The Shrewsbury and Telford Hospital NHS Trust

# Board of Directors' Meeting
# 8 December 2020

| | | | | |
|---|---|---|---|---|
| **Agenda item** | xxx/20 | | | |
| **Report** | Quality Account 2019/20 | | | |
| **Executive Lead** | Director of Nursing | | | |
| *√ tick only those applicable* | **Link to strategic pillar:** | | **Link to CQC domain:** | |
| | Our patients and community | | Safe | √ |
| | Our people | | Effective | √ |
| | Our service delivery | √ | Caring | √ |
| | Our partners | | Responsive | √ |
| | Our governance | √ | Well Led | √ |
| *√ tick / input only those applicable, usually only one* | **Report recommendations:** | | **Link to BAF / risk:** | |
| | For assurance | √ | 561/1771 | |
| | For decision / approval | | **Link to risk register:** | |
| | For review / discussion | √ | | |
| | For noting | | | |
| | For information | | | |
| | For consent | | | |
| **Presented to:** | Quality and Safety Assurance Committee | | | |
| **Dependent upon** (if applicable)**:** | | | | |
| **Executive summary:** | The Quality Account for 2019/2020 is included for the Board.<br><br>The Quality Account outlines the progress the Trust has made over the last 12 months, as well as the areas we need to improve on as we continue our improvement journey and strive to achieve our aim of "Getting to Good" so we ensure we deliver an high quality care and patient experience across all services provided by the Shrewsbury and Telford Hospitals NHS Trust. It always looks to our priorities for improvement in 2020/21.<br><br>In 2019/2020 we set out 10 Quality Priorities for the year, these were the key priorities identified how we would improve the quality of care and services for our patients. Throughout the year there was a significant amount of improvement work within the Emergency Departments to improve care and patient experience. There were improvements in our screening of patients for sepsis on admission to the emergency departments and the use of the sepsis 6 bundle.<br><br>We also saw an overall reduction in the number of category 3 pressure ulcers and the number of falls in 2019/20 although we know that we have considerable work to do to eliminate category 3 pressure ulcers in the hospitals and reduce further our number of falls and in particular those with harm over the coming year. The National Friends and Family Test continues to be one way in which we seek to gain the views of our patients | | | |

| | |
|---|---|
| | in relation to their experience of the quality of care they receive across our services. The FFT results continue to be extremely positive and above the national average for inpatients, the emergency department, maternity and outpatient services.<br><br>The priorities for 2020/21 include a continuation of one priority from 2019/20 in relation to recognising and responding to the deteriorating patient, alongside some new priorities which include transition of services to support children to adulthood, improving our patient experience through engagement with patients and learning from complaints, learning from serious incidents and development of a safety culture. |
| **Appendices** | Appendix 1:Quality Account 2019/20 |

## 1.0 Introduction

- Purpose of the Quality Account
- Statement on Quality from the Chief Executive Officer

## 2.0 Review of the Priorities for Improvement 2019-2020

- The Emergency Department
- Maternity Services
- Our Staff
- Patient Access to Services
- Infection Prevention and Control

2.2 Statement of Assurance from the Board

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- Statement from the Care Quality Commission and Our Improvement Plan
- Participation in clinical audit and confidential enquiries
- Participation in Clinical Research
- Use of the Commissioning for Quality and Innovation Payment Framework
- NHS Number and General Medical Practice Code Validity
- Data Security and Protection Toolkit Attainment Levels
- Learning from Deaths
- Implementing the Priority Clinical Standards for 7 Days Services
- Encouraging Staff to Speak Up
- Guardians of Safe Working

2.3 Reporting against Core Quality Account Indicators

- Summary Hospital Level Mortality Indicator
- Percentage of Patient Deaths Coded at either Diagnosis or Speciality Level.
- Patient Reported Outcome Measures (PROMs)
- Patients Readmitted to hospital
- Responsiveness to the needs of Patients
- Percentage of staff who would recommend the Trust to a friend or family needing care
- Patients admitted to hospital who were risk assessed for venous thromboembolism 9VTE)
- Patient Safety Incidents and the Percentage Reported that Resulted in Severe Harm or Death
- Rate of Clostridium Difficile

2.4 Looking forward to our Priorities for Quality Improvement 2020-2021

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- National Patient Safety Alert Compliance
- Serious Incidents
- Never Events
- Falls

- Pressure Ulcer
- Friends and Family Test
- Patient Complaints
- Patient Led Assessment of the Care Environment (PLACE)

## 4.0 Statements from External Organisations

- Healthwatch Shropshire
- Healthwatch Telford & Wrekin
- Shropshire, Telford & Wrekin Clinical Commissioning Group (CCG)
- Powys Teaching Health Board
- Feedback Form

Director of Nursing
November 2020

NHS
The Shrewsbury and Telford Hospital
NHS Trust

# Quality Account
## 2019/20

Partnering
Ambitious
Caring
Trusted

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

## Section 1: Introduction



## Section 2: Priorities for Improvement and Statement of Assurance from the Board

## Section 3: Other Information Relevant to the Quality of Care

### 3.1 Performance Against the Relevant Indicators and Performance Thresholds

### 3.2 Other Quality Information

National Patient Safety Alert Compliance
Serious Incidents
Never Events
Falls
Pressure Ulcer
Friends and Family Test
Patient Complaints
Patient Led Assessment of the Care Environment (PLACE)

## Section 4: Statements from External Organisation

HealthWatch Shropshire
HealthWatch Telford and Wrekin
Shropshire, Telford and Wrekin Clinical Commissioning Group
Powys Teaching Health Board
Feedback Form

# Section 1: Introduction

## 1.0 Statement on Quality from the Chief Executive Officer

## The Shrewsbury and Telford Hospital NHS Trust

The Shrewsbury and Telford Hospitals NHS Trust is the main provider of hospital services for Shropshire, Telford and Wrekin and North Powys. It is an acute teaching hospital working across two main sites: the Royal Shrewsbury Hospital in Shrewsbury and the Princess Royal Hospital in Telford.

Both hospital sites provide a wide range of acute hospital services including emergency services, critical care services, diagnostics, outpatients, trauma and orthopaedics and renal dialysis services. Inpatient vascular, general surgery and oncology services are provided at the Royal Shrewsbury Hospital. Inpatient paediatrics, gynaecology, and consultant-led obstetrics services are provided at the Princess Royal Hospital. Acute Stroke and Stroke rehabilitation services are also provided at the Princess Royal Hospital site.

The Trust also provides community and outreach services such as:

- Consultant-led outreach clinics (including the Wrekin Community Clinic at Euston House in Telford
- Renal dialysis outreach and Ludlow Hospital
- Community services including audiology, therapies and maternity services

## Purpose of the Quality Account

A Quality Account is a report to the public from providers of NHS healthcare services about the quality and standard of services they provide. Every acute NHS trust is required by the Government to publish a Quality Account annually. They are an important way for trusts to show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided. Due to the impact of COVID-19, in this year's Quality Accounts, the routine external auditor assurance has been suspended.

## Statement on Quality from the Chief Executive Officer

Welcome to the 2019/2020 Quality Account from Shrewsbury and Telford Hospitals NHS Trust. This Quality Account outlines the progress the Trust has made over the last 12 months. It also describes the areas we need to improve on as we continue our improvement journey

and strive to achieve our aim of “Getting to Good” so we ensure we deliver high quality care and patient experience across all services provided by the Shrewsbury and Telford Hospitals NHS Trust. It always looks to our priorities for improvement in 2020/21.

This year has been another challenging year for the Trust. Following our CQC inspection in November 2019, we remain in special measures and our overall Trust rating remains “inadequate”. Improvements were seen in our maternity services. Since then we have developed a comprehensive action plan following the feedback from the CQC to address all the concerns and issues to ensure our patients receive high quality, individualised care. A significant amount of focussed work to drive quality improvements for our patients has been undertaken and progress will continue to be made throughout 2020/21.

In 2019/2020 we set out 10 Quality Priorities for the year; these were the key priorities identifying how we would improve the quality of care and services for our patients. These priorities were determined by stakeholder engagement, and analysis of our performance and data from the previous 12 months. Throughout the year there was a significant amount of improvement work within the Emergency Departments. There were improvements in our screening of patients for sepsis on admission to the emergency departments and the use of the sepsis 6 bundle. Despite a significant effort by the emergency department team we continued to see sustained challenges in relation to our 4 hour emergency target. We will continue to work with our partner organisations and the NHS Improvement Emergency Care Intensive Support Team to improve our performance, care and patient experience in 2020/21.

We also saw an overall reduction in the number of category 3 pressure ulcers and the number of falls in 2019/20 although we know that we have considerable work to do to eliminate category 3 pressure ulcers in the hospitals and reduce further our number of falls and in particular those with harm over the coming year. The National Friends and Family Test continues to be one way in which we seek to gain the views of our patients in relation to their experience of the quality of care they receive across our services. I am pleased to say that our results continue to be extremely positive and above the national average for inpatients, the emergency department, maternity and outpatient services.

This year’s priorities include a continuation of one priority from 2019/20; this relates to recognising and responding to the deteriorating patient, alongside some new priorities which include transition of services to support children to adulthood, improving our patient experience through engagement with patients and learning from complaints, learning from serious incidents and development of a safety culture. We are committed to ensuring all of our patients have a positive patient experience when a patient in our hospitals and that they get the right care, in the right place, at the right time.

I am pleased to present the Shrewsbury and Telford Hospitals NHS Trust Quality Account for 2019 to 2020. This document is an honest reflection of our performance in relation to quality, safety and patient care, challenges and achievements during 2019 to 2020.

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# Section 2: Priorities for Improvement and Statement of Assurance

This section outlines the detail behind each of the quality priorities for 2019/2020 and provides a summary of our performance and achievements in relation to these priorities throughout the year.

It also provides a statement of assurance from the Board and a review of the Shrewsbury and Telford Hospital performance for core quality indicators. A summary of the priorities identified for 2020/2021 are outlined, why we have chosen these and the actions we will take to achieve these throughout 2020/2021.

## 2.1 Review of the Priorities for Improvement 2019-2020.

In 2019/2020 we set out 10 Quality Priorities for the year, these were the key priorities identified how we would improve the quality of care and services for our patients. These priorities spanned a number of clinical services as well as including cross cutting priorities across the Trust and included:

- The Emergency Department
- Maternity Services
- Our Staff
- Patient Access to services
- Infection Prevention and Control

## Quality Priorities for the Emergency Department

Ensuring that patients receive high quality, safe care is a key priority for our Emergency Departments. There were 4 quality priorities included in the Quality Account for 2019/2020 for the Emergency Departments. These priorities aimed to improve the quality of care provided. The priorities included ensuring that the sickest patients were reviewed in the mostly timely way, and that there was the appropriate identification, escalation and management of patients with potential sepsis and deterioration. Other patient safety priorities included learning from serious incidents for missed diagnosis and reducing the number of overdue Datix in the Emergency Departments.

| Priority Area | Why have we chosen this? | What are we aiming to achieve? | How will we measure if we have improved? | Current Status |
|---|---|---|---|---|
| **Emergency Department (ED) Care** | Providing high quality ED services remains a significant challenge for the Trust | **Priority 1:**We will focus on key measures to ensure we know patients in the ED are being seen quickly | Time to be seen for majors patients: we will reduce the average time to be seen for majors patients in 2019/20 | **Not Achieved** |
| | | **Priority 2:** We will continue to look at the way we respond when patients are at risk of sepsis and use of the 'sepsis' 6 bundle | Audit of compliance with the sepsis 6 bundle: We will continue to audit our compliance with the sepsis 6 bundle and update on how we did in our next quality account | **Partially achieved** |
| | | **Priority 3:** We will demonstrate how we have learnt from incidents of missed diagnosis in ED and how we have used learning from incidents to improve | Numbers of serious incidents (SIs) related to missed diagnosis: we will publish learning from SIs related to missed diagnosis in 2019/20 and outline improvements have been made. | **Achieved** |
| | | **Priority 4:** We will demonstrate we are responding in a timely way when staff in ED submit 'datix' incident reports so we know we are learning when staff raise concerns around safety | Timely responses to Datix incident reports: we will reduce the number of overdue responses in our Emergency Department | **Partially achieved** (requires on-going monitoring) |

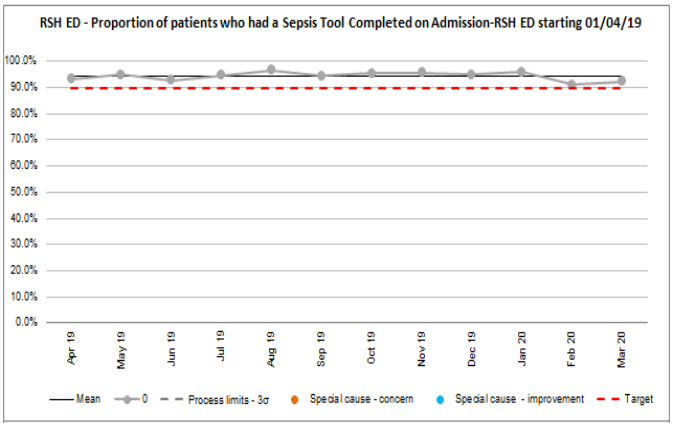
## Priority 1: We will focus on key measures to ensure we know patients in the ED are being seen quickly.

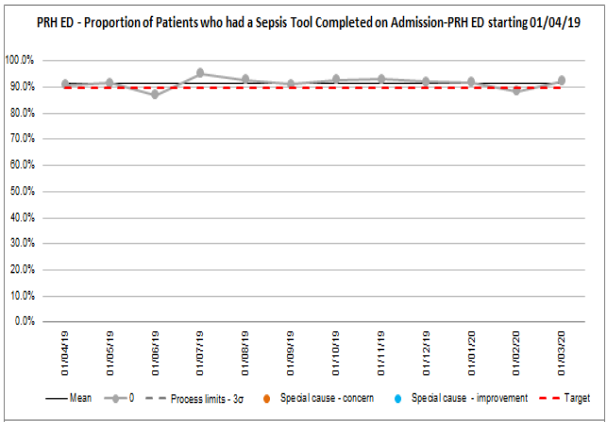
In 2019/20 a key priority for the Trust was to ensure that patients in the Emergency Departments were seen quickly. We aimed to achieve this by reducing the average time to be seen for majors patients. The average wait time to be seen for majors patients in the ED department declined in 2019/20. Current performance for wait to be seen for majors patients has deteriorated from an average 162 minutes wait to be seen to an average 175 minutes wait to be seen. Overseas recruitment to ED middle grade doctors in 2019/20 will see an improvement in the waiting time to be seen for majors patients from April 2020.

## Priority 2: We will continue to look at the way we respond when patients are at risk of sepsis and use of the 'sepsis' 6 bundle

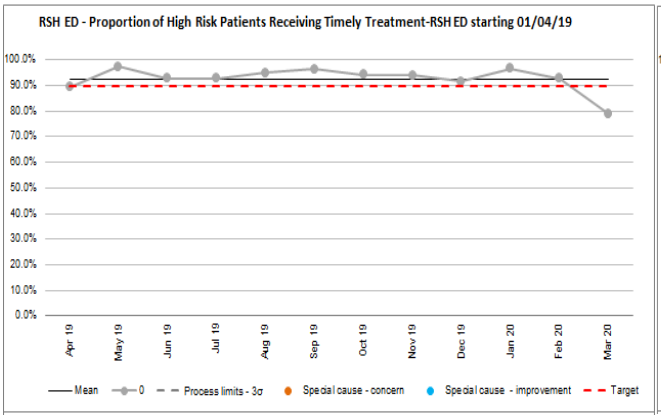
The Sepsis Screening tool utilised within the Trust across the Emergency Department and wider ward area is a modification of the UK Sepsis Trust Screening tool utilising the Red Flag method of identification and Amber Flag to identify those patients at risk of deteriorating. The use of the Sepsis 6 bundle in the management of the Sepsis patient standardises the delivery of care in line with recommended early goal directed therapy. NEWS2 has been implemented and used across the hospital in the management of the deteriorating patient and the Sepsis patient.

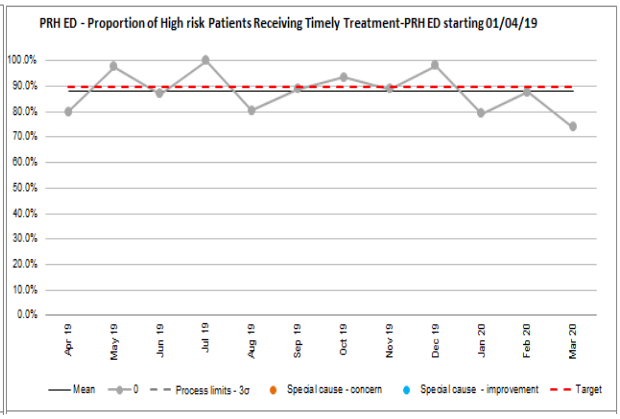
As part of our improvement work the Emergency Departments at both sites have undertaken daily spot check audits, undertaken on 140 patients in each emergency department. The monthly results of the Sepsis Screening Tool audits completed on admission to the Emergency Department show that the monthly compliance has been above 90% consistently at the Royal Shrewsbury Hospital throughout 2019/21 and 90% or above for 10 out of the 12 months at the Princess Royal Hospital Emergency Department.




The audits also evaluate whether for those patients identified at high risk of sepsis on screening have the appropriate care put in place as per the Sepsis 6 bundle. These results show that compliance is more inconsistent, and remain a focus for improvement to ensure that all our patients get timely, appropriate care.




There has been ongoing improvement work in relation to the recognition, escalation and management of potential sepsis and deteriorating patients in both the Emergency Departments during 2019/20. The following actions specific to the EDs have been put in place:

- Design and roll out new adult sepsis screening tools and pathway in the Emergency Departments and the assessment units.
- Delivery of sepsis training focused on the Emergency Departments
- Appointment of an additional Sepsis Nurse to help provide face to face training and support improving compliance.

