by the Trust Development Authority to inform the quality and governance assessment as part of their Oversight Model for NHS Trusts.

The 2019 Adult Inpatient Survey was the seventh national inpatient survey carried out and involved 143 acute and specialist NHS Trusts. Responses were received from 76,915 patients giving an overall response rate of 45%. Each Trust was required to send the survey to 1250 patients aged 16 years or over, who had at least one overnight stay in hospital during the month of July 2019. Maternity/obstetric and psychiatric service users, as well as current inpatients were excluded.

The patient sample is drawn in accordance with stipulated criteria issued by the CQC, and is checked for recently deceased and current inpatients. The postal survey includes 63 core questions which are divided into 11 sections, with an additional overall experience section. The remaining questions comprised filter questions (designed to identify whether a set of questions were applicable to the patient), and respondent profile questions, such as age, sex, religion etc. There is also the chance for patients to give their comments at the end.

The initial postal survey is followed up with two written reminders to non-responders.

A total of 615 usable questionnaires were completed and returned to the Trust. This gave a response rate of 51.16% which is lower than the previous year (53.9%) however compares favourably to the national response rate of 45%.

Background

On 2nd July 2020 the Care Quality Commission (CQC) published the results of the 2019 National Inpatient Survey.

The questions in the annual Inpatient Survey are grouped into eleven Sections and Trusts are rated as ‘Worse’, ‘About the Same’ or ‘Better’ than other Trusts in England in each section.

Results indicate that for the majority of questions patients rated their experience as ‘About the Same’ as other Trusts (59). In addition to this of the questions which were comparable to those used the previous year the vast majority (57) did not demonstrate a statistically significant difference in score. This suggests that patients report a similar level of satisfaction as the previous year and in comparison to other Trusts.

A statistically significant score means that the change is unlikely to be due to chance. Significance is tested using a two-sample t-test.

When reviewing the questions which scored lower:

The Trust results were significantly lower than the national average for 4 questions:

- 20. Were you offered a choice of food?
- 54. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?
- 64. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?
- 65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?

There are 4 questions where the Trust demonstrates a statistically significant decline from 2018 to 2019, these are:

- 19. How would you rate the hospital food?
- 20. Were you offered a choice of food?
- 64. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?
- 65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?

		2018	2019	Change 2018/19	Performance compared to other trusts
Section 4: The hospital and ward					
Q19	How would you rate the hospital food?	5.8	5.3	↓	
Q20	Were you offered a choice of food?	8.5	8.0	↓	Worse
Section 9: Leaving Hospital					
Q54	After leaving hospital, did you get enough support from health or social care professionals to help you recover and manager your condition?	6.2	5.7		Worse
Q64	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	8.2	6.9	↓	Worse
Q65	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?	8.1	7.3	↓	Worse

Whilst previous National Inpatient Surveys have been led by the Trust Clinical Audit Team, for the 2019 survey a nationally approved survey contractor Patient Perspective was commissioned by the Trust. Patient Perspective were contacted to:

- Provide telephone helpline support to patients throughout the process
- Provide a full detailed review of the 2019 National Inpatient Survey results
- Provide a breakdown of the comments provided by patients
- Present an overview of the results
- Lead a Trust workshop session around the survey results to identify key actions for improvement
- Establish a process for on-going monitoring of actions and communicating progress to stakeholders

The Patient Perspective headline report summarising the National Inpatient Survey results for the Trust is attached as an appendix to this paper. Within this report all questions which

demonstrate a change of 5% or greater on the previous year's data are highlighted regardless of statistical significance. This approach identifies 10 questions of which 6 are linked with discharge from hospital which identifies a consistent theme.

When interpreting the data, it is important to note that the CQC benchmark report identifies the rate of deviation from the average of all Trusts. However the Patient Perspective report benchmarks against the 2018 national results which are calculated to enable the Trust data to be categorised in the bottom 20%, middle 60% or top 20% of Trusts nationally.

Assessment

There is a clear correlation between the results of the CQC data with three of the questions reflected in both categories. The themes from the questions which scored lower both in comparison to the national average and on the previous year identify discharge home from hospital and the quality and choice of hospital food. This feedback enables the Trust to focus upon the two areas identified for improvement, based upon what patients experience when accessing services within SaTH.

The themes which were identified support feedback which has been received from patients during focus groups (discharge from hospital) and patient assessors on Patient Led Assessments of the Care Environment (food). This gives assurance that the Trust are aware of improvements which need to be made through listening to what matters to patients and a number of priorities have been identified to improve the service which include:

Discharge home from hospital:

- The number of Patient Journey Facilitators within the Trust has been increased, providing a visible presence at Ward level to educate and support home first decision making.
- Patient pathways have been introduced to provide specialised rehabilitation in community hospitals.
- Enhanced discharge summaries have been introduced to improve communication with Primary Care.
- All adult patients with a hospital stay of 14 days or greater are tracked to expedite treatment and discharge and ensure there are no unnecessary delays.
- An integrated discharge hub has been established to support rapid complex discharges, supporting patients to be discharged home or to a therapeutic environment.
- Providing an increased focus upon identifying and supporting carers.

The quality and choice of hospital food:

- Matron quality checks incorporate questions for patients which focus upon patient experience, in response to the survey the questions have been updated to include questions on food choice and quality.
- In August 2020 a new food service will be piloted on a ward at RSH.
- Following review of the pilot, learning will be taken into account and in September 2020 the new service will be introduced across all of RSH.
- The new food service will incorporate a new patient menu and a hostess service which will enable patients more choice in relation to their food and portion size.
- Once introduced the new menu will be made available in different languages, large print and easy read format to support patients accessing food choice information.
- Regular food tasting sessions involving patient representatives are being introduced to enable regular feedback to be obtained.

Recommendation

Further analysis will take place when Patient Perspective provide comparison to the 2019

National Inpatient Survey data.

A Trust workshop on the survey results will be delivered and incorporate key actions for improvement which can be taken forward to support Care Groups in developing patient experience action plans in response to the results.

If the Trust commissions Patient Perspective for all National Surveys during 2020/21 then consideration should be given to increasing the sample size to enable feedback to be provided to each individual Ward and Department. This would provide the Trust with richer data and enable focus to be placed upon local ownership at Ward and Department level.

The Committee is asked to receive and note the content of this paper.

PATIENT EXPERIENCE SURVEY HEADLINE REPORT

Shrewsbury and Telford Hospital NHS Trust

National Inpatient Survey 2019

Sample: Patients discharged in July 2019

Note: to access full suite of data and reports use the online reporting portal at www.patientperspective.co.uk

patient PERSPECTIVE

EXECUTIVE SUMMARY

This report summarises the results of the National Inpatient Survey of patients seen in July 2019.

With 615 surveys returned completed, the Trust had a response rate of 51.2% (national average response was 44%)

The Trust scored an average score of 70.8% which is lower than the previous year.

Compared with the 2018 survey, the Trust showed a 5% or greater improvement on no question scores and a 5% or greater reduction in score on 10 questions.

The Trust scored in the top 20% of Trusts on no questions and the bottom 20% of Trusts on 45 questions .

The full sample of patient comments is provided separately for reference. We highly recommend detailed coding and thematic analysis of these comments in order to understand the views expressed and to add detail to this analysis of individual question scores. This will also assist in improvement priority setting.

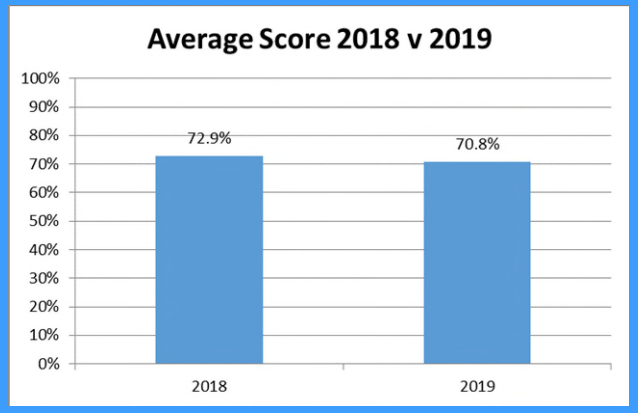
The results show areas for improvement across all key topic areas of the survey.