Recognising and responding to the deteriorating patient remains a key priority which will continue in 2020/21.

## Priority 3: We will demonstrate how we have learnt from incidents of missed diagnosis in ED and how we have used learning from incidents to improve

There have been 6 serious incidents relating to delayed/missed diagnosis across the Royal Shrewsbury Hospital and the Princess Royal Hospital Emergency Departments in 2019/20. Sharing of learning via ED governance meetings, safety huddles and other forms of staff communication such as key information posters can be evidenced.

Action plans have been monitored so we are able to update on learning and actions taken. This has included thematic learning relating to:

- Consistent availability of ambulance handover information to focus clinical decision making;
- Atypical presentation of patients with an Aortic Aneurism/Myocardial Infarction

Cross specialty/department learning has enabled changes to pathways to improve safety and outcomes such as availability of CT angiograms and pathways to University Hospitals North Midlands.

## Priority 4: We will demonstrate we are responding in a timely way when staff in ED submit 'Datix' incident reports so we know we are learning when staff raise concerns around safety

In 20219/2020 we aimed to reduce the number of overdue responses in our Emergency Department. From a peak in Quarter 1 of 2019/2020, there was a significant reduction in the number of overdue datix reports in Quarter 2 and Quarter 3 of 2019/20. This reduction continued in Quarter 4 with the position improving from 390 incidents to 237 across the two Emergency Departments. On-going work is still required to further reduce the number of overdue responses and to maintain timely oversight of datix reports (particularly given current challenges of emergency demand).

The improvement in the timely response to datix incidents is in part attributable to the Unscheduled Care Governance Facilitator taking up post in 2019/202, this has allowed focused support for the Emergency Department team to review and appropriately close down overdue datix reports.

Final approval of patient safety related datix reports is via the patient safety team. The 'push' on reducing the overdue datix reports across all care groups has created additional pressure within the constraint of existing patient safety team capacity. Additional support has been secured to enable appropriate final approval of datix reports and ensure the overdue backlog doesn't shift to those datix reports requiring final approval.

On-going monitoring of the overdue datix situation (all area and care groups including ED) is being maintained by reporting to the Executive Serious Incident Review Group/Executive Team meeting and Clinical Governance Executive.

## Maternity Services

In November 2018 following an inspection by the Care Quality Commission our maternity services were rated as “inadequate” for the Safe Domain and “Requires Improvement” overall. Ensuring safe care for our mothers and babies is a key priority for the Trust.

Two Quality Priorities were included in the 2019/20 Quality Account.

| Priority Area | Why have we chosen this? | What are we aiming to achieve? | How will we measure if we have improved? | Current Status |
|---|---|---|---|---|
| **Maternity** | We need to prioritise and ensure safe care for our mothers and babies | **Priority 5:**<br>Saving Babies Lives Care Bundle Version 2 will continue to be implemented focusing on the five elements of care are widely recognised as evidence-based and/or best practice:<br>1. Reducing smoking in pregnancy:<br>2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)<br>3. Raising awareness of reduced fetal movement (RFM)<br>4. Effective fetal monitoring during labour<br>5. Reducing preterm birth | The second version of the care bundle includes a greater emphasis on continuous improvement with a reduced number of process and outcome measures. The implementation of each element will require a commitment to quality improvement with a focus on how processes and pathways can be developed and where improvements can be made<br>Specifically in relation to smoking we will:<br><br>Work to reduce the number of women who smoke during pregnancy who use the Trust maternity services to 11% or below in 2019/20 (as part of a plan to reduce this to 6% by 2022). | **Partially Achieved**<br><br>(reduction in smoking during pregnancy target set not achieved) |
| | To continue to deliver high quality care in line with the 5 year forward plan | **Priority 6:**<br>Our maternity unit to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information | To deliver improvements in line with the national recommendations and proposed time frames working with our local partners as part of the transformation | **Achieved** |

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| | | to enable her to make decisions about her care; and where she and her baby can access support that it is centred around their individual needs and circumstances | programme. This will be monitored through maternity oversight group | |

## Priority 5: Saving Babies Lives Care Bundle Version 2 will continue to be implemented focusing on the five elements of care are widely recognised as evidence-based and/or best practice:

In 2019/20 we aimed to prioritise and ensure safe care for our mothers and babies, specifically work to reduce the number of women who smoke during pregnancy who use the Trust maternity services to 11% or below in 2019/20 (as part of a plan to reduce this to 6% by 2022).

The revised care bundle has 5 elements and a gap analysis has been completed against each element and actions being developed including updating of relevant guidelines and identifying areas for staff training. Following the revised CNST incentive scheme submission funding was requested and granted for a 1.0WTE band 7 midwife to oversee the implementation of the bundle including assurance audits. In addition funding was approved for 0.4WTE fetal monitoring lead midwife post for 12 months.

The smoking rate at booking decreased in 2019/20 to 15.1% from 16.4% in 2018/19. The rate of smoking at birth also decreased from 16.5% in 2018/19 to 13.3% in 2019/20. As a result of the Covid-19 pandemic, carbon monoxide (CO) monitoring was ceased in all maternity units. Women have continue to be referred to smoking cessation services but this is based on their response to the question about smoking. As a result the smoking cessation rate may not be as accurate moving forward.

## Priority 6: Our maternity unit to become safer, more personalised, kinder, professional and more family friendly

Maternity services were inspected in September 2018 by the Care Quality Commission (CQC), following which they were rated as inadequate in the safe and well-led domain, the Trust was issues with a Section 31 notice. The Trust has submitted weekly reports to the CQC since last September 2018 pertaining to those issues outlined in the Section 31 notice on the following 5 elements:

- CTG Interpretation
- Assurance regarding escalation for medical review for Triage
- Management of reduced fetal movements

- Appropriate documentation and escalation of the Maternity Obstetric Early Warning Score

Maternity services were again inspected in April 2019 when the CQC findings concluded there had been some improvements in relation to the safety and governance of the services provided by the Trust; this report was published on December 2019. Improvements were found in relation to:

- Cardiotocography (CTG),
- Maternity Early Obstetric Warning System (MEOWS)
- Implementation of reduced fetal movement and triage

The Maternity Services latest inspection from the CQC took place in November 2019, following which they were rated as requires improvement in the safe and well-led domain. The service was issued with 8 must take actions and 4 should take actions. A detailed maternity improvement plan is in place which includes the CQC actions.

Key priorities for the service in 2020/21 include:

- Ongoing progress against the Maternity Improvement Plan
- Implementation of the Saving Babies lives care bundle
- Compliance with CNST Maternity Incentive Scheme
- Implementation of Maternity Transformation Programme

## Improving the Experience of Staff

The NHS Staff Survey is carried out annually across England to capture staff views of their experience at work and of NHS services. The results for the Trust in the 2018 staff survey which was published in February 2019, these were in the lowest quartile and showed a deteriorating picture which was of concern given the close correlation between staff between how staff feel and the quality of care delivered to patients.

| Priority Area | Why have we chosen this? | What are we aiming to achieve? | How will we measure if we have improved? | Current Status |
|---|---|---|---|---|
| **Staff Survey** | Our staff survey results were in the lowest quartile across the country<br><br>We know there is a strong link between how staff feel and the quality of care we deliver<br><br>Recruitment and staff shortages are an on-going challenge and we need to be able to retain our staff | **Priority 7**:<br>We will am to improve our staff survey response to the question 'care of patients is my organisation top priority' as a key staff survey measure | We will improve from a positive response rate of 62.3% to a minimum of 68% by next staff survey in 2019 with the aim to use this as a basis to be at national average or above by the 2020/21 staff survey | **Partially achieved**<br><br>(results improved from 2018 but did not meet set target) |

### Priority 7: We will am to improve our staff survey response to the question 'care of patients is my organisation top priority' as a key staff survey measure A priority area for improvement in 2019/20 in relation to the staff survey was to improve the positive responses in relation to the question "Care of patients is my organisation's top priority".

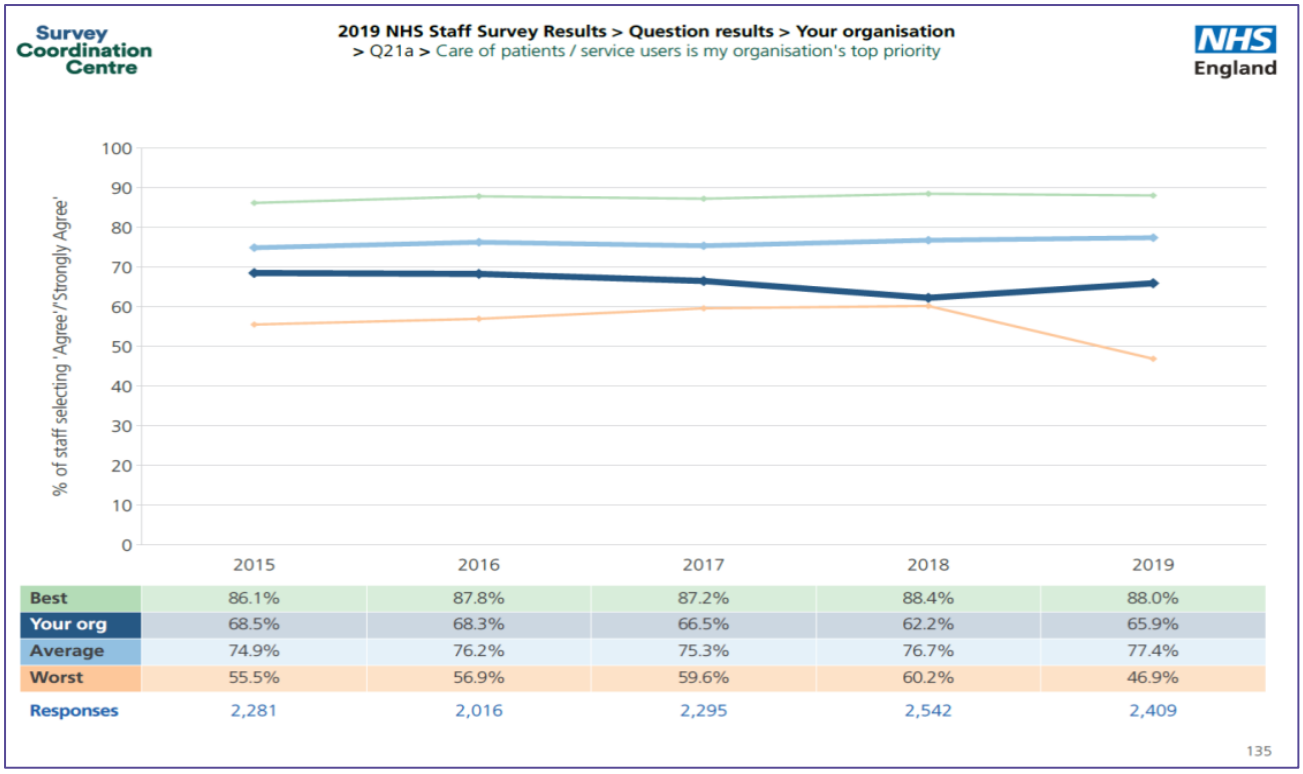
The most recent national staff survey was undertaken from September 2019 to December 2019; all staff employed by the Trust from the 1st September 2019 were eligible to take part. The results were published in February 2020.

The Trusts response rate for the 2019 staff survey was 41% which represented 2,450 completed surveys. This was a slight percentage decrease from the 2018 survey which saw a response rate of 45%, 2,580 responses; it is of note that although there is a 4% decrease in percentage, we saw only 130 fewer respondents. This is as a result of an increased Trust headcount per year. The 2019 staff survey results showed some local improvements in staff

experience, however we still flag below average nationally and therefore does not represent where we want to be as a Trust.

The previous results in relation to the question "*care of patients is my organisation's top priority*" had showed a decline year on year since 2015 when the Trust was overall rated as requires improvement by the CQC to the inadequate CQC rating in November 2018. In the 2019 survey the results for this question improved to 65.9% but did not meet the quality priority target set for the 2019 Staff Survey by the Trust of at least 68% and remained lower than the national average score of 77.4%.

## Care of Patients in my Organisations Top Priority




Three key areas for improvement following the staff survey results from the 2019 survey included:

- Safety Culture – Governance facilitator posts are now in place across all Care Groups and a weekly Executive Serious Incident Review Group has been implemented.
- Staff Engagement – A People Strategy is being developed by the HR Director
- Health and Wellbeing – The Health and Wellbeing policy is being revised in partnership with the Union, to provide a framework that is fair, consistent, transparent, supportive and effective, balancing the interests of the individual, patients and the service

The staff survey results showed that almost three quarters of staff, 70%, continued to feel enthusiastic about their job and improvements in relation to:

- recognition for good work
- working unpaid hours
- reporting physical violence
- having an appraisal

The People Plan being developed at the Trust has five main work streams, one of which is specifically targeted at nursing due to the number of vacancies across the system which could potentially double in the next 5 years. The nursing phase in particular will include the development of pathways to support the future growth of Registered Nurses such as the 2 year top up programme for Nursing Associates and the Registered Nurse Degree Apprenticeship pathway.

The plan also includes a focus on Health and Well-being of staff, a focus on leadership and inclusion, organisational development and a clear plan to attract and retain staff.. The Trust People Strategy aims to address our specific challenges and focusses particularly on resourcing our hospitals and leadership. Over the coming year workforce models will aim to be linked to system plans and there will be a continued focus on implementing retention initiatives across the organisation. There will be support offered to those clinical areas that need to make improvements to their patient safety culture work and plans developed to complete the NHSI culture assessment toolkit to help measure improvements.

Staff will be offered the opportunity to attend regular well-being clinics that are aimed to make a difference to people. There will be a launch of a Senior Leadership Programme and talent management initiatives

## Patient Access to Services

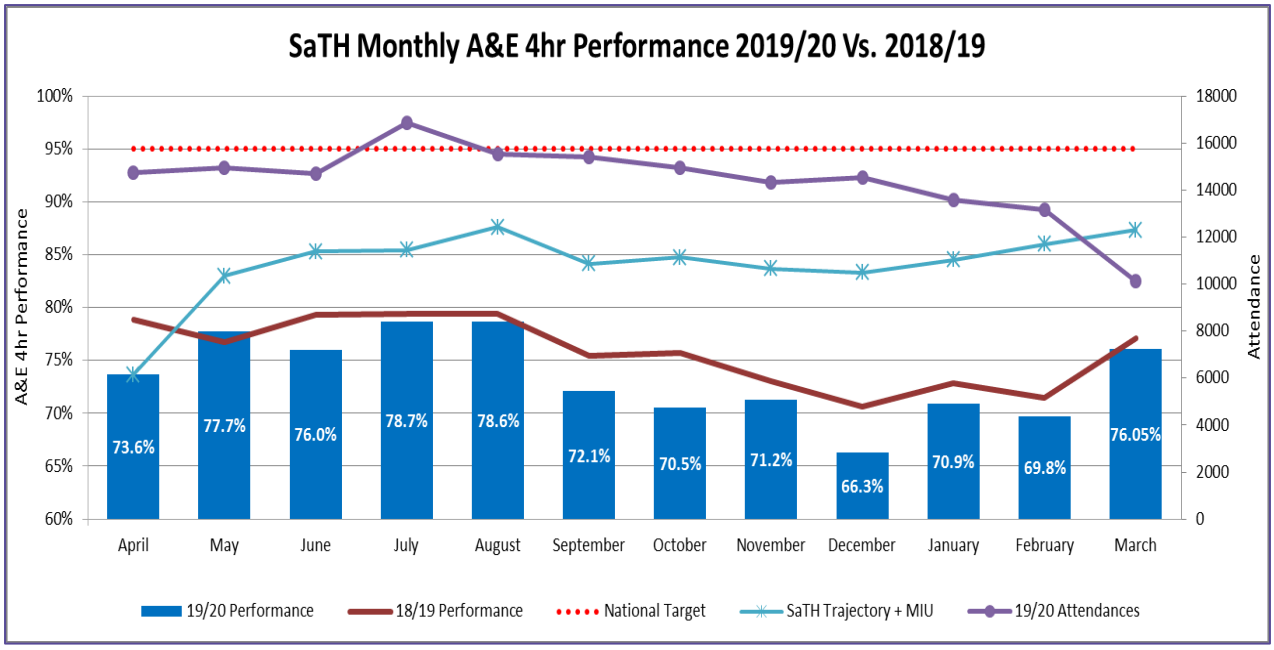
The quality improvement priorities set for patient access in 2019/20 related to improvements in the Trust achievement of the ED 4 hour target and a reduction in the number of ‘stranded’ patients. Achievement of these priorities has been impacted upon by the increase in activity in the Emergency Department, the bed gap across both sites and staffing.

| Priority Area | Why have we chosen this? | What are we aiming to achieve? | How will we measure if we have improved? | Current Status |
|---|---|---|---|---|
| **Patient Access** | Getting patients from the ED to the right bed when they need admitting remains a challenge<br><br>Patients forced to wait in the ED (particularly on corridors) have a poor experience which compromises their dignity and cause them distress<br><br>An overcrowded ED makes it more difficult for staff to provide safe care and causes staff significant stress | **Priority 8:** Linked to our operational plan we are aiming to ensure patients who are admitted via our ED who need admitting get into an appropriate bed as quickly as possible | A 10% improvement on the 4 hrs target to admit or discharge patients seen in the emergency department | **Not Achieved** |
| | | **Priority 9:** Creating the right capacity and 'flow' of emergency patients will reduce waits in our ED and allow staff to provide high quality and safe care. | Further reduction in 'stranded' patients (patients medically fit for discharge who are waiting to leave hospital): No more than 220 patients over 7 days during 2019/20 | **Achieved** |

## Priority 8: Linked to our operational plan we are aiming to ensure patients who are admitted via our ED who need admitting get into an appropriate bed as quickly as possible.

In 2019/2020 we aimed to achieve a 10% improvement on the 4 hrs target to admit or discharge patients seen in the emergency department. The improvement in relation to the Trust performance against the 4 hour target was not achieved in 2019/2020. Making improvements in relation to the 4 hour target during this 2019/20 has been significantly impacted by the increase in activity in the Emergency Department, the Trust bed gap and staffing.

Overall there was a 4.4% increase in ED attendances during 2019/20. In March 2020 there was a significant reduction in ED attendances attributed to the Covid19 pandemic.




A detailed demand and capacity bed modelling exercise has also indicated a significant acute beds gap (114 beds) during 2019/20 across the two hospital sites; this is impacting on patient flow out of the emergency department and has resulted in significant bed wait delays for patients. During these times additional temporary staffing has been provided to ensure patients are cared for as safely and in as dignified a way as possible, additional support has also been provided by the corporate nursing team. Additional bed capacity was in place from January through to March 2020 to improve the core bed stock by the equivalent of 61 beds. Alongside this, recruitment to the ED middle grade doctor's rotas will also see improvements later into 2020.

During 2020/21 the Clinical Teams will continue to work with the Emergency Care Intensive Support Team (ECIST) in relation to improvements in the Emergency Department and across the hospitals with the aim of improving the activity and flow through the Emergency Departments and adult inpatient wards to benefit the quality and safety of patient care.

The quality improvement priorities set for patient access in 2019/20 related to improvements in the Trust achievement of the ED 4 hour target and a reduction in the number of 'stranded' patients. Achievement of these priorities has been impacted upon by the increase in activity in the Emergency Department, the bed gap across both sites and staffing.

## Priority 9: Creating the right capacity and 'flow' of emergency patients will reduce waits in our ED and allow staff to provide high quality and safe care.

In order to achieve this priority in 2019/2020 we aimed to achieve a further reduction in 'stranded' patients (patients medically fit for discharge who are waiting to leave hospital), having no more than 220 patients over 7 days during 2019/20. There was a reduction in the

number of stranded patients in 2019/2020. This reduction in the stranded patient cohort meant savings on average of 46 beds per day compared to the 2017 baseline. There was on-going work which took place across the health economy with our system partners throughout 2019/2020 to reduce the stranded and super-stranded cohort of patients (length of stay over 21 days) and to maintain the stranded patient metric at 220 or less.

Despite an overall increase in Emergency admissions in 2019/2020, there was a reduction in the stranded patient. Due to the Covid pandemic, at the end of March there were 162 stranded patients across both sites.

## Infection Prevention and Control

Compliance in relation to Infection Prevention and Control (IPC) standards were rated as inadequate (red) at Shrewsbury and Telford NHS Trust by the Assistant Director of Infection Prevention and Control Advisor at NHS Improvement Midlands in June 2018.

| Priority Area | Why have we chosen this? | What are we aiming to achieve? | How will we measure if we have improved? | Current Status |
|---|---|---|---|---|
| **Infection Prevention and Control** | Our patients need to know they are being treated in an environment where the chance of acquiring an infection during their stay is as low as possible | **Priority 10**:<br>During 2018/19 our infection prevention and control processes were reviewed by NHS Improvement<br><br>We are currently rated as 'red' in terms of progress against the NHSI infection control action plan<br>To comply with all areas highlighted as part of the NHSI assessment | We will be rated as 'green' (fully compliant) against the NHSI action plan by quarter three in 2019/20 | **Achieved** |

## Priority 10: To comply with all areas highlighted as part of the NHS Improvement IPC Assessment

Following the inspection in June 2018 an action plan was developed by the Director of Infection Prevention and Control and the Infection Prevention and Control Team who have worked in collaboration with the Care Groups in implementing and embedding changes in IPC practices in all clinical areas across the Trust.

The action plan was regularly reviewed and monitored at the Infection Prevention and Control Committee and Care Group meetings. Alongside this there were individual actions plans developed for those clinical areas visited as part of the NHSI inspections to address non-compliance; these were monitored through confirm and challenge meetings. The Infection Prevention and Control Team also reviewed IPC processes which led to the development of standardised cleaning checklists and additional training. The IPC team members were also aligned to individual ward areas to facilitate better teamwork and support and undertook regular Quality walks in the clinical areas. The follow up visit by NHSI in November 2018 rated the Trust as 'amber'. A subsequent re-inspection in June 2019 again rated the Trust as 'red'.

The most recent visit undertaken by NHSI in November 2019 rated the Trust as 'green'. On-going work has continued across the Care Groups supported by the IPC team to ensure all issues identified from the most recent visit are addressed and that IPC standards are maintained particularly on relation to hand hygiene and bare-below the elbow.

## 2.2 Statement of Assurance from the Board

All NHS trusts are required in accordance with the statutory regulations to provide prescribed information in their Quality Account. This enables the Trust to inform the reader about the quality of their care and services during 2019/20 according to the national requirements. The data used in this section of the report has been gathered within the Trust from many different sources or provided to us from the Health and Social Care Information Centre (HSCIC). The information, format and presentation of the information in this part of the Quality Account is as prescribed in the National Health Service (Quality Accounts) Regulations 2010 and Amendment Regulations 2012 / 2017.

### Relevant Health Services and Income

During 2019/20 Shrewsbury and Telford Hospitals NHS Trust provided a wide spectrum of acute services to NHS patients through our contracts with Clinical Commissioning Groups, NHS England and other commissioning organisations to the value of £384,954. Service delivery was underpinned by the regular monitoring of metrics reflecting patient safety, clinical effectiveness and patient experience.

In 2019/2020 the Shrewsbury and Telford Hospital NHS Trust provided or subcontracted NHS services which included:

- 55,412 of elective and daycases
- 64,944 of non-elective cases
- 128,194 emergency attendances
- 420,145 outpatients attendances

The Shrewsbury and Telford Hospitals NHS Trust reviews the data available on the quality of care in these NHS Services.

## Examples of how we reviewed services in 2019/2020

A variety of performance and quality information is considered when reviewing our services. Some examples include:

- Quality Governance Report presented at Quality and Safety Assurance Committee
- Integrated Performance Report presented at Trust Board
- Monthly Performance Review Meetings chaired by the Chief Executive
- Participation in clinical audit programmes
- Complaints, safety and patient experience
- Review of risk registers
- Outcomes from Commissioner Quality Visits
- Results from Peer reviews and other external accreditation
- Outcome data including mortality is reviewed at Mortality Committee
- Annual reports from services

## Statement from the Care Quality Commission (CQC) and Our CQC Improvement Plan

The Shrewsbury and Telford Hospital NHS Trust is registered with the CQC. The Trust was inspected by the Care Quality Commission from the 12th November to the 10th January 2019. The core services inspected included:

- Urgent and Emergency Services
- Medical Care (including care of older people
- End of Life Care
- Surgery
- Outpatients
- Maternity Services
- Services for Children and Young People

The subsequent report was published on the 8th April 2020. Overall the ratings for the Trust remained the same since the previous inspection with the Trust rated as “inadequate” overall. Improvements were reported in relation to maternity services which improved in both the Safe and Effective Domains.

## Rating for acute services/acute trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Royal Shrewsbury Hospital | Requires improvement ↑ Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement ↓ Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement ↑ Apr 2020 | Requires improvement ↑ Apr 2020 |
| Princess Royal Hospital | Inadequate →← Apr 2020 | Inadequate ↓ Apr 2020 | Requires improvement ↓ Apr 2020 | Inadequate ↓ Apr 2020 | Inadequate →← Apr 2020 | Inadequate →← Apr 2020 |
| **Overall trust** | Inadequate →← Apr 2020 | Inadequate ↓ Apr 2020 | Requires improvement ↓ Apr 2020 | Inadequate ↓ Apr 2020 | Inadequate →← Apr 2020 | Inadequate →← Apr 2020 |

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Royal Shrewsbury Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate →← Apr 2020 | Inadequate ↓ Apr 2020 | Requires improvement ↓ Apr 2020 | Inadequate ↓ Apr 2020 | Inadequate →← Apr 2020 | Inadequate →← Apr 2020 |
| Medical care (including older people's care) | Requires improvement →← Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement ↓ Apr 2020 | Requires improvement ↓ Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement →← Apr 2020 |
| Surgery | Requires improvement →← Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement ↓ Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement →← Apr 2020 |
| Critical care | Requires improvement Nov 2018 | Requires improvement Nov 2018 | Good Nov 2018 | Requires improvement Nov 2018 | Requires improvement Nov 2018 | Requires improvement Nov 2018 |
| End of life care | Requires improvement →← Apr 2020 | Requires improvement →← Apr 2020 | Good →← Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement ↑ Apr 2020 | Requires improvement →← Apr 2020 |
| Outpatients | Requires improvement Apr 2020 | Not rated | Good Apr 2020 | Requires improvement Apr 2020 | Good Apr 2020 | Requires improvement Apr 2020 |
| **Overall*** | Requires improvement ↑ Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement ↓ Apr 2020 | Requires improvement →← Apr 2020 | Requires improvement ↑ Apr 2020 | Requires improvement ↑ Apr 2020 |

**Ratings for Princess Royal Hospital.**

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | Inadequate ↔ Apr 2020 | Inadequate ↓ Apr 2020 | Requires improvement ↓ Apr 2020 | Inadequate ↓ Apr 2020 | Inadequate ↔ Apr 2020 | Inadequate ↔ Apr 2020 |
| Medical care (including older people's care) | Inadequate ↓ Apr 2020 | Inadequate ↓ Apr 2020 | Requires improvement ↔ Apr 2020 | Requires improvement ↔ Apr 2020 | Inadequate ↓ Apr 2020 | Inadequate ↓ Apr 2020 |
| Surgery | Requires improvement ↔ Apr 2020 | Requires improvement ↔ Apr 2020 | Good ↔ Apr 2020 | Requires improvement ↔ Apr 2020 | Requires improvement ↔ Apr 2020 | Requires improvement ↔ Apr 2020 |
| Critical care | Requires improvement Nov 2018 | Requires improvement Nov 2018 | Good Nov 2018 | Requires improvement Nov 2018 | Requires improvement Nov 2018 | Requires improvement Nov 2018 |
| Maternity | Requires improvement ↑ Apr 2020 | Good ↑ Apr 2020 | Good ↔ Apr 2020 | Good ↔ Apr 2020 | Requires improvement ↔ Apr | Requires improvement ↔ Apr |
| Services for children and young people | Requires improvement ↓ Apr 2020 | Requires improvement ↓ Apr 2020 | Requires improvement ↓ Apr 2020 | Inadequate ↓↓ Apr 2020 | Requires improvement ↓ Apr 2020 | Requires improvement ↓ Apr 2020 |
| End of life care | Requires improvement ↔ Apr 2020 | Requires improvement ↔ Apr 2020 | Requires improvement ↓ Apr 2020 | Requires improvement ↔ Apr 2020 | Requires improvement ↑ Apr 2020 | Requires improvement ↔ Apr 2020 |
| Outpatients | Good Apr 2020 | Not rated | Good Apr 2020 | Good Apr 2020 | Good Apr 2020 | Good Apr 2020 |
| **Overall*** | Inadequate ↔ Apr 2020 | Inadequate ↓ Apr 2020 | Requires improvement ↓ Apr 2020 | Inadequate ↓ Apr 2020 | Inadequate ↔ Apr 2020 | Inadequate ↔ Apr 2020 |

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

The Trust is rated as "requires improvement" in relation to the use of resources**.**

The Trust currently has conditions in place in relation to its registration. The CQC previously took enforcement action against the Trust in 2018-19. Following the CQC inspection in November 2019, some of the existing conditions were varied and some new conditions were included:

| Regulated Activity | Reason | Area |
|---|---|---|
| **Regulation 31 Section 31 of the Health and Social Care Act 2008 Treatment of disease and injury** | Sepsis and Deterioration<br>Paediatric pathway in the ED including triage within 15 minutes, left without seen and follow up<br>Mental health risk assessment<br>All Adults assessed within 15 minutes<br>Environment safe for intended purposed<br>Effective environmental risk assessment and management across ED | Emergency Departments (including existing from 2018, varied, and new conditions in 2019) |

| | | |
|---|---|---|
| | Effective systems in place to account for patient acuity and location of patient in ED<br>Effective monitoring of patient pathways through the Department<br>Suitably qualified and competent staff to carry out their roles | |
| | Deteriorating Patient and Sepsis | Trust-wide (varied conditions) |
| | Management of de-escalation and intervention holds | Trust-wide (new conditions) |
| | Medical Review for women regarding: CTG, MEOWS, reduced fetal movement, triage and delivery ward handover/board rounds | Maternity (existing conditions since 2018) |
| **Regulation 17 and 18 Section 29 (issued 2018)**<br><br>**Tissue viability, Nutrition and Hydration assessment and risk assessments**<br><br>**Staffing level is in ED, Critical Care and EOLC and training requirements** | Risk assessments not being Documented<br><br>Staffing levels not meeting national requirements | Ward 10 and 15 at Princess Royal Hospital<br><br>ED , Critical Care and End of Life Care Team |

## Our CQC Improvement Plan

A comprehensive CQC Improvement Plan was developed following the CQC inspection in November 2019. The plan includes all actions relating to the “Must Do” and “Should Do” actions identified by the CQC, actions in relation to the Section 29a and the Section 31 areas for improvement. This is shown and indicates the summary of actions by overarching theme and initial progress following its development at the end of April

| Summary of Themes | Total Actions | Embedded | Complete | In Progress | Off Track | Percentage Complete |
|---|---|---|---|---|---|---|
| Governance | 51 | 1 | 7 | 42 | - | 14% |
| Staffing | 51 | 1 | 3 | 47 | - | 6% |
| Embedding Policies | 22 | - | - | 22 | - | 0% |
| Safeguarding | 28 | 1 | 2 | 25 | - | 7% |
| MCA/DOLS | 8 | - | 1 | 7 | - | 13% |
| Paediatrics | 13 | - | - | 13 | - | 0% |
| Safe Environment | 8 | - | 2 | 6 | - | 25% |
| Deteriorating Patients | 27 | 2 | 6 | 19 | - | 22% |
| Streaming / Triage | 20 | - | 8 | 12 | - | 40% |
| Sepsis | 13 | 1 | 4 | 8 | - | 31% |
| Falls | 11 | - | 3 | 8 | - | 27% |
| Restraint | 3 | - | 1 | 2 | - | 33% |
| IPC | 8 | - | 2 | 6 | - | 25% |
| Person Centred Care | 13 | - | 1 | 10 | - | 8% |
| Medicines | 10 | - | - | 10 | - | 0% |
| System | 3 | - | 1 | 2 | - | 33% |
| Incident Mgt | 11 | - | - | 11 | - | 0% |
| Environment | 21 | - | - | 21 | - | 0% |
| End of Life | 8 | - | - | 7 | - | 0% |
| Mandatory Training | 10 | - | - | 10 | - | 0% |
| Information | 16 | - | - | 16 | - | 0% |
| Privacy and Dignity | 15 | - | - | 15 | - | 0% |
| Leadership | 12 | - | - | 12 | - | 0% |
| Patient Engagement | 8 | - | - | 8 | - | 0% |
| Complaints | 6 | - | - | 6 | - | 0% |
| Vision & Strategy | 3 | - | - | 3 | - | 0% |
| Operations Management | 6 | - | - | 6 | - | 0% |
| **Total** | **405** | **6** | **41** | **354** | **-** | **10%** |

The CQC Improvement plan was agreed by Trust Board in May 2020. Weekly Confirm and Challenge sessions have been set up with the Care Groups, chaired by the Chief Nurse who is supported by the CQC Improvement Lead. These weekly sessions aim to monitor and provide assurance in relation to the completion of actions and support the Care Groups to deliver the improvements required.