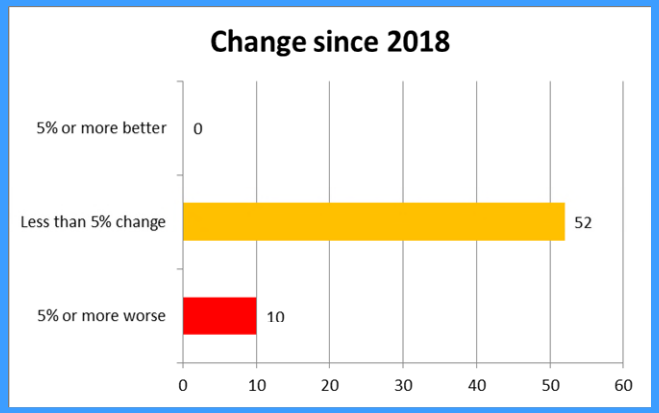
To access the full suite of data and reports please use the online reporting portal at www.patientperspective.co.uk

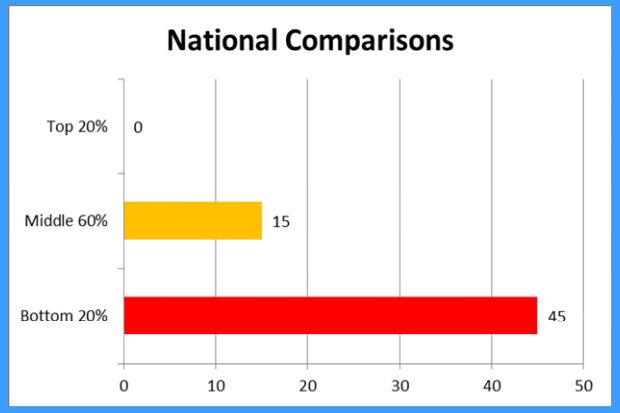
Suggestions for approaches to identifying improvement priorities are provided at the end of this report.

patient PERSPECTIVE

RESULTS DASHBOARD
NATIONAL INPATIENT SURVEY 2019







- 615 surveys returned completed
- Response rate of 51.2%

patient PERSPECTIVE

SCORES AND COMPARISONS

Question	Text	2018	2019	Change Since 2018	National Comparison
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	79.3%	76.9%	-2%	Bottom 20%
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	88.3%	86.2%	-2%	Middle 60%
Q6	How do you feel about the length of time you were on the waiting list before your admission to hospital?	78.9%	83.1%	4%	Middle 60%
Q7	Was your admission date changed by the hospital?	92.7%	87.4%	-5%	Bottom 20%
Q8	In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?	86.5%	87.5%	1%	Bottom 20%
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	66.4%	61.6%	-5%	Bottom 20%
Q11	While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	89.9%	88.6%	-1%	Bottom 20%
Q13	Did the hospital staff explain the reasons for being moved in a way you could understand?	64.1%	67.3%	3%	Middle 60%
Q14	Were you ever bothered by noise at night from other patients?	59.5%	60.7%	1%	Middle 60%
Q15	Were you ever bothered by noise at night from hospital staff?	76.4%	76.7%	0%	Bottom 20%
Q16	In your opinion, how clean was the hospital room or ward that you were in?	89.0%	88.0%	-1%	Middle 60%
Q17	Did you get enough help from staff to wash or keep yourself clean?	79.6%	77.6%	-2%	Middle 60%
Q18	If you brought your own medication with you to hospital, were you able to take it when you needed to?	71.1%	63.9%	-7%	Bottom 20%
Q19	How would you rate the hospital food?	57.6%	53.7%	-4%	Middle 60%
Q20	Were you offered a choice of food?	85.6%	81.9%	-4%	Bottom 20%
Q21	Did you get enough help from staff to eat your meals?	74.5%	67.6%	-7%	Bottom 20%
Q22	During your time in hospital, did you get enough to drink?	93.8%	91.8%	-2%	Middle 60%
Q23	When you had important questions to ask a doctor, did you get answers that you could understand?	78.7%	78.8%	0%	Middle 60%
Q24	Did you have confidence and trust in the doctors treating you?	86.8%	85.4%	-1%	Bottom 20%
Q25	Did doctors talk in front of you as if you weren't there?	80.0%	83.0%	3%	Bottom 20%

patient PERSPECTIVE

Question	Text	2018	2019	Change Since 2018	National Comparison
Q26	When you had important questions to ask a nurse, did you get answers that you could understand?	82.8%	79.0%	-4%	Bottom 20%
Q27	Did you have confidence and trust in the nurses treating you?	87.0%	85.7%	-1%	Bottom 20%
Q28	Did nurses talk in front of you as if you weren't there?	88.1%	88.6%	0%	Middle 60%
Q29	In your opinion, were there enough nurses on duty to care for you in hospital?	70.3%	68.7%	-2%	Bottom 20%
Q30	Did you know which nurse was in charge of looking after you?	60.9%	58.3%	-3%	Bottom 20%
Q31	Did you have confidence and trust in any other clinical staff treating you (e.g. physiotherapists, speech therapists, psychologists)?	85.3%	84.2%	-1%	Middle 60%
Q32	In your opinion, did the members of staff caring for you work well together?	86.0%	84.1%	-2%	Bottom 20%
Q33	Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	79.2%	77.8%	-1%	Bottom 20%
Q34	Were you involved as much as you wanted to be in decisions about your care and treatment?	67.5%	67.6%	0%	Bottom 20%
Q35	Did you have confidence in the decisions made about your condition or treatment?	80.2%	77.9%	-2%	Bottom 20%
Q36	How much information about your condition or treatment was given to you?	85.4%	84.1%	-1%	Bottom 20%
Q37	Did you find someone on the hospital staff to talk to about your worries and fears?	54.0%	48.0%	-6%	Bottom 20%
Q38	Do you feel you got enough emotional support from hospital staff during your stay?	68.9%	65.3%	-4%	Bottom 20%
Q39	Were you given enough privacy when discussing your condition or treatment?	79.8%	79.4%	0%	Bottom 20%
Q40	Were you given enough privacy when being examined or treated?	93.1%	93.0%	0%	Bottom 20%
Q42	Do you think the hospital staff did everything they could to help control your pain?	80.1%	77.1%	-3%	Bottom 20%
Q43	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	76.5%	73.0%	-4%	Bottom 20%
Q45	Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	86.6%	86.1%	0%	Bottom 20%
Q46	Beforehand, were you told how you could expect to feel after you had the operation or procedure?	70.8%	72.6%	2%	Middle 60%
Q47	After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	77.7%	75.1%	-3%	Bottom 20%

patient PERSPECTIVE

Question	Text	2018	2019	Change Since 2018	National Comparison
Q48	Did you feel you were involved in decisions about your discharge from hospital?	65.4%	64.8%	-1%	Bottom 20%
Q49	Were you given enough notice about when you were going to be discharged?	68.8%	70.3%	1%	Middle 60%
Q50	On the day you left hospital, was your discharge delayed for any reason?	59.5%	60.8%	1%	
Q52	How long was the delay?	30.5%	33.2%	3%	
Q54	After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	62.3%	56.8%	-6%	Bottom 20%
Q55	When you left hospital, did you know what would happen next with your care?	64.2%	60.7%	-4%	Bottom 20%
Q56	Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	60.4%	54.8%	-6%	Bottom 20%
Q57	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	80.0%	78.2%	-2%	Bottom 20%
Q58	Did a member of staff tell you about medication side effects to watch for when you went home?	42.0%	39.1%	-3%	Bottom 20%
Q59	Were you given clear written or printed information about your medicines?	75.9%	72.9%	-3%	Middle 60%
Q60	Did a member of staff tell you about any danger signals you should watch for after you went home?	46.4%	45.2%	-1%	Bottom 20%
Q61	Did hospital staff take your family or home situation into account when planning your discharge?	69.7%	67.0%	-3%	Bottom 20%
Q62	Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?	61.1%	55.5%	-6%	Bottom 20%
Q63	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	72.0%	68.3%	-4%	Bottom 20%
Q64	Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?	82.9%	66.4%	-16%	Bottom 20%
Q65	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	79.7%	71.4%	-8%	Bottom 20%
Q66	Was the care and support you expected available when you needed it?	81.0%	75.8%	-5%	Bottom 20%
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	87.9%	87.0%	-1%	Bottom 20%
Q68	Overall, how good was your experience (0=very poor, 10= very good)?	78.6%	77.2%	-1%	Bottom 20%
Q70	During your hospital stay, were you ever asked to give your views on the quality of your care?	14.2%	10.9%	-3%	Bottom 20%
Q71	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	16.8%	14.5%	-2%	Bottom 20%
Q72	Did you feel well looked after by the non-clinical hospital staff (e.g. cleaners, porters, catering staff)?	92.0%	90.6%	-1%	Middle 60%