A weekly update on progress in relation to the CQC Improvement Plan is provided by the Chief Nurse at the Executive Team Meeting. A monthly report on progress is provided to the Quality and Safety Assurance Committee and Trust Board

## Participation in clinical audits and confidential enquiries

During 2019/20 72 national clinical audits and 7 national confidential enquiries covered relevant health services that the Shrewsbury and Telford Hospitals NHS Trust provides. During that period the Shrewsbury and Telford Hospitals NHS Trust participated in 89% national clinical audits and 71% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The Trust also undertook 119 local audits

The national clinical audits and national confidential enquiries which the Shrewsbury and Telford Hospitals NHS Trust contributed to in 2019/2020 and the local audits undertaken in 2019/20 are outlined:

| TABLE 5 | | |
|---|---|---|
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| **CLINICAL SUPPORT - PATHOLOGY & RADIOLOGY AND THERAPIES** | | |
| **1** | Cervical spine imaging for trauma 2019 (4320) | • There has been an overall reduction in the number of patients imaged, suggesting that the application of clear guidelines has been of benefit<br>• A further re-audit is planned |
| **2** | Ultrasound guided fine needle aspiration (FNA) of thyroid nodules (4324) | • Audit demonstrates reporting within national targets |
| **3** | Audit of thyroid u-scoring and subsequent fine needle aspiration cytology (4325) Thyroid U scoring and subsequent fine needle aspiration cytology - re-audit (4389) | • Laminated 'u guidelines' and educational posters have been put on display in every ultrasound room<br>• Teaching sessions have taken place for staff on 'U score'<br>• Re-audit has shown a significant reduction in number of thyroid nodules not 'u-scored' following implementation of above actions |
| **4** | Numbers of Reports created During Weekend Working Sessions (4326) | • Circulate to ensure those consultants not attending Audit meeting are aware of the results<br>• A re-audit is planned |
| **6** | An evaluation of the RSH MRI/Ultrasound fusion guided biopsy service for the detection of prostate cancer (4390) | • The Trusts detection rate is better than the quoted literature<br>• Radiologists have increased fusion marking. |
| **CORPORATE – TRUST WIDE** | | |
| **7** | Analysis of the quality of recent discharge summaries from the Trust 2018 (4136) | • The FY1 and FY2 doctors have received an update on the learning points raised by audit<br>• Further junior doctor training has also been undertaken throughout the 2019/20 education programme. |
| **8** | Carer's Survey – Learning disabilities (Jan -Oct 2018) (4254 & 4258) | • 90% of carers felt that the patient passport is useful to staff.<br>• The audit showed an improvement in the proportion of carers who felt that they opportunities to discuss difficulties concerning the person they care for with staff. |

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| | | • Information was re-circulated to GP Practices, Carers Trust 4 all and the Carers Centre to raise awareness with carers and relatives in their newsletters of the benefit of taking the patient passport to hospital when the patient is admitted<br>• Learning disabilities is now included in the Trust Induction programme with dementia. |
| **9** | End of life care plan Jun-19 (4262) | • On-going support is provided for patients who are EOL |
| **10** | DCT and AND Audit - January 2019 (4277) | • The ReSPECT process has now been implemented in alignment with local healthcare economy<br>• Discussion of DCT & AND with the patient and the family was well documented, with discussions taking place in over **75**% of cases<br>• Evidence as part of the appraisal process |
| **11** | Mouth care audit 2019 (4314) | • Taste for pleasure was well supported on the wards<br>• The use of mouth eZe guidelines has been formulated.<br>• Further publicity to raise awareness will continue in-house and on the intranet |
| **12** | Defined Ceiling of Treatment (DCT) and Allow Natural Death (AND) Audit - July 2019 (4318) | • Discussion of DCT & AND with the patient and the family was well documented<br>• A re-audit has been carried out following the introduction of the ReSPECT process |
| **13** | The Deteriorating Patient (Jul to Dec 2018) (4344) | • Key personnel will be identified to lead the deteriorating patient process<br>• The Trust have appointed a Sepsis lead nurse |
| **14** | Mental Capacity Act (MCA)/Deprivation of Liberty (DOLs) & Adult Safeguarding Audit 2019 (4387) | • Level 3 Adult safeguarding training will commence in during 2020<br>• A hospital-wide review of documentation has started to ensure consistent and standardized documentation. |
| **SCHEDULED - ANAESTHETICS, THEATRES & CRITICAL CARE** | | |
| **15** | Anaesthetic Casenote Audit 2018 (PRH) (4237) | • A column will be inserted in anaesthetic chart so that documentation of blood loss can be recorded<br>• A re-audit is planned |
| **16** | Obstetric theatre cases re-audit 2018 (4281) | • The audit showed improvement in documentation however, further education will be provided to improve Medway documentation. |
| **17** | Epidural Cases 2018 (4282) | • Good patient satisfaction was recorded. |

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| | | • A re-audit is planned |
| **18** | Labour ward anaesthetic cover 2020 (re-audit) (4482) | • Recruitment of obstetric anaesthetist has commenced. |
| **SCHEDULED - HEAD, NECK AND OPHTHALMOLOGY** | | |
| **19** | Patient satisfaction survey – DESP (3600) | • The audit highlighted there were no major causes for concern or improvement<br>• Weekend clinics have now been implemented, and evening appointments are being discussed. |
| **20** | Macular oedema (retinal vein occlusion) – ranibizumab TAG283 + Macular oedema (central retinal vein occlusion) - aflibercept solution for injection - TAG305 (4150) | • One stop injection clinics are working well preventing delays.<br>• More doctors have been recruited. |
| **21** | Choroidal neovascularisation (pathological myopia) - ranibizumab - TAG298 (4156) | • Patients on both Lucentis and Eyelea show improvement in BCVA following treatment with both anti VEGF agents. |
| **22** | Endoscopic stapling of pharyngeal pouch – IPG22 - re-audit (4161) | • The audit highlighted good compliance with NICE guidance.<br>• Information leaflets have been produced |
| **23** | VTE Compliance (4186) | • The audit provided reassurance that VTE compliance is higher than recorded figure |
| **24** | Head and Neck Oncology audit (Nov-18) (4192) | • The audit demonstrated good outcomes and successful team / protocols. |
| **25** | Day case adenotonsillectomy for children with obstructive sleep apnoea (4217) | • The audit highlighted that day-case tonsillectomy for children with obstructive sleep apnoea is safe<br>• Day-case rates have improved with the introduction of the new criteria |
| **26** | ENT Casenote Audit 2019 (4244) | • A new ward round proforma sheet has been designed and implemented to improve documentation further. |
| **27** | BCC & SCC removal & surgical margin assessment (4379) | • The audit confirmed good practice so continue annual audit to monitor patterns. |
| **28** | Dental assessment & treatment prior to radical radiotherapy for H&N cancer (4411) | • The audit identified timely assessment of these patients. |
| **29** | Frequency of visual fields in chronic open angle glaucoma (4460) | • To raise awareness to physicians treating glaucoma patients, regarding national guidelines of visual field intervals a poster has been put on display in all clinic rooms where glaucoma patients are examined. |
| **SCHEDULED - SURGERY, ONCOLOGY & HAEMATOLOGY** | | |

| | | |
|---|---|---|
| **30** | Non conformities from 1st April – 31st July 2019 198 (4493) | • Public Health England Safer Radiotherapy analyses have produced targets going forward for all centres to meet.<br>• A re-audit is planned to access these targets |
| **31** | Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas – NICE CG118 (3756) | • A re-audit is planned |
| **32** | Consent - Surgery 2017 (3786) | • A 10 point plan has been introduced for reducing unplanned extubation |
| **33** | Stoma Patient Satisfaction Audit (3931) | • Overall positive feedback was received.<br>• A stoma discharge booklet is in the process of being updated and will be available for patients this year. |
| **34** | Management of patients with head injury - NICE CG176 (4058) | • To improve standards, the Head injury policy has been re-written<br>• An online referral / advice form to neurosurgeons is now available |
| **35** | Hospital Palliative Care Team - patient survey 2018 (4078) | • All positive feedback, no areas for development identified<br>• A re-audit has commenced |
| **36** | Neoadjuvant chemotherapy, a local experience (4092) | • The audit shows a good, effective, safe service |
| **37** | Reconstruction rate following mastectomy for DCIS 5year audit 2012- 2017 (4212) | • No issues identified with reconstruction rate after audit. |
| **38** | Minimising interruptions in theatre (never event action - CQC) (4214) | • Posters have been put up on all entry doors to the operating rooms as a visual cue to remind staff the importance of not interrupting and that they should speak to the theatre coordinator.<br>• Following sharing of the audit results, endoscopy have also displayed the posters. |
| **39** | Disease free survival & BMI in breast cancer patients (4218) | • Further studies are needed to clarify aspects of the audit outcome and whether methods of reducing BMI may improve disease free survival. |
| **40** | Dosimetry equipment – 160 (4269) | • An overhaul of commissioning procedures and documentation is in progress |
| **41** | Endoscopy Unit Patient Satisfaction Questionnaire (13) - re-audit (4254) | • The survey showed that 90% of carers felt the patient passport is useful to staff.<br>• Plastic bedside holders have been introduced to increase visibility of the Patient Passport. |

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| **42** | Endoscopy Unit Patient Satisfaction Questionnaire (13) - re-audit (4259) | • Good feedback on the whole. Patients found their procedure acceptable and would have it again if required. Privacy and dignity was maintained.<br>• Patient information leaflets have been updated and ratified by patient panel and have more of an emphasis on waiting times.<br>• Staff have been reminded to keep patients informed if there are delays |
| **43** | Patient information: are we getting it right? (re-audit) (4260) | • The audit showed a vast improvement in actually providing patient information leaflets across all domains of surgery. |
| **44** | Document & data control – 156 (4265) | • The distribution list and master reference list requires checking – to ensure physics requirements are covered. |
| **45** | IMRT and VMAT QA – 157 (4266) | • The system is generally working well and being followed correctly for most patients. |
| **46** | Linac Maintenance – 158 (4267) | • New maintenance schedule paperwork has been developed, up-dated and implemented. Document template is electronic but paper version is more practical and saved in linac maintenance folder. |
| **47** | Timeliness of Plans – 159 (4268) | • The prostate pathway is currently under review to identify stages that cause delays. |
| **48** | Review of % single fraction treatments – 162 (4271) | • A review data collection has taken place to ensure correct info is collected at correct point. |
| **49** | Management Review – 163 (4272) | • The audit showed an improvement throughout the year of the content and flow of the management minutes as the agendas have been reviewed and tightened and the actions from each meeting are clearer. |
| **50** | IPEM Radiotherapy CT scans – 164 (4273) | • 4DCT documentation has been updated to reflect new process. This will reduce dose. |
| **51** | Tinzaparin prescribing on discharge in vascular patients (4283) | • Recommendations from previous audits had a clear effect resulting in 100% of patients being prescribed Tinzaparin on discharge as they should. |
| **52** | Patient information audit – 165 (4308) | • A follow up audit will take place looking at Gynae/colorectal and palliative patients, to see if situation has changed. |
| **53** | Breast IGRT and CBCT usage Audit Official – 166 (4309) | • The current process is working well |
| **54** | IMC audit March 2019 – 167 (4310) | • The Technique was introduced successfully<br>• A re-audit has commenced |

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| **55** | Urology single slice audit form – 168 (4311) | • The QA document has been changed to new single slices as there has been an improvement from previous practice |
| **56** | IMC patients – 169 (4312) | • The audit has proved that the need for single slices is now unnecessary as the extra radiation dose is providing no benefit to the patient. |
| **57** | Planning work flow – 170 (4313) | • A review of the pathways for each patient is underway. |
| **58** | Brachy audit 2018 - 2019 – 171 (4391) | • All patients received treatment within the target.<br>• A re-audit is planned |
| **59** | Retrospective review of last 12 radical cervix patients – 172 (4392) | • To ensure accuracy of data, the audit will be repeated to obtain additional patient data. |
| **60** | Scan Limit Audit – 173 (4393) | • No problems with scan limits uncovered |
| **61** | Non cons received by QA radiographer – 174 (4394) | • We compared well against the national data within this period<br>• A re-audit has been undertaken |
| **62** | Non cons received by QA radiographer (dec18 - mar19) – 175 (4395) | • The audit indicates a strong reporting culture.<br>• A re-audit is planned |
| **63** | MV Electrons Linac Optics – 176 (4396) | • It was felt that additional time was required for qc on LA1 electrons, this was requested and has been implemented. |
| **64** | E-referral Audit – 177 (4397) | • All referrals were acceptable against requirements |
| **65** | Physics Training Records audit June 2019 – 178 (4398) | • Consideration is being given to move to an electronic system in future. |
| **66** | Timeliness of Plans (3 month period) – 179 (4399) | • A review of the current plan is underway |
| **67** | Compliance to the head and neck imaging protocol for IMRT/VMAT 30 fractions or more – 180 (4400) | • Improvement in practice identified |
| **68** | Non DIBH Audit table – 181 (4401) | • Review breast imaging using this information to attempt to streamline the protocol |
| **69** | Breast MV KV Aug 19 ES – 182 (4402) | • A review of the breast imaging protocol in light of audit 181/182 is underway to streamline the process |
| **70** | Patients with MSCC treated with radiotherapy Aug17 and Jan18 – 183 (4403) | • No concerns identified |

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|---|---|---|
| **71** | Gynae colorectal single slice audit – 184 (4404) | • The protocol is working well, no recommendations necessary |
| **72** | 6 Degrees of Freedom couch (6DOF) – 185 (4443) | • A review of the current protocol is in-progress |
| **73** | Consent checked prior to first radiotherapy treatment – 186 (4444) | • The audit showed full compliance. |
| **74** | Pregnancy status check prior to any exposure to ionising radiation – 187 (4445) | • The audit showed full compliance. |
| **75** | Imaging protocol compliance - Q.A.P 7.3.5.1RP (4.1-IGRT) – 188 (4446) | • A reminder was sent to staff regarding the importance of completing review/approved buttons in offline review. |
| **76** | Handover logbook QAP 3.6-TRT – 189 (4447) | • A re-audit has commenced |
| **77** | Compliance with QAP 7.6.2 – Technical Test Equipment – 190 (4448) | • No concerns identified |
| **78** | Review of Concessions – 191 (4449) | • No concerns identified |
| **79** | Systematic Error – 192 (4450) | • Overall there has been an improvement since the last audit.<br>• A reminder was sent to staff regarding the need for patient orientation to be considered more when completing SE calculations. |
| **80** | Laterality checks 3rd weekly – 193 (4451) | • A re-audit is planned |
| **81** | Archeck measurement – 194 (4452) | • An adjustment to the LA1_TB DLG to reduce dose delivered has been completed. |
| **82** | Daily spotlight CBCT's for Gynae and Anal Cancer patients – 195 (4453) | • A larger audit is required to make more conclusive recommendations. |
| **83** | CBCT consistency – 196 (4454) | • To improve documentation, training is currently being formulated and will be rolled out later in the year |
| **84** | Patient Identification – 197 (4455) | • Some areas of the QAP have been updating to reflect changes in practice<br>• A re-audit is planned |
| **85** | 90 day readmission after prostatectomy (4483) | • Following measures introduced in the previous, the re-audit has showed that readmissions have improved. |
| **86** | Patient Feedback – 199 (4494) | • No concerns identified |

| | | |
|---|---|---|
| **SCHEDULED - MSK** | | |
| **87** | Orthopaedic operation notes (4220) | • The proforma needs redesigning to capture important information, this is currently under review. |
| **88** | Fracture clinic optimisation (4417) | • The audit provided foundation for VFC pilots |
| **89** | NHSLA Case note Orthopaedic RSH 2018 (4118) | • The department has written to the Medical Director to highlight concerns. |
| **90** | Venous thromboembolism assessment in the orthopaedic department at PRH (4367) | • A re-audit has been undertaken |
| **91** | Venous thromboembolism assessment in the orthopaedic department at PRH re-audit (4406) | • No concerns identified |
| **92** | NOF pathway documentation (4418) | • The audit highlighted to importance of documentation within the NOF pathway and also the need to remove some sections that are not required. |
| **UNSCHEDULED – EMERGENCY ASSESSMENT & MEDICINE** | | |
| **93** | Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS-TBNA) for mediastinal masses - IPG254 (3871) | • The audit identified waiting times were too long. A business case submitted to Lingen-Davies, who have agreed to fund equipment. The aim is to have 2nd list running by the end of 2020. |
| **94** | Cardiovascular risk assessment as part of MDT foot clinic (3986) | • To comply with the guidance, HCAs will now take the new patients' BP.<br>• To ensure all the relevant data is collected, the proforma has been redesigned. |
| **95** | IPC sleeves (4082) | • Learning points from the audit were disseminated to staff and reinforced via email.<br>• A re-audit has commenced |
| **96** | Pneumothorax management (4101) | • The audit highlighted some issues with coding. A discussion with coding manager has taken place to help identify the right primary diagnosis and refine the issue. |
| **97** | Pneumonia in adults: diagnosis and management - CG191 (4147) | • A patient information leaflet has been designed and will be made available shortly.<br>• A re-audit is planned |
| **98** | Hyperglycaemia in Acute Coronary Syndrome (4206) | • A larger audit is required to enable the current guidelines to be updated |

| | | |
|---|---|---|
| **99** | Warfarin prescription during evening shift (4234) | • After the board round, the team will then discuss warfarin prescription. |
| **100** | Should we be checking Vitamin D levels? (4275) | • To ensure routine Vit D levels in are checked, the epilepsy clinic proforma now includes bone health guidance in identified patients |
| **101** | Reviewing and documentation of ECGs on daily ward rounds (4287) | • Creating awareness and providing knowledge about ECG checks and documentation led to a substantial increase in the number of both. |
| **102** | Lumbar Punctures RSH (4329) | • The audit results provided evidence that documentation quality varies greatly so, a lumbar puncture proforma has been designed and published on neurology website. |
| **103** | National Lung Cancer Audit 2019 (following external review) (4343) | • A direct to CT pathway has been designed and approved in principle by CCG cancer lead<br>• Patient information leaflet designed, approved and awaiting distribution to GP practices and radiology departments<br>• Diagnostic test bundles designed, approved via USC governance and implemented<br>• The Lung CNS team has been expanded<br>• A regular forum for lung cancer MDT to discuss difficult cases, clinical updates and governance concerns is in progress<br>• The Medical Director has agreed to act as executive sponsor for the lung cancer value stream |
| **WOMEN & CHILDREN'S** | | |
| **104** | Feverish illness in children under 5 years - QS64 (3841) | • The importance of documentation has been reiterated at doctor's induction. |
| **105** | Depth of excision with LLETZ cervical treatment (4077) | • The audit showed full compliance with the standards. |
| **106** | Case note Paediatrics 2017 & 2018 (4085) | • The importance of documentation has been reiterated at doctor's induction. |
| **107** | Gynaecology Case note audit 2018 (4113) | • College tutors have been emailed to remind them to continue to put documentation on junior doctors induction programme |
| **108** | Miscarriage diagnosis and management - QS69 (4149) | • New updated NICE guideline has been published and being transcribed into local guidance |
| **109** | Intravesicle botox administration (4153) | • Incorporating follow up by telephone calls into specialist nurse job planning is under way |
| **110** | Neonatal 2 year Follow Up Outcomes (4171) | • Overall results of the audit do not show areas of major concern. |

| | | |
|---|---|---|
| | | • Neonatal consultants to contact Community Paediatricians/Health Visitors for feedback on 2 year developmental assessments |
| **111** | Speech and Language Delay on Bayley Assessment and Outcomes (4208) | • SLT referral at the same time as community paediatric referral has been implemented. |
| **112** | Paediatric Pneumonia Audit (4228) | • The majority of guidelines are being followed. An email was sent to the paediatric team reminding them to follow current guidelines. |
| **113** | Parent Communication Sheet (4303) | • The parent's communication log has been altered to include a signature box, updated from names to "Who present" and add separate box for documentation of breast milk discussion. |
| **114** | Neonatal resuscitation documentation audit (4306) | • The majority of resuscitaires had all the appropriate documentation,<br>• To ensure NLS algorithm can be easily accessed, these have been laminated and displayed in the all relevant areas. |
| **115** | Documentation of breastfeeding discussion (4307) | • Addition of a breastfeeding documentation box has been added to the parent's communication sheet. |
| **116** | Child Protection Medical Report & Timeliness audit (4331) | • Learning points of the audit have been reinforced at induction and peer review meeting. |
| **117** | Surgical Management of Tubal Pregnancy 2019 (re-audit) (4332) | • To minimize delays to treatment, weekly meetings have been arranged for Monday pm or Tuesday morning. |
| **118** | Cystic Fibrosis, Paediatric, Service User Audit (4342) | • Adequate sharps bin provisions are now in place for home IV courses.<br>• Catering have provided a snack and meal list which gives additional off menu options to our Cystic Fibrosis patients and these can be ordered at ward level. |
| **119** | Colposcopy patient satisfaction survey 2019 (4353) | • Overall the results were excellent.<br>• A re-audit is planned |

| **Title: National clinical audits and national confidential enquiries** | | **Eligible** | **Participating** | **Submission rate (%) / Comment** |
|---|---|---|---|---|
| National Clinical Audit of Anxiety and Depression (NCAAD) | *Core audit | × | × | Not applicable |
| | *Psychological Therapies Spotlight | × | × | Not applicable |

| Title: National clinical audits and national confidential enquiries | | Eligible | Participating | Submission rate (%) / Comment |
|---|---|---|---|---|
| British Association of Dermatologists (BAD) | Hidradenitis suppurativa | ✓ | ✓ | Currently in progress |
| | Skin surgery | ✓ | ✓ | Currently in progress |
| British Association of Urological Surgeons | *Cystectomy | ✓ | ✓ | 73% |
| | *Nephrectomy audit | ✓ | ✓ | 86% |
| | *Percutaneous Nephrolithotomy (PCNL) | ✓ | × | Not applicable |
| | *Radical Prostatectomy Audit | ✓ | ✓ | 100% |
| | *Female Stress Urinary Incontinence Audit | × | × | Not applicable |
| British Thoracic Society (BTS) | Community Acquired Pneumonia | ✓ | ✓ | 86 – PRH<br>93 – RSH |
| | Adult Non-Invasive Ventilation Audit | ✓ | ✓ | PRH – 16<br>RSH – 16 |
| | *Smoking Cessation Audit | ✓ | ✓ | PRH – 114<br>RSH – 130 |
| Cancer Patient Experience Survey 2018 | | ✓ | ✓ | 71% response rate |
| Care in Emergency Departments (CEM) | Feverish Child | ✓ | ✓ | 207 cases submitted |
| | Vital signs- adults | ✓ | ✓ | 258 cases submitted |
| | VTE | ✓ | ✓ | 86 cases submitted |

| Title: National clinical audits and national confidential enquiries | | Eligible | Participating | Submission rate (%) / Comment |
|---|---|---|---|---|
| | *Assessing Cognitive Impairment in Older People | ✓ | ✓ | Currently in progress |
| | *Care of Children | ✓ | ✓ | Currently in progress |
| | *Mental Health | ✓ | ✓ | Currently in progress |
| *Case Mix Programme (CMP) - ICNARC | | ✓ | ✓ | All applicable 100% |
| Child Health Clinical Outcome Review Programme (NCEPOD) | *Long-Term ventilation | ✓ | × | Time constraints |
| | *Young People's Mental Health | ✓ | ✓ | 83% |
| Children and Young People's Patient Experience Survey 2018 | | ✓ | ✓ | 33% response rate |
| National Asthma & COPD Audit Programme (NACAP) | *Chronic Obstructive Pulmonary Disease (COPD) Secondary Care | ✓ | ✓ | 212 for 2019 |
| | *Pulmonary rehabilitation | × | × | Not applicable |
| | *Adult Asthma Secondary Care | ✓ | × | Lack of resources |
| | *Paediatric Asthma Secondary Care | ✓ | × | |
| *National Audit of Dementia (care in general hospitals) | | ✓ | ✓ | PRH 54 casenotes<br>59 staff surveys<br>12 carer survey<br>RSH 59 casenotes |

| Title: National clinical audits and national confidential enquiries | | Eligible | Participating | Submission rate (%) / Comment |
|---|---|---|---|---|
| | | | | 51 staff surveys<br>19 carer survey |
| *Elective surgery (National Proms Programme) | | ✓ | ✓ | 340 questionnaires returned |
| *Endocrine and Thyroid National Audit | | ✓ | ✓ | 50 cases submitted |
| Falls and Fragility Fractures Audit programme (FFFAP) | *Fracture Liaison Service Database | ✓ | × | Not applicable |
| | *Inpatient Falls | ✓ | ✓ | 16 cases identified |
| | *National Hip Fracture Database (NHFD) | ✓ | ✓ | On-going |
| | *Fracture Liaison Service Database / Vertebral Fracture Sprint Audit | × | × | Not applicable |
| *Inflammatory bowel disease (IBD) Registry, Biological Therapies Audit* | | ✓ | × | Not applicable |
| *Major Trauma Audit (TARN) | | ✓ | ✓ | 98.3% of 587 eligible |
| *Mandatory Surveillance of bloodstream infections and clostridium difficile infection | | ✓ | ✓ | 369 Ecoli; 78 Cdiff; 80 Klebsiella; 121 MSSA; 30 Pseudomonas |
| Maternal, Newbrn and Infant Clinical Outcome Review Programme (MBRRACE) | *Maternal mortality surveillance and mortality confidential enquiries | ✓ | ✓ | All applicable 100% |
| | *Perinatal Mortality Surveillance | ✓ | ✓ | 36 cases reported for 2018 |

| Title: National clinical audits and national confidential enquiries | | Eligible | Participating | Submission rate (%) / Comment |
|---|---|---|---|---|
| | *Maternal morbidity confidential enquiries | ✓ | ✓ | All applicable 100% |
| Medical and Surgical Clinical Outcome Review Programme (NCEPOD) | *Acute Bowel Obstruction | ✓ | ✓ | 2/9 questionnaires returned |
| | *In-hospital management of out-of-hospital cardiac arrest | ✓ | ✓ | 6/7 questionnaires returned |
| | *Physical Health in Mental Health Hospitals | ✓ | ✓ | Currently in progress |
| | *Pulmonary Embolism | ✓ | ✓ | 11/12 questionnaires returned |
| | *Dysphagia in Parkinson's Disease | ✓ | × | Lack of resources |
| Mental Health Clinical Outcome Review Programme | *Suicide by middle-aged men | × | × | Not applicable |
| | *Suicide in children and young people (CYP) (NCISH) | × | × | Not applicable |
| | *Suicide & Homicide | × | × | Not applicable |
| | *The Assessment of Risk and Safety in Mental Health Services (NCISH) | × | × | Not applicable |
| National Audit of Breast Cancer in Older People (NABCOP) | | ✓ | ✓ | All applicable 100% |
| *National Audit of Cardiac Rehabilitation | | × | × | Not applicable |
| *National Audit of Care at the End of Life (NACEL) 2019 | | ✓ | ✓ | PRH – 38<br>RSH – 40 |

| Title: National clinical audits and national confidential enquiries | | Eligible | Participating | Submission rate (%) / Comment |
|---|---|---|---|---|
| *National Audit of Care at the End of Life (NACEL) 2018 | | ✓ | ✓ | PRH – 50<br>RSH – 71 |
| National audit of meningitis management- a NITCAR audit (NAMM) | | ✓ | ✓ | 25 cases |
| *National Audit of Seizure management in Hospitals (NASH) | | ✓ | ✓ | All applicable 100% |
| *National Bariatric Surgery Registry (NBSR) | | ✓ | ✓ | All applicable 100% |
| National Cardiac Audit Programme (NCAP) – NICOR | *National Adult Cardiac Surgery Audit | × | × | Not applicable |
| | *National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) | × | × | Not applicable |
| | *National Audit of Cardiac Rhythm Management (CRM) | ✓ | ✓ | All eligible cases 100% |
| | *Congenital Heart Disease (CHD) | × | × | Not applicable |
| | *Myocardial Ischaemia National Audit Project (MINAP) | ✓ | ✓ | Jan – Dec 2019:<br>PRH - 289<br>RSH - 299 |
| | *Heart Failure Audit | ✓ | ✓ | Information not provided by lead |
| *National Cardiac Arrest Audit (NCAA) | | ✓ | ✓ | PRH - 43 / RSH - 35 submitted for last report |
| *National Early Inflammatory Arthritis Audit (NEIAA) | | × | × | Not applicable |
| *National Clinical Audit of Psychosis | | × | × | Not applicable |

| Title: National clinical audits and national confidential enquiries | | Eligible | Participating | Submission rate (%) / Comment |
|---|---|---|---|---|
| National audit for breast radiotherapy | | ✓ | ✓ | All applicable 100% |
| National Comparative Audit of Blood Transfusion programme | Management of massive haemorrhage | ✓ | ✓ | 2 cases identified |
| | Re-audit of the medical use of blood | ✓ | ✓ | Currently in progress |
| National Diabetes Audit – Adult | *Core Diabetes Audit | ✓ | × | No access to database |
| | *Foot Care Audit | ✓ | ✓ | All applicable 100% |
| | *NaDIA Harms | ✓ | ✓ | All applicable 100% |
| | *Inpatient Audit NaDIA | ✓ | ✓ | All applicable 100% |
| | *Pregnancy in Diabetes | ✓ | ✓ | 100% of consented cases |
| | *Transition | ✓ | × | Not applicable |
| *National Emergency Laparotomy audit (NELA) | | ✓ | ✓ | All applicable 100% |
| *National Joint Registry (NJR) | | ✓ | ✓ | 492+ procedures undertaken |
| *National Lung Cancer Audit (NLCA) | | ✓ | ✓ | 100% |
| *National Maternity and Perinatal Audit (NMPA) | | ✓ | ✓ | All applicable 100% |
| National Maternity Survey 2019 | | ✓ | ✓ | 151 responses received |
| *National Paediatric Diabetes Audit (NPDA) | | ✓ | ✓ | 310 CYP treated |
| *National Vascular Registry | | ✓ | ✓ | 100% |
| *Neonatal intensive and special care (NNAP) | | ✓ | ✓ | 100% |
| *Neurosurgical National Audit Programme | | × | × | Not applicable |
| National GastroIntestinal Cancer Programme | *Oesophago-gastric Cancer (NAOGC) | ✓ | ✓ | 100% |
| | *National Bowel Cancer (NBOCA) | ✓ | ✓ | 324 cases |
| *Ophthalmology Audit | | ✓ | ✓ | 95.9% |

| Title: National clinical audits and national confidential enquiries | | Eligible | Participating | Submission rate (%) / Comment |
|---|---|---|---|---|
| *Paediatric intensive care (PICaNet) | | × | × | Not applicable |
| *Perioperative Quality Improvement Programme | | × | × | Not applicable |
| Prescribing Observatory for Mental Health (POMH-UK) | *Assessment of side effects of depot and LA antipsychotic medication | × | × | Not applicable |
| | *Monitoring of patients prescribed lithium | × | × | Not applicable |
| | * Prescribing for depression in adult mental health services | × | × | Not applicable |
| | * Prescribing valproate | × | × | Not applicable |
| | * Antipsychotic prescribing in people with a learning disability | × | × | Not applicable |
| | *Prescribing Clozapine | × | × | Not applicable |
| | * Use of depot/LAI antipsychotics for relapse prevention | × | × | Not applicable |
| *Prostate Cancer Audit | | ✓ | ✓ | 365 cases included |
| *Pulmonary Hypertension | | × | × | Not applicable |
| *Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis) | | ✓ | ✓ | All applicable 100% |
| *Society for Acute Medicine's Benchmarking Audit (SAMBA) | | × | × | |
| *Seizures and Epilepsies in Children and Young People (Epilepsy12) | | ✓ | ✓ | All applicable 100% |
| *Sentinel Stroke National Audit Programme (SSNAP) | | ✓ | ✓ | All eligible cases |

| Title: National clinical audits and national confidential enquiries | Eligible | Participating | Submission rate (%) / Comment |
|---|---|---|---|
| *Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme | ✓ | ✓ | All eligible cases |
| Seven Day Hospital Services | ✓ | ✓ | 620 cases included |
| *Surgical Site Infection Surveillance Service | ✓ | ✓ | All eligible cases |
| *UK Cystic Fibrosis Registry | × | × | Not applicable |
| *UK Parkinson's Audit | ✓ | ✓ | 41 cases |

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

***Audits on HQIP List 2019/20**

| Examples of actions taken following National audits | |
|---|---|
| **Title** | **Action / Outcome** |
| UK Parkinsons Audit 2017 (3776) | • A new proforma for clinics has been developed to ensure better recording of consultations<br>• To improve assessment of mental health, the mental health team are now part of the steering group |
| Bronchiectasis (BTS) PRH (3887) | • Work with the CCG's is underway to improve access to home intravenous antibiotics |
| Cancer Patient Experience Survey 2017 (National) (4029) | • The survey demonstrated sustained improvement in areas of previous poor patient experience |
| College of Emergency Medicine VTE Risk in Lower Limb Immobilisation (4097/4098) | • All ENPs/ECPs complete a competency assessment and are signed off against this by a consultant. Those ENPs/ECPs who are independent prescribers have the ability to prescribe Tinzaparin on formulary |
| NAP6 - Survey of incidence of severe anaphylaxis associated with anaesthesia (3701) | • Advice re immediate management and follow-up have been identified and disseminated locally.<br>• New guidance on the intranet and crash box reviewed |

| Examples of actions taken following National audits | |
|---|---|
| **Title** | **Action / Outcome** |
| National Dementia audit - PRH 2018 (4024) | • A business case has been completed to enable the Trust to have 24/7 specialist dementia cover<br>• John's Campaign fully endorsed and promoted at the Trust<br>• Personal preferences are now recorded in This is Me document, these are displayed, and followed<br>• A paper has been produced to ensure all signage and orientation cues comply with SATH agreed dementia friendly guidelines |
| National Hip Fracture Audit Database (NHFD) PRH (1668) | • Posters are on display in the ED and Orthopaedic wards promoting FAB (fluids, analgesia and bloods) in fracture neck of femur patients, as well as highlighting key co-morbidities and actions required.<br>• Training package has been updated to include the importance of minimising time nil by mouth and to maintain appropriate hydration and analgesia whilst awaiting theatre.<br>• The education package has been updated by the anaesthetic team. Trainees are educated at induction<br>• Physiotherapy Team have held sessions to re-educate nursing teams on wards with regard to refreshing and relaunching the triggers and referral criteria for physiotherapy. |
| National Joint Registry (NJR) - hip, knee and ankle joint replacements (2021) | • The audit provided reassurance that safe and appropriate care is being delivered in accordance with the audit standards |
| National Maternity Survey 2017 (3747) | • The results showed SaTH performed "Better" than most other trusts in 13 areas; these included 2 Antenatal questions, 6 Birth questions and 5 postnatal questions |

| Examples of actions taken following National audits | |
|---|---|
| **Title** | **Action / Outcome** |
| | • Patient information is now included in new Baby Buddy App<br>• There is an ongoing project to review patient information with the with the Maternity Voices Partnership |
| National Maternity Survey 2018 (4226) | • To promote the opportunity to adopt different positions during labour, the MLU rooms are being refurbished |
| National Neonatal Audit Programme 2019 (annual report on 2018 data) (4034) | • Overall positive outcomes in all parameters with some above the national rates |
| National Prostate Cancer Audit (NPCA) 2019 (April 2017 to March 2018) (3173) | • Early two-week Trial without Catheter (TWOC) has been implemented<br>• Modification to criteria used for lymph node dissection has been implemented<br>• A re-audit has been undertaken |
| Sentinel Stroke National Audit Programme | • A business case is being compiled to identify the resources necessary to deliver many of SaTH's planned stroke improvements including a sustainable 7-day service |
| UK Trauma audit and research network (TARN) - Severe Trauma 2019 (4317) | • T & O consultant to carry out a full review of relevant patients to identify areas for improvement |

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

## Research and Development

The number of patients receiving relevant health services provided or subcontracted by Shrewsbury and Telford Hospital NHS Trust in 2019-2020 was 1896. This target is set by the National Institute of Health Research (NIHR) Clinical Research Network based upon the funding we receive from them, and only includes studies adopted onto the national research portfolio.

Research ultimately is about developing and delivering more effective treatments and more efficient care to patients. There is a growing body of evidence demonstrating that research active organisations have improved patient outcomes, and lower mortality rates. Shrewsbury and Telford Hospitals NHS Trust is committed to active participation in Clinical Research in order to improve the quality of care we offer our patients, and also to make a contribution to wider health improvement.

In 2019/2020 the Radiotherapy and Physics team was awarded ‘Team of the Year’ in the West Midlands Clinical Research Network annual awards, in recognition of the fantastic work and contribution they have made to cancer clinical research. It also saw the Trust submit its first proposal to the Health Technology Assessment fund, being led by a clinician from the Trust. The Trust had previous success as supporting applicants on major grants, but this year, with the support of the West Midlands Clinical Research Network (WMCRN) via investment into the Clinical Trial Scholars posts this has enabled a submission as lead from the Trust. The department is supporting a number of clinicians to increase the number of funding submissions, to enable their ideas to be developed into national and international research projects answering the questions to enable better treatment and care for our communities.

## A summary of research activity for 2019/20 included:

| Research Activity 2019/2020 | Number of Studies |
|---|---|
| New studies opened in 2019/20 | 23 |
| Total number of studies open during the period | 114 |
| Studies in Follow up during this period. | 40 |

As part of the COVID 19 pandemic response, the Research and Innovation Team underwent a dramatic re-deployment and expansion of the team and activity to enable the Trust to participate in appropriate Covid19 research with urgent Public Health status. The Department temporarily suspended 89% of studies on site in response to the pandemic or at the sponsor’s request apart from a limited number of interventional oncology studies.

## Use of the Commissioning for Quality and Innovation Payment Framework

In 2019/2020 the Shrewsbury and Telford NHS Trust had 5 mandated National CQUINs, each with a weighting of £ 606,000. Further details of the agreed goals for 2019/2020 are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

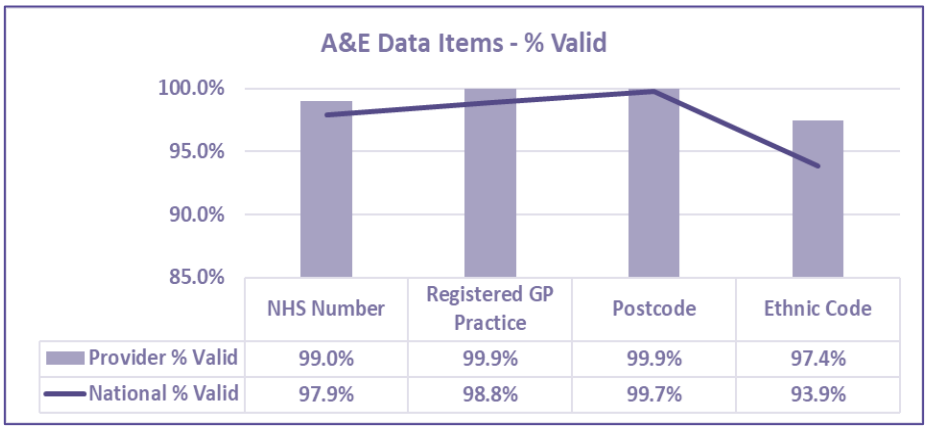
Payment with this year's National CQUIN schemes was based on performance falling between the minimum and maximum thresholds for each indicator for each financial Quarter, with overall payment based on Q1-4 combined performance.

For the Trust the biggest challenges and financial losses were associated with 2 elements of 2 of the CQUINS and one further CQUIN scheme: Antibiotic Resistance- Lower Urinary Tract Infection, Alcohol and Tobacco Screening and the three High Impact Actions to Prevent Hospital Falls CQUIN.

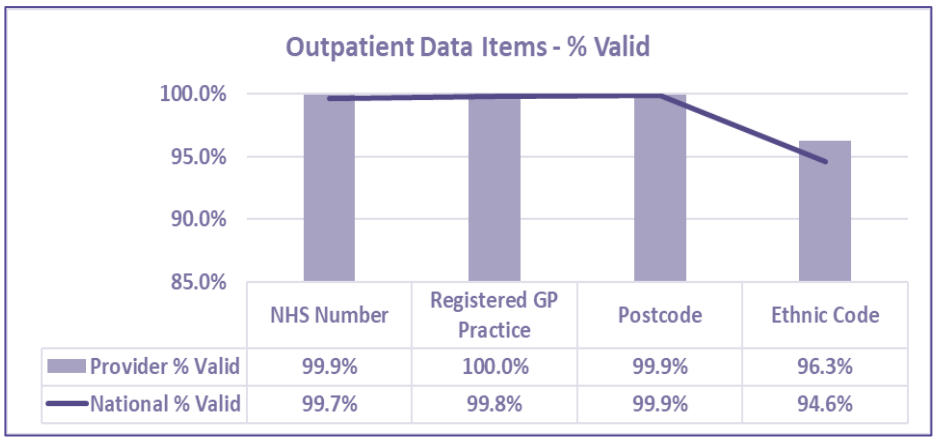
Nationally, due to the small number of patients having the three interventions in Q1 the National CQUIN team decided to remove Q1 performance form the 2019/2020 performance and payment calculation for the three High Impact Actions to Prevent Hospital Falls CQUIN. Performance for Q2 and Q3 at the Trust was poor, with a significant financial impact. As with the Falls CQUIN, the national team took the decision to remove Q1 performance from the 2019/2020 performance and payment calculation for this CQUIN. Despite this the CQUIN remained challenging for the Trust.

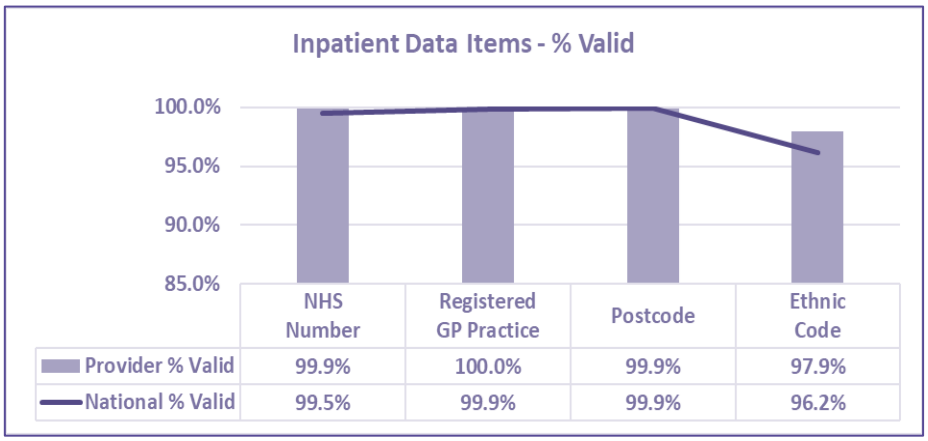
## NHS Number and General Medical Practice Code Validity

The Shrewsbury and Telford Hospital NHS Trust submitted records during 2019/2020 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentages of records in the published data (April 2019 to January 2020) which included the patient's valid NHS number and valid General Medical Practice Codes are shown:




| | NHS Number | Registered GP Practice | Postcode | Ethnic Code |
|---|---|---|---|---|
| Provider % Valid | 99.0% | 99.9% | 99.9% | 97.4% |
| National % Valid | 97.9% | 98.8% | 99.7% | 93.9% |




Percentage of records which included valid NHS Number was:

- 99% for A&E
- 99.9% for Inpatients
- 99.9% for Outpatients

The Percentage of records which included a valid General Medical Practice Code was:

- 99.9% for A&E
- 100% for Inpatients
- 99.9% for Outpatients

All percentages were above national results

## Data Security and Protection Toolkit Attainment Levels

The Data Security and Protection Toolkit (DSPT) has now replaced the Information Governance toolkit as the standard for cyber and data security for healthcare organisations.

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. Compliance with the DSP Toolkit requires organisations to demonstrate

that they are implementing the ten data security standards recommended by the National Data Guardian Review as well as complying with the requirements of the General Data Protection Requirements (GDPR).

All organisations that have access to NHS patient data and system must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly. Under normal circumstances the yearly submission date is 31st March however due to Coronavirus pandemic NHS Digital advised that the submission date was extended to the 30th September 2020. Therefore at the time of writing, the Trust has not made its 2019/20 submission but plans to do so in September 2020.

Information Governance (IG) incidents are reported via the Trust's incident reporting system and there have been 14 incidents which have been reported to the Information Commissioner in 2019/20. These incidents have been themed which include staff accessing patient records who are not within their direct care and patient information that has been lost, stolen or disclosed in error. The Shrewsbury and Telford Hospital NHS Trust monitors compliance of IG Training which is part of the statutory and mandatory compliance with staff required to undertake yearly data awareness training. In addition, any areas or individuals identified through incidents are directly fed back to and supported to improve their IG practices.

## Learning from Deaths

During 2019/2020 2040 patients were part of the Learning from Deaths process within the Shrewsbury and Telford NHS Trust.

| Number of Deaths included in the Learning from Deaths Process 2019/2020 | |
|---|---|
| **Time Period** | **Number of Deaths** |
| **April 2019 to March 2020** | |
| Q1 | 469 |
| Q2 | 468 |
| Q3 | 541 |
| Q4 | 562 |

By the end of March 2020, 718 (35%) of case reviews and 433 investigations were carried out in relation to the 2040 deaths. In four cases a death was subject to a case review and an investigation.

| Number of Case Record Reviews in 2019/2020 | |
|---|---|
| **Time of Death** | **Death Reviewed or Investigated** |
| **April 2019 to March 2020** | |
| Q1 | 253 |

| | |
|---|---|
| Q2 | 327 |
| Q3 | 203 review only (no of investigations not recorded) |
| Q4 | 368 |

Of the 2040 deaths in 2019/20, 1,151 cases were reviewed through the local specialty mortality and morbidity meeting (56%). From this initial review 58 cases (2.8%) identified possible deficits in the care delivered to the patient in the days leading up to their death. Although this is an increase on the number reported in the 2018/19 Quality Account this is due to an improved mortality review process and as such an increase in the opportunity to learn from the care delivered to patients at the end of their life to improve care provided for all patients. This is in line with the national picture.

| **Number of Deaths reviewed or investigated in 2019/2020 (to date) and judged to be more likely than not to have been due to problems in the care provided to the patient** | |
|---|---|
| **Time Period** April 2019 – March 2020 | **Deaths reviewed or investigated in and judged to be more likely than not to have been due to problems in the care provided to the patient (% of all deaths in that period)** |
| Q1 | 3.62% |
| Q2 | 4.48% |
| Q3 | (no data recorded) |
| Q4 | 3.55% |

8 of the deaths were found to have problems in care but these were considered unlikely to have contributed to the death. Learning from deaths through ensuring we have a robust mortality review process with strengthened governance is a key priority for the Shrewsbury and Telford NHS Trust in 2020/21. The actions being taken to achieve this are outlined on the Section 2.4 when we have discussed the key priorities moving forward for 2020/21.

## Implementing the Priority Clinical Standards for 7 Days Services

The seven day service national survey covers the management of patients admitted as an emergency measured against the four priority standards.

| **Priority Clinical Standards** | | | |
|---|---|---|---|
| **Standard 2: Time to Consultant Review** | **Standard 5: Diagnostics** | **Standard 6: Consultant Direct Intervention** | **Standard 8: On-going daily consultant-directed review** |

| | | | |
|---|---|---|---|
| All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant within 14 hours from the time of admission to hospital | Hospital inpatients must have scheduled seven day access to consultant-directed diagnostic tests and completed reporting will available seven days a week | Hospital inpatients must have timely 24 hour access, seven days a week to consultant-directed interventions that meet the relevant speciality guideline, either on-site or through formally agreed networked arrangements with clear protocols. | All patients with high-dependency needs should be reviewed twice daily by a consultant and all other inpatients should be reviewed by a consultant once daily seven days a week, unless it has been determined that this would not affect the patient's care pathway |

Progression towards the 7 day standards are measured twice a year through the 7 Day Service Self-Assessment Tool. All acute NHS provider Trusts undertake and submit a sample of case notes reviews for standards 2 and 8 across a 7 day period and a self-assessment for standards 5 and 6.

Some progress has been made in 2019/2020 in relation to the 4 clinical standards, this includes:

**Clinical Standard 2:** Increased demand and workforce challenges have had an impact on performance in relation to this standard. The Trust Board have committed to investment in the clinical workforce; there will be an improvement in this area following recruitment over the next 12 months. Ears, Nose and Throat (ENT) have appointed an additional Consultant and through proactive and innovative job planning have been able to meet both clinical standard 2 and clinical standard 8.

**Clinical Standard 5:** Improvements have been made in the weekend availability by formal arrangement of ultrasound at weekends. There is currently a transition from Consultant-led to Sonographer-led ultrasound at weekends which will enable the Trust to meet the full requirement. MRI is also now available at weekends by formal arrangements.

**Clinical Standard 6:** Discussions continue with the University Hospital North Midlands NHS Trust in relation to Interventional Radiology. An effective memorandum of understanding is working well for urological surgery. Further discussions are taking place regarding vascular and interventional work.

**Clinical Standard 8**: The most recent audit results have demonstrated a significant improvement with twice daily reviews achieving 100% at both weekdays and weekends. Whilst these patients are a small cohort, they are the sickest patients. This is due to an improved staffing model of the critical units at weekends.

Regular updates on the Trust's position have been provided to Workforce Committee and Trust Board throughout 2019/2020, including:

- Repeated self-assessments reported to Trust Board via the Board Assurance Briefing Paper in June and October 2019.
- Repeated audits carried out on the 4 priority standards
- Peer comparison of weekend rates of discharge
- ENT compliant with 7 day services Clinical Standards 2 and 8
- Dispensing Pharmacy now available on Saturdays
- Improved Radiology provision at weekends with ultrasounds and MRI
- Trial of additional Consultant Surgeon on call to improve access to emergency operating, in line with Clinical Standard 6

The Shrewsbury and Telford Hospital NHS Trust is partially compliant with the standards but still faces challenges in achieving these and will struggle to meet the national expectation of being fully compliant with the 4 standards by March 2020.

## Encouraging Staff to Speak Up

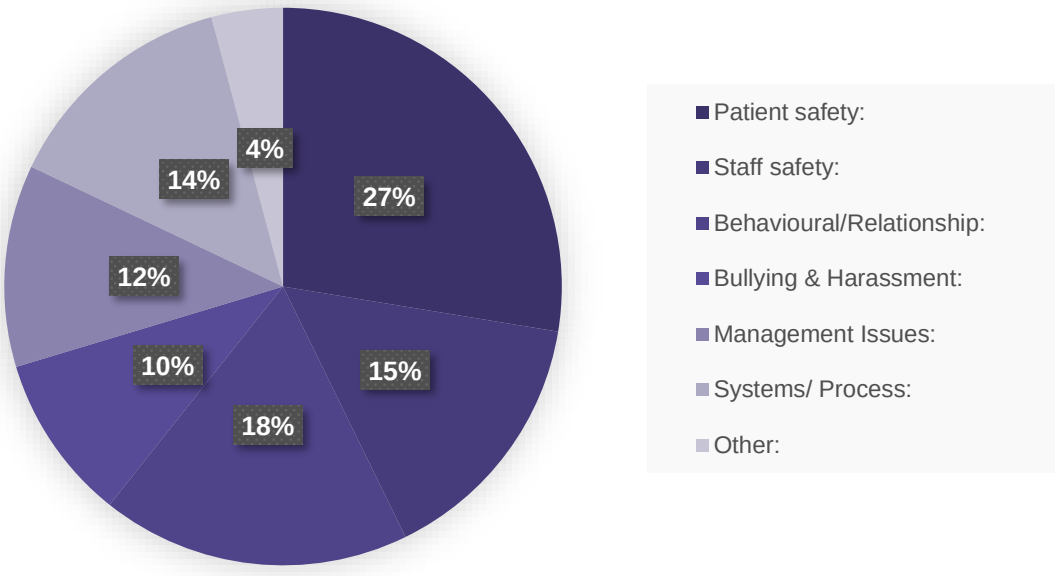
In response to concerns about culture in the NHS, the Secretary of State for Health and Social Care commissioned Sir Robert Francis to carry out an independent review and that some individuals have suffered detriment as a result of raising concerns. The review recommended that every NHS organisation should understand the value of speaking up which complies with national standards and enables organisations to support workers to speak up, respond appropriately and take necessary action as recommended by the report.

The report established the Freedom to Speak Up Guardian role as a way of encouraging and supporting staff to speak up. Freedom to Speak Up Guardians (FTSU Guardians) were appointed by Shrewsbury and Telford Hospitals NHS Trust in February 2017 following on from the recommendations in Sir Robert Francis' report. FTSU Guardians are in place to ensure that speaking up becomes 'business as usual' and our staff do not suffer repercussions for speaking up.

In 2020 the FTSU Organisational Structure was updated, to further embed the culture of speaking up. A Lead FTSU Guardian was appointed with two FTSU Guardians, they report into the Medical Director. The Trust has FTSU Advocates who promote FTSU and sign post to the Guardians. There are 46 Advocates in total, of clinical and non-clinical background across a range of different job role, These are voluntary roles undertaken by members of staff in addition to their substantive posts. There is a FTSU on line e-learning module for Advocates to undertake and training sessions with the support of the National Guardian Office have been delivered.  Helene Donnelly, Ambassador for Cultural Change has delivered a training session to the FTSU Guardians and Advocates. .

In 2019/2020 the total number of concerns raised to FTSU Guardians was 145 indicating staff are confident to use the FTSU guardians to speak up and gain support to ensure action is taken.

Of the concerns raised 27% related to patient safety, 18% to behaviours/relationships, 15% staff safety and 14% to systems and processes. All FTSU concerns are acknowledged within 48 hours as per the FTSU Policy.




The Lead FTSU Guardian reports to Trust Board reports monthly to the Workforce Committee, six monthly to the Senior Leadership Team Meeting and Quality and Safety Assurance Committee and on a quarterly basis to Trust Board.

## The Guardian of Safe Working

The Shrewsbury and Telford Hospital Guardian of Safe Working (GOSW) is now a member of the Senior Medical Leadership Team which enables issues to be raised and dealt with proactively.

In the past year there has been a focus on:

- Supporting Junior doctors in training with respect to their safe working hours
- Providing regular forums and drop in sessions as platforms for doctor to raise concerns with BMA and FTSU being attendees at these
- Ensuring compliance with a reporting system as mandated in the Junior Doctor Contract to enable junior doctors to report variations in their work schedule

The Shrewsbury and Telford Hospital NHS Trust GOSW has also undertaken the role of champion of Fatigue and Facilities Charter, in this role they raise concerns regarding rest to the attention of the Trust as well as champion of BMA Well Being Charter.

In addition to this the GOSW has encouraged and promoted e-rostering software to enable cohesion of rotas/job plans/work schedules to meet service needs.

# 2.3 Reporting against Core Quality Account Indicators

Since 2012/13 NHS Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. These core indicators align closely with the NHS Outcomes Framework (NHSOF). The majority of core indicators are reported by financial year, e.g. from 1st April 2019 to 31st March 2020, however some indicators report on a calendar year or partial year basis. Where indicators are report on a non-financial year time period this is stated in the data table. It is important to note that some national data sets report in significant arrears and therefore not all data presented are available to the end of the current reporting period and others were suspended in Q4 of 2019/2020 due to the COVID 19 pandemic.

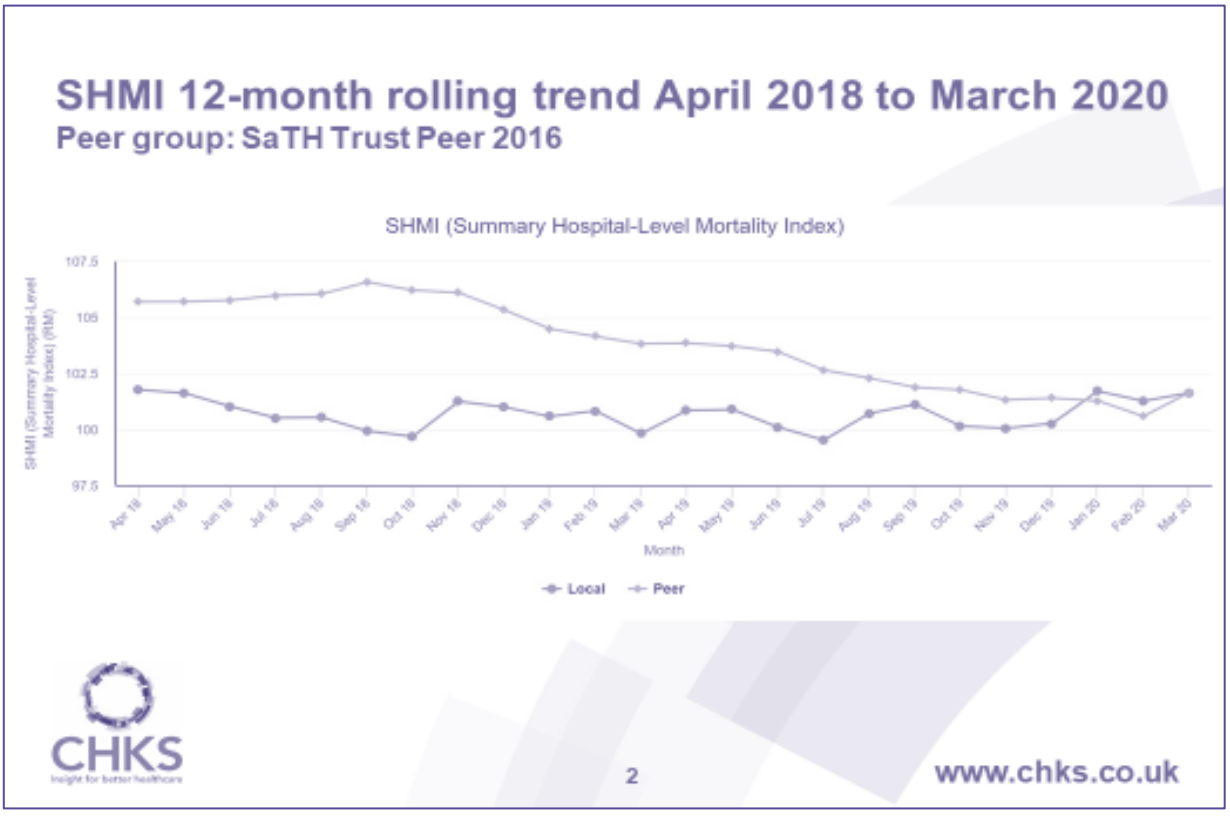
## Summary Hospital-Level Mortality Indicator

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

| Indicator | Summary Hospital-Level Mortality Indicator | | | | | |
|---|---|---|---|---|---|---|
| **Domain** | **Preventing people from dying prematurely** | | | | | |
| **SATH 2019/20** | **National Average 2019/20** | **Best Performing Trust 2019/20** | **Worst Performing Trust 2019/20** | **SATH 2018** | **SATH 2017** | **SATH 2016** |
| 101.64 *"as expected"* | 99.83 *"as expected"* | 67.92 *"lower than expected"* | 118.64 *"higher than expected"* | 99.83 | 102.84 | 103.7 |
| **Data Source** CHKS, Insight for Better Healthcare | | | | | | |

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

Overall, the Summary Hospital Level Mortality Indicator for the Shrewsbury and Telford Hospital NHS Trust in 2019/20 was "as expected" and compares with the national average in 2019/20.



Overall Mortality Metrics for the Shrewsbury and Telford Hospital NHS Trust in 2019/2020 show that these mortality metrics were within the expected range. For the year of April 2019 to March 2020 the crude mortality rate for the Trust was 0.99%, remaining below the average of 1.25% for the peer group of comparable trusts, but the rate was higher at Princess Royal Hospital at 1.2% than the Royal Shrewsbury Hospital, with a rate of 0.94%. When adjusted for case-mix, both the RAMI and HSMR mortality indicators show a slightly favourable position for the Trust overall compared to the peer group.

| Description | Local Numerator | Local Denominator | Apr 19 - Mar 20 | Apr 18 - Mar 19 | Peer Value | Performance |
|---|---|---|---|---|---|---|
| HSMR (Hospital Standardised Mortality Ratio) | 1520 | 1760 | 86.38 | 85.83 | 88.89 | |
| SHMI (Summary Hospital-Level Mortality Index) + | 2041 | 1965 | 103.85 | 98.44 | 100.54 | |
| In-Hospital SHMI (Summary Hospital-Level Mortality Index) 2018 | 1691 | 2847 | 59.39 | 57.59 | 66.48 | |
| Mortality Rate | 1691 | 171179 | 0.9879% | 0.9647% | 1.1846% | |
| RAMI (Risk adjusted mortality index) 2018 | 1691 | 1944 | 86.98 | 85.60 | 89.66 | |
| Rate of Mortality in hospital within 30 days of elective surgery | 2 | 3146 | 0.06357% | 0.030750% | 0.12446% | |
| Rate of Mortality in hospital within 30 days of Non elective surgery | 85 | 7986 | 1.0644% | 1.0530% | 1.3643% | |
| % Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over) | 8 | 234 | 3.419% | 2.5000% | 4.762% | |
| Rates of mortality in hospital within 30 days of emergency admission with a stroke | 74 | 938 | 7.889% | 12.252% | 11.692% | |
| % Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74 | 4 | 343 | 1.1662% | 0.6579% | 3.1447% | |
| Deaths in Low Mortality CCS Groups | 20 | 12462 | 0.16049% | 0.11924% | 0.11200% | |
| Post operative pulmonary embolism or deep vein thrombosis | 11 | 25502 | 0.04313% | 0.015427% | 0.03865% | |
| % Still Births | 15 | 4208 | 0.3565% | 0.3510% | 0.3879% | |
| Mortality Rate - Admitted via A&E | 1312 | 34531 | 3.799% | 3.745% | 3.560% | |

The Shrewsbury and Telford Hospital NHS Trust implemented actions to improve this score, and quality of its services by routinely monitoring mortality rates at the Trust Mortality Review Group. This includes looking at mortality rates by specialty, diagnosis and procedure. Other actions to improve this are outlined elsewhere in this report.

## Percentage of Patient Deaths Coded at either Diagnosis or Speciality Level.

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

| Indicator | Percentage of patient whose deaths were included in the SHMI and whose treatment included palliative care (contextual indicator) |
|---|---|

| Domain | Preventing people from dying prematurely | | | | | |
|---|---|---|---|---|---|---|
| **SATH 2019/20** | **National Average 2019/20** | **Highest Score Trust 2019/20** | **Lowest Score Trust 2019/20** | **SATH 2018** | **SATH 2017** | **SATH 2016** |
| 23.81% | 35.25% | 66.59% | 9.26% | 22.51 | 17.51 | 21.27 |
| **Data Source** – CHKS - FCE (Finished Consultant Episode) deaths with palliative care code Z515. HES data used against Peer | | | | | | |

The Shrewsbury and Telford Hospital NHS Trust considers this data is accurate as it is taken from a well-established national source. The Trust regularly monitoring mortality data at the Trust Mortality Review Group to improve this score, and so the quality of its services provided.

## Patient Reported Outcome Measures (PROMs)

Patient Reported Outcomes Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering 2 surgical procedures, PROMS calculate the health gains after surgical treatment using pre and post-operative surveys.

The two procedures are:

- Hip replacement
- Knee replacement

PROMs are collected by all providers of NHS funded care. They consist of a series of questions that patients are asked in order to gauge their views of their own health. Patients are asked to score their health before and after surgery. It is then possible to ascertain whether a patient sees a health gain following their surgery.

| Indicator | Patient Reported Outcome Measures EQ 5D Index (case-mix adjusted health gain) | | | | | | |
|---|---|---|---|---|---|---|---|
| **Domain** | **Helping people to recover from episodes of ill health or following injury** | | | | | | |
| | **SATH 2019/20** | **National Average 2019/20** | **Highest Score Trust 2019/20** | **Lowest Score Trust 2019/20** | **SATH 2018** | **SATH 2017** | **SATH 2016** |
| Hip Replacement | 0.47 | 0.46 | 0.53 | 0.339 | 0.43 | 0.5 | 0.42 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Knee Replacement | 0.373 | 0.33 | 0.405 | 0.243 | 0.32 | 0.34 | 0.34 |
| **Data Source -** https://digital.nhs.uk/data-and-information/data-tools-and-services/dataservices/patient-reported-outcome-measures-proms<br>Please note the figures are subject to change as they are still provisional | | | | | | | |

The Shrewsbury and Telford Hospital NHS Trust considers this data is accurate as it is taken from a national source, however, the most recent data is still provisional at the time of this report.

The PROMs figures reflect the average adjusted health gain (unadjusted average difference between pre- and post-operative scores), using the EQ-5D Index. Based on the provisional data, the Trust scored above the national average for both procedures in 2019/20.

## The Percentage of Patients Readmitted to Hospital within 28 Days of Discharge

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

| **Indicator** | **Readmission Rate for patients readmitted to a hospital within 28 days of being discharged** | | | | | | |
|---|---|---|---|---|---|---|---|
| **Domain** | **Helping people to recover from episodes of ill health or following injury** | | | | | | |
| | **SATH 2019/20** | **National Average 2019/20** | **Highest Score Trust 2019/20** | **Lowest Score Trust 2019/20** | **SATH 2018** | **SATH 2017** | **SATH 2016** |
| 0-15 | 13.57% (Apr-Mar 20 | 9.89% (Apr-Mar 20) | 9.89% (Apr-Mar 20) | 16.95% (Apr-Mar 20) | 12.659 | 10.86 | 9.90 |
| 16 and over | 8.44% (Apr-Mar 2) | 8.44% (Apr-Mar 20) | 3.25% (Apr-Mar 20) | 12.38% (Apr-Mar 20) | 8.872 | 8.17 | 7.78 |
| **Data Source -** Data from CHKS, filters used Patient readmitted with 28 days where the age is less than or equal to 15 or greater than equal to 16 | | | | | | | |

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

The data is collected so that Shrewsbury and Telford Hospital NHS Trust can understand how many patient discharged from the Trust are readmitted within less than a month. This can highlight areas where discharge planning needs to be improved and where the Trust needs to work more closely with its community providers to ensure patients do not have to return to hospital. The Trust will continue to work closely with its health care partners and commissioner to identify patients who are at risk of re-admission in 2021/21 in order to improve the quality of services and reduce emergency readmissions.

## The Trust Responsiveness to the Inpatients' Personal Needs

This indicator provides a measure of quality based on a composite score from 5 questions taken from the Care Quality Commission National Inpatient Survey. They are:

- Were you involved as much as you wanted to be in decisions about your care and treatment
- Did you find someone from the hospital staff to talk to about your worries and fears
- Were you given enough privacy when discussing your condition or treatment
- Did a member of staff tell you about medication side effects to watch for when you went home
- Did hospital staff tell you who to contact if you were worried about your condition after you left hospital

| **Indicator** | **Responsiveness to Inpatients' Personal Needs** | | | | | |
|---|---|---|---|---|---|---|
| **Domain** | **Ensuring People have a Positive Experience of Care** | | | | | |
| **SATH 2019/20** | **National Average 2019/20** | **Best Performing Trust 2019/20** | **Worst Performing Trust 2019/20** | **SATH 2018** | **SATH 2017** | **SATH 2016** |
| 62.8 | 67.1 | 86.2 | 54.4 | 63.8 stay: | 67.1 | 68.2 |
| **Data Source -** NHS digital. Data set 4.2, forms part of the NHS Outcomes Framework Patient experience measured by scoring results of a selection of questions from the National Inpatient Survey, based on the Hospital stay: 01/07/2019 to 31/07/2019; Survey collected 01/08/2019 to 31/01/2020. | | | | | | |

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

Based on the main issues raised in the National Patient Survey, the Trust has taken actions to improve the services provided including improvements in providing privacy and dignity, patient involvement, discharge planning, information for patients and food and drinks.

## Percentage of Staff who would recommend the Trust to a Friends or Family needing Care

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

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

| **Indicator** | **Percentage of staff who would recommend the Trust as a provider of care to their friends and family** | | | | | |
|---|---|---|---|---|---|---|
| **Domain** | **Ensuring People have a Positive Experience of Care** | | | | | |
| **SATH 2019/20** | **National Average 2019/20** | **Best Performing Trust 2019/20** | **Worst Performing Trust 2019/20** | **SATH 2018** | **SATH 2017** | **SATH 2016** |
| 53.6% | 70.5% | 87.4% | 39.7% | 52.6 | 60 | 80 |
| **Data Source -** NHS Digital http://www.nhsstaffsurveyresults.com/wpcontent/uploads/2020/02/NHS_staff_survey_2019_RXH_full.pdf. The Survey collected 2019. NHS employers invited to participate in the survey between Sept – December 2019 | | | | | | |

The Shrewsbury and Telford Hospitals NHS Trust considers this data accurate as it is produced by the Picker Institute in accordance with strict criteria.

The Trust has implemented actions to improve the quality of its staffs' experience of working at the Trust, this includes the development of new Trust Values, a Behavioural Framework and a People Strategy; these are outlined in a previous section of this report.

## Venous Thromboembolism (VTE)

A venous thromboembolism is a blood clot that forms in a vein. The Department of Health requires all Trusts to assess patients who are admitted for their risk of having a VTE. This is

to try to reduce preventable deaths that occur following a VTE while in hospital. We report our achievements for VTE against the national target (95%). The calculation is based on the number of inpatients

| **Indicator** | **The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism** | | | | | |
|---|---|---|---|---|---|---|
| **Domain** | **Treating and caring for people in a safe environment and protecting them from avoidable harm** | | | | | |
| **SATH 2019/20** | **National Average 2019/20** | **Best Performing Trust 2019/20** | **Worst Performing Trust 2019/20** | **SATH 2018/19** | **SATH 2017/18** | **SATH 2016/17** |
| 94.37% (Apr-Dec 2019) 94% (Apr-Mar 20) | 95.77% | 99.87% | 75.71% | 95.81% | 95.58% | 95.68 |
| **Data Source -** https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/. First figure represents the Benchmarking performance Nationally. As of December 2019, the national VTE return was stopped. The Trust however reinstated the monitoring of VTE. The Apr-Mar 2019/20 figure is provided using SemaHelix and Vital Pack. | | | | | | |

The Shrewsbury and Telford Hospital NHS Trust considers that the data is as described for the following reasons it is taken from a national data source and the data is routinely monitored and scrutinised in the monthly Quality Governance Report presented to the Quality and Safety Assurance Committee.

The Trust intends to take the following actions to ensure improvement the quality of its services to ensure every patient has a VTE risk assessment completed on admission:

- Continue to monitor compliance of VTE assessment on admission through our integrated Performance Dashboard and Report which is reported to the Trust Board monthly
- Continue to monitor centrally through the Executive Medical Director's Office who liaise directly with the Care Group Medical Directors and Clinical Directors
- Monitoring compliance through Care Group Performance Review Meetings held monthly

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

A patient safety incident is an unintended or unexpected incident which could have or did lead to harm for patients receiving NHS care.

The number and, the rate of patient safety incidents reported within the Trust during 2019/2020 and the number and percentage of such patient safety incidents that resulted in severe harm or death. i) rate of incidents reported per 1000 bed days ii) rate of incidents that resulted in severe harm or death per 1000 bed days iii) number of incidents resulting in severe harm or death iv) % of severe harm or death over number of reported incidents

| **Indicator** | **Patient safety incidents and the percentage that resulted in severe harm or death** | | | | | | |
|---|---|---|---|---|---|---|---|
| **Domain** | **Treating and caring for people in a safe environment and protecting them from avoidable harm** | | | | | | |
| | **SATH 2019/20** | **National Average 2019/20** | **Best Performing Trust 2019/20** | **Worst Performing Trust 2019/20** | **SATH 2018/19** | **SATH 2017/18** | **SATH 2016/17** |
| Number of Patient Safety Incidents | 7199 | 6575 | 22340 | 1271 | 6316 | 5505 | 4398 |
| Rate of Patient Safety Incidents per 100 admissions | 57.9 | 50.7 | 110.2 | 15.69 | 54.8 | 44.63 | 35.93 |
| Percentage of Patient safety incidents which resulted in severe harm or death | 0.22 | 0.33 | 0 | 1.49 | 0.16 | | |
| **Data Source -** For incidents occurring in England from 1 October 2019 to 30 March 2020 and were submitted to the National Reporting and Learning System (NRLS) by 31 May 2020. | | | | | | | |

The Shrewsbury and Telford Hospital NHS Trust considers this data to be accurate as it has been generated from the National Reporting and Learning System (NRLS). All patient safety incidents are monitored by the National Reporting and Learning System

(NRLS). Every 6 months the NRLS produce a comparative report comparing the Trust with similar sized large acute Trusts. This data is published on the NHS improvement website.

A daily report of all incidents across the Trust is circulated to all Executive Directors and Care Group Senior Management Team and Care Group Governance Leads, All patient incidents reported as moderate or above are validated by the Patient Safety Team and Care Group Senior Clinical Team/Governance Leads at the weekly Rapid Review Meeting. An Executive Serious Incident Review Group was set up in 2019, this meets weekly to scope incidents which meet the Serious Incident reporting threshold, review and sign off completed investigations. Learning from Serious Incidents and developing a Safety Culture is a Priority for 2020/21 and is discussed later in the report.

## Rate of Clostridium Difficile

Clostridium difficile (C.difficile) is a bacterium found in the gut which can cause diarrhoea after antibiotics. The rate per 100,000 bed days of cases of Clostridium Difficile infection reported within the Trust amongst patients aged 2 or over during 2019/2020 are shown.

| **Indicator** | **The rate per 100,000 bed days of Trust apportioned cases of C.Difficile Infection that have occurred within the Trust amongst Patients aged 2 or over** | | | | | |
|---|---|---|---|---|---|---|
| **Domain** | **Treating and caring for people in a safe environment and protecting them from avoidable harm** | | | | | |
| **SATH 2019/20** | **National Average 2019/20** | **Best Performing Trust 2019/20** | **Worst Performing Trust 2019/20** | **SATH 2018/19** | **SATH 2017/18** | **SATH 2016/17** |
| 19.44 | 15.34 | 3.39 | 34.68 | 7.03 | 11.74 | 6.99 |
| **Data Source -** https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-byprior-trust-exposure | | | | | | |

The Shrewsbury and Telford NHS Trust considers this data to be as described for the following reasons every case is scrutinised using a Root Cause Analysis (RCA) process to determine whether the case was linked with a lapse in the quality of care provided to patients, the data is routinely monitored through the Infection Control Committee, Quality Operational Committee and Quality and Safety Assurance Committee to Trust Board

At end of the 2019/2020 year there were 54 trust apportioned cases so we have exceeded our limit of 43 trust apportioned cases. This was a very challenging target for the Trust as the previous year's figures, which were used as the baseline, were anomalously low with 18 cases apportioned to the Trust against a target of 24 in 2018/19. The target also changed in

2019/20 to reflect cases in the community which were probably acquired in the Hospital Trust from a recent admission. Of the cases reported in 2019/20, 26 cases were Hospital Onset Healthcare Associated i.e. the sample was 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 with the inclusion of these Community Onset cases.

All Clostridium Difficile cases attributed to the Trust have a Root Cause Analysis (RCA) Investigation undertaken. Antibiotics usage continue to be the most common cause of Clostridium difficile cases and the Trust sees very few cases that suggest transmission in hospital. In 2020/21 the Trust will continue to strengthen its antimicrobial stewardship (monitoring use of antibiotics) with an aim to reduce the incidence of Clostridium difficile infection across the Trust and work in collaboration with our health economy partners on an approach in relation to the management of Clostridium Difficile which includes surveillance, implementation of best practice, audit and root cause analysis

## 2.4 Looking forward to our Priorities for Quality Improvement 2020-2021

This year's Quality Account has been produced during the unfolding of the COVID 19 pandemic. Consequently the normal processes, discussions and collaboration that would normally occur has been compromised. These priorities were identified following review of our quality data, discussions with staff and were discussed with our patient representatives at the Trust Patient and Carer Experience Panel. The Trust Board has identified and agreed 9 key Quality Priorities for 2019/2020, one of these priorities has been rolled over from 2019/2020, the other 8 priorities are new for 2020/21. These are presented using the Darzi framework for quality: Patient Safety, Clinical Effectiveness and the Experience of Patients.

| **PATIENT SAFETY** |
|---|
| Priority 1 : Recognise and respond to the deteriorating patient (Sepsis) |
| Priority 2 : Learning from serious incidents and development of a safety culture |
| Priority 3 : Deliver the key requirements for Infection Prevention and Control |
| **CLINICAL EFFECTIVENESS** |
| Priority 4 : Ensure learning from deaths through clear mortality review processes |
| Priority 5 : Compliance with NICE guidance |
| Priority 6 : Focus on referral to treatment times on the cancer pathway |
| **THE EXPERIENCE OF PATIENTS** |
| Priority 7 : Patient experience and community engagement |

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| Priority 8 : Responsiveness and learning from complaints |
| Priority 9:  Transitional care from Child to Adult |

## Patient Safety

## Quality Priority 1: Recognise and Respond to the Deteriorating Patient (sepsis)

This is an existing priority. Recognising and responding to the deteriorating patient remains a key priority which will continue in 2020/21. Improvement actions implemented in the Emergency Departments in 2019/2020 including the local audits of sepsis screening and implementation of the sepsis 6 bundle for patients screened as high risk of sepsis will continue for 140 patients a week in each department will continue to be undertaken. In addition new improvement actions will be implemented in 2020/21.

**The aim and objectives, including the measures/metrics:**

- Compliance with the sepsis screening tool and implementation of the sepsis 6 bundle for patients screened as high risk to be greater than 95% in both emergency departments
- Improvements on the adult inpatient wards in relation to the recognition and escalation of deteriorating patients who have triggered a NEWS score of 5, with audit results greater than 90%
- Improvements in the use of the sepsis screening tool on the adult inpatient wards and timely treatment of sepsis

**The planned activity to achieve this:**

- Implementation of Vitals electronic observation and decision support system in the emergecy departments
- Implementation of electronic Sepsis Screening tool via VitalPAC
- Roll out of sepsis screening tool and sepsis pathways to all wards.
- Delivery of new Sepsis training across all adult inpoatient areas
- Review of datix indicents regarding sepsis and deteriorating patients, investigations to identify themes and share learning and improvements across the Trust
- Revise Sepsis and Deterioating Patient Policies to ensure relflect best evidnece based practice
- Analysis of the Trust position using national Suspicion of Sepsis Database

**How will this be monitored?**

- Review of audit results for sepsis and deteriorating patient at the monthly Sepsis and Deteriorating Patient Group
- Compliance will be reported monthly to the Quality Operational Committee and Quality and Safety Assurance Committee

## Quality Priority 2: Learning from Serious Incidents and Development of a Safety Culture

One of the most common issues is the way that organisations investigate, communicate and learn when things go wrong.  We want to continue to focus our improvements on learning from, in particular from serious incident and never events. Safety culture is about the attitudes, values and behaviours that staff share about safety, often described as the “the way we do things around here to keep patients and staff safe”.

In developing our safety culture we aim to ensure that patient safety is a universal priority for all staff groups, that we learn from incidents and deliver improved care. A high reporting rate reflects a positive reporting culture; the Trust has seen an increase in incident reporting year on year since 2016. In 2019 the number of incidents reported was above the national average, as was the number of incidents per 100 admissions and the percentage of patient safety incidents which resulted in severe harm or death was 0.22, below the national average.

In 2019/20 we implemented processes to improve our oversight and management of incidents and serious incidents. A weekly rapid review meeting reviews all incidents graded as moderate harm and above. Incidents which are deemed to potentially meet the threshold for an serious incidents (SI) are reviewed at the weekly Executive Serious Incident Review Group chaired by the Medical Director. Incidents that are deemed to be serious incidents or never events then undergo an investigation which involves root cause analysis (a

systematic investigation) that looks beyond the people concerned to try and understand the underlying causes and environmental context in which the incident happened.

In 2020/21 embedding the learning from incidents including serious incidents and developing our safety culture has been identified as a key priority.

**The aim and objectives, including the measures/metrics:**

- Improvements to the quality of serious incident investigations as measured by a reduction in the number of reports returned from the commissioners with queries before they can be closed,
- An increase in the number of serious incident reports submitted on time
- Improve the proportion of incidents reported as “near misses” and ensure these are more thoroughly investigated
- Increase the number of incidents reporting  as part of improving our open learning culture so we are in the top quartile for reporting and dev
- Reduce the most commonly occurring Serious Incidents
- Reduction in Never Events
- Improvements in the percentages of staff responding positively to the relevant safety culture elements included in the staff survey
- Improve how we are enacting the duty of candour and being open with our patients when things go wrong

**The planned activity to achieve this:**

- Monitor and publish “near miss” reporting rates as part of our monthly Patient Safety Newsletter
- Undertake thematic reviews to see if there are common or linked issues which provide additional learning
- Investment in additional resources in the Patient Safety Team
- Develop and implement a suite of new products to support staff to complete quality investigations, including new templates for the 72 hour report and the final serious incident report.
- Appoint a Specialist in Human Factors and Ergonomics
- Introduce training for serious incidents which incorporates human factors in the investigation process and action plans
- Incorporate human factor into a range of already established training
- Undertake a review of clinical governance processes and implement the recommendations to strengthen the Governance processes in the Care Groups and across the Trust
- Audit Care Group Governance meeting minutes to check for evidence of learning from serious incidents

- Audit duty of candour for serious incidents and internal investigation, using results to embed changes to ensure all patients receiving both a verbal and written explanation and apology for all appropriate incidents in over 90 per cent of cases,

**How will this be monitored?**

- Monthly reporting of lessons learnt from incidents at the Quality Operational Committee and Quality and Safety Assurance Committee
- Monitoring of the serious incidents, investigations and findings at the weekly Executive Serious Incident Review Group

## Quality Priority 3: Deliver the Key Requirements for Infection Prevention and Control

The Infection Prevention and Control Service is provided through a structured annual programme of work which includes audit, teaching, policy development and review as well as advice and support to staff and patients. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust. This is agreed annually at the Infection Prevention and Control Committee chaired by the Director of Nursing. The delivery of this programme is also monitored through the IPC Committee and then reported to the Quality Operational Committee, Quality and Safety Assurance Committee and to Board with an Annual Infection Prevention and Control Report.

In 2019/20, there was one Trust apportioned MRSA bacteraemia case; this was against a target of zero. The source was identified as arising from a skin/soft tissue infection. Two further cases of MRSA bacteraemia were identified and apportioned to the community. There were no further cases of MRSA bacteraemia in 2019/20, meaning this was a significant reduction from the 5 cases reported in 2018/2019. The Trust had a MRSA recovery action plan in place which focused on ensuring staff were competent in taking blood cultures. This was monitored monthly through the Infection Prevention and Control Committee.

Clostridium Difficile has been reported in Section 2.3. The Trust had a target of no more than 43 cases. At end of the 2019/2020 there were 54 trust apportioned cases so we have exceeded our limit of 43 trust apportioned cases.

The Infection Prevention and Control (IPC) team continue to focus on the basic principles of good hand hygiene, environmental cleanliness, adequate decontamination of shared equipment and ensuring that good practice in managing medical devices are complied with consistently. In October 2019, following focused improvement work, the Trust was rated as “green” by the NHSI/E Midlands Assistant Director of Infection Prevention and Control. However, the CQC report published in April 2020 raised concerns and NHSI/E downgraded the Trust rating to “red” in response to this. In Trust implemented improvements which were

included in its Quality Improvement Plan to address these IPC concerns raised in relation to hand hygiene compliance and the appropriate use of personal protective equipment (PPE).

During 2019/20, other challenges in relation to IPC across the Trust were associated with the increasingly high patient activity and lack of capacity to isolate patients with infection effectively. The arrival of the COVID 19 pandemic at the end of February 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

A key priority for 2020/21 is to ensure we deliver the key requirements in relation to Infection Prevention and Control including all national targets in relation to Health Care Associated Infections, IPC screening as well as managing the COVID 19 pandemic.

**The aim and objectives, including the measures/metrics:**

- Achieving the national target of 0 cases of MRSA bacteraemia
- Reduce the incidence of Clostridium difficile infection in the Trust based on a strong health economy partnership approach including surveillance, implementation of best practice, audit and root cause analysis to enable us to achieve our Clostridium Difficile target of no more than 43 cases
- Reduce device related health care associated infections (HCAI)
- Ensure all IPC mandatory training is above 90%
- Ensure the effective implementation of all IPC guidance in relation to the management of the COVID 19 pandemic to minimise the risk of hospital acquired COVID 19 infections and staff transmissions

**The planned activity to achieve this:**

- Ensure compliance with all core IPC standards across all clinical areas and staff groups
- Reducing catheter associated urinary tract infections through implementation of a programme of improvement work and implementation of a catheter care plan
- Deliver ongoing training in relation to IPC and PPE for COVID 19
- Ensure adherence to national guidance in relation to swabbing of patients admitted to the Trust, robust isolation and cohorting plans, appropriate use of PPE, social distancing
- Ensure IPC guidelines for COVID 19 are continuously updated in line with newly published guidance and this is disseminated across the Trust

- Use the NHS IPC Board Assurance Framework to ensure that all guidance and risks relating to the COVID 19 pandemic are addressed and that gaps in compliance are promptly acted on.
- Ensure robust processes are in place for RCA investigations of suspected hospital acquired COVID 19 cases and the management of outbreaks

**How will this be monitored?**

- Monthly reporting to the Infection Prevention and Control Committee
- Monthly reporting to Quality Operational Group and Quality and Safety Assurance Committee
- Monthly IPC reporting to Trust Board

## Clinical Effectiveness

## Quality Priority 4: Ensure Learning from Deaths through Clear Mortality Review Processes

For many people, death whilst in the care of the NHS is an inevitable outcome and they experience excellent care. However, some patients experience poor care resulting from a variety of factors. The purpose of reviewing deaths is to identify areas for improvement so we can learn and provide better care for future patients. The Care Quality Commission (CQC) report *'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England (2016)'* found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do as a healthcare provider to engage families and carers and to recognise their insights as a vital source of learning.

The National Guidance on Learning from Deaths has driven a national endeavour on this front. The purpose of the guidance is to help initiate a standardised approach to the way in which we approach and learn from the care and treatment given to our patients prior to their death. This will continue to evolve as we learn.

**Learning from Death - Mortality Review**

It is now compulsory to review all deaths of patients in the care of the NHS. When mistakes happen or poor care is delivered, it is important to do more to understand the causes and make improvements. The purpose of the review/investigation into patient deaths where there may have been problems, is to learn from this process, offer explanations to those who are bereaved and prevent recurrence in the future for other patients Implementation of the National Learning from Deaths guidance is key to the way in which the Trust can

maximise the learning opportunities from the review of care delivered to our patients in the days leading up to their death, whilst an inpatient in one of our hospitals.

Reviews and investigations can only be useful for learning purposes if their findings are valued, shared and acted upon in the positive spirit of transparency and improvement. This process can also support and acknowledge good practice, and provide positive opportunities to share and help other teams. Learning from a review of the care provided to patients who die is integral to our overall clinical governance and quality improvement work. To fulfil the standards and the reporting set out in this guidance for our hospitals the Trust is carrying out a comprehensive review of governance systems and processes and in particular strengthening the wider learning from deaths agenda across the organisation.

**Engagement with Bereaved Relatives and Medical Examiner Role**

The engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one is a vitally important element of how the Trust learns and improves the care for all patients. The Trust endeavours to work closely with bereaved families and carers to ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken. The Trust Bereavement Service has made great progress toward meeting all these expectations and the implementation of the Medical Examiner service has further supported this.

The Trust complies with the legal requirements of having a Medical Examiner Service following the enforcement of the Coroners and Justice Act 2009. The Medical Examiner has an independent role in the Trust but remains professionally accountable to the Medical Director and is in the employment of the Trust. The independent nature of the role is of the upmost importance. Each local Medical Examiner is also accountable to the regional and national Medical Examiners. The introduction of the Medical Examiner role at the Trust has provided further clarity about which deaths should be reviewed. Medical Examiners are able to refer the death of any patient for review with this mechanism ensuring a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient’s death.

**The aim and objectives, including the measures/metrics:**

The aims of this priority for 2020/21 will focus on strengthening practice and governance in relation to mortality reviews by:

- Increase total number of mortality reviews that take place across the Trust
- Improve the governance processes around mortality reviews ensuring the appropriate learning opportunities and improvements are actioned from these reviews

- Introduce a standard approach of mortality reviews with a robust structure and the introduction of an electronic system for mortality reviews

This will give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. A key focus of this work will be to ensure we share and act upon any learning derived from our review processes

**The planned activity to achieve this:**

- Enhance the skills and training of clinical teams. We will need to ensure that staff reporting deaths have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.
- Adopt the Royal College of Physician's Structured Judgement Review (SJR) methodology as the standardised Mortality Review mechanism. This is new to the organisation thus a programme of training is being developed to support timely and effective implementation and will be delivered through 2021/22.
- The adoption of the Structured Judgement Review methodology will ensure standardisation and consistency of the review process, allow for national and regional benchmarking and provide assurance that we provide the safest, highest quality of care
- Regardless of whether the care provided to a patient who dies is examined using case record review or an investigation, the findings will feed into robust clinical governance processes and structures via a strengthened Learning from Deaths Mortality Group which will meet monthly.
- Introduce the Medical Examiner role at the Princess Royal Hospital

**How will progress be monitored and reported?**

- Progress in relation to the improvements in the Mortality Review Process will be monitored and reported via the newly re-structured monthly "Learning from Deaths Mortality Group".
- A quarterly report will be submitted to the Quality Operational Committee and then the Quality and Safety Assurance Committee to provide assurance in relation to achievements against the measures and actions being undertaken
- The Trust will continue to keep its stakeholders informed in relation to its mortality review process, progress and the shared learning throughout the year by providing a quarterly update to the commissioners

### Quality Priority 5: Improving Compliance with National Institute for Health and Care Excellence (NICE) Guidance

This is a new priority for 2019/20. NICE guidelines are evidence-based recommendations for health and care in England. They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings. NICE guidance helps the Shrewsbury and Telford Hospital NHS Trust staff to standardise and

clarify care and improve efficiency, productivity, and safety. Confirmation that the National Institute for Health and Care Excellence (NICE