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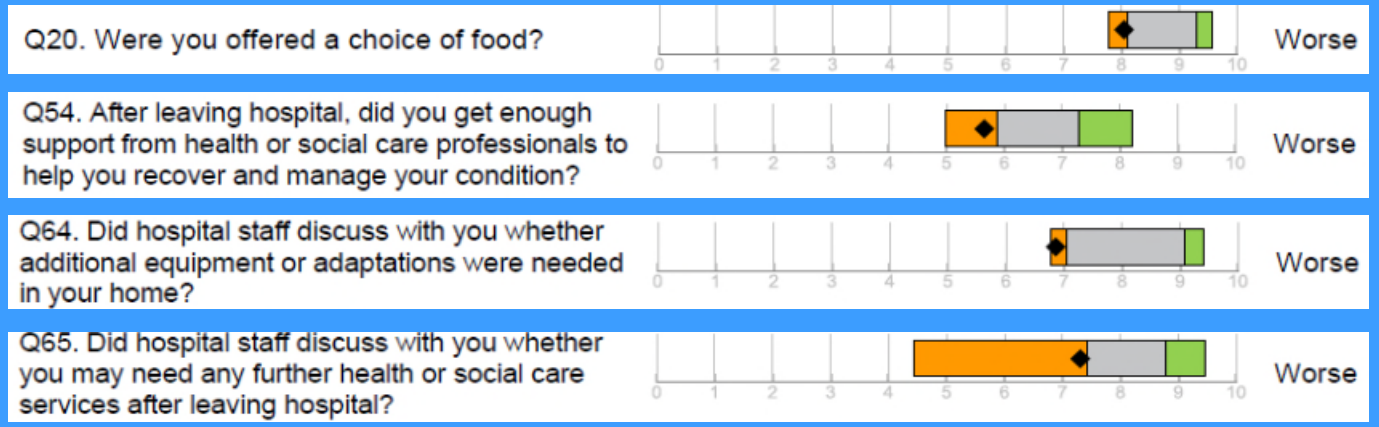
CQC RESULTS
NATIONAL INPATIENT SURVEY 2019

- The Trust scored in the '**Best performing Trusts**' on **no questions**
- The Trust scored '**About the same**' on **59 questions**
- The Trust scored in the '**Worst performing Trusts**' on the following **4 questions**:



patient PERSPECTIVE

CQC RESULTS
NATIONAL INPATIENT SURVEY 2019

- The Trust had a statistically significantly **better** score since the 2018 survey on **no questions**
- The Trust had a statistically significant **worsening** in score since the 2018 survey on the following **4 questions**:

Question	2019 Trust Score	2018 Trust Score	Lowest score in England	Highest score in England
Q19 How would you rate the hospital food?	53	58	45	79
Q20 Were you offered a choice of food?	80	85	78	96
Q64 Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	69	82	68	94
Q65 Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	73	81	44	95

IDENTIFYING IMPROVEMENT ACTIONS

The following questions are useful for guiding discussions aimed at identifying areas/actions for improvement based upon the survey results. These discussions should only be held after time has been spent first reviewing and reflecting on the results and interrogating the data. The questions are suitable for use in pairs/trios and small groups as well as to support individual reflection and analysis. Using these questions to stimulate discussion, aim to identify 3 to 5 priority areas for improvement.

- In which areas do we compare unfavourably with other Trusts (eg where do we perform in the bottom 20% of Trusts, in the middle but a lot worse than the highest scoring Trusts or below the National average)? Refer to the online benchmarking report at www.patientperspective.co.uk
- In which areas has our performance got worse since the last survey? In particular, where have results shown statistically significant worsening (more than 5% reduction in score)?
- What areas for improvement do patients comment upon the most? What are the question scores in these areas?
- What do we already know (and what do the results tell us) about 'what works', so we can do more of that in order to make improvements in other areas? Have we shown previously that we can improve our scores and patient feedback in certain areas? If so, how did we do that? What can we learn from that?
- Do any other data and existing organisational priorities also point us towards areas for improvement in line with these results, or help us to understand the results we have seen today (eg staff survey results, FFT results, complaints and accolades, incidents and risks, other surveys, informal concerns raised via PALS and local patient panels/participation groups, other data such as waiting list or cancellation data)?
- What if any are the existing improvement efforts we have been / are working on already? Do these match with what the survey results are suggesting should be priorities for improvement? Are we working on the 'right things' for patients? Do we need to rethink our priorities and adjust current plans or do our current plans help us address the issues raised in the survey results? Can we link quality improvement activities rather than duplicate effort? Have any concerns been raised by patients that were resolved in previous action plans but should now be revisited?
- What is do-able?– what can we actually do something about?
- Are there any 'quick wins' ie changes that are relatively easy to make but which will make a difference and help get the patient experience improvements started? What small changes (ie easy to make) are likely to have the biggest impact upon patient experience?
- What hasn't worked so far? What have we learned from what hasn't worked that we can either avoid doing in future or can do differently from now on?
- What should we STOP doing, START doing and CONTINUE doing?
- What is URGENT and what is IMPORTANT but not necessarily urgent?

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LEARNING FROM THESE RESULTS: POINTS TO DISCUSS WITH STAFF

Research has shown that spending time discussing the results with ward/department staff (rather than just sending them out) is more likely to lead to action being taken to make improvements. The following are useful questions to prompt review and discussion:

- What is your overall impression of these results?
- What are you most pleased about in these results?
- What are you most unhappy about in these results?
- Which results confirm what you already knew about your services and which results brought shocks or surprises?
- What works? What have you learned from your successes that you can use to help you make improvements in other areas of patient experience?
- What hasn't worked so far? What have you learned from what hasn't worked that you can either avoid doing in future or can do differently next time?
- What should you stop, start and continue doing based upon these results?
- Which areas would be relatively easy to act upon and would make a big difference to patients (quick wins)?

Staff should also consider the evidence about patient priorities – published research suggests that there are 8 core domains of patient experience which matter to patients:

What matters most to patients?

Research has identified 8 dimensions of quality important to patients:

- ✓ fast access to reliable health advice
- ✓ effective treatment delivered by trusted professionals
- ✓ participation in decisions and respect for preferences
- ✓ clear, comprehensible information and support for self-care
- ✓ attention to physical and environmental needs
- ✓ emotional support, empathy and respect
- ✓ involvement of, and support for family and carers
- ✓ continuity of care and smooth transitions

(source: Picker Institute)

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NEXT STEPS AND ACTIONS

- Detailed review of the results
- Dissemination of results – consider with which stakeholder groups (internal and external), in which level of detail and in what format to share the results widely
- Identify your priority areas for improvement – ensuring these are linked with current priorities and are fully integrated into existing service improvement initiatives will mean they are more likely to be acted upon
- Involve staff and patients in deciding upon the actions to take to make the improvements real and lasting
- Set up a process for ongoing monitoring of the actions and improvements and regular communication about progress to stakeholders
- Consider whether any further detailed analysis would be helpful in supporting your quality improvement initiatives and whether there is anything else we can help you with

To add further detail to your analysis and reporting of patient experience, and assist you in your quality improvement initiatives, you might wish to consider the following **enhanced services from Patient Perspective**:

- Increasing your sample size will enable ward level, business unit or specialty reporting
- Individual clinician surveys enable comparisons between patients' experiences of care provided by different clinicians
- Detailed thematic analysis of comments from patients will improve the depth of reporting about what patients are telling you
- Monthly survey programmes that enable detailed analysis and measurement of patients' experiences over time
- Training for staff (including train the trainer programmes) in the interpretation of survey results and how to get the most from your survey programme will build capacity for improvement
- Dedicated service improvement workshops and events built around your patient experience survey results

To discuss how we can help you further please contact our Senior Project Manager, Chris Henderson: chris.henderson@patientperspective.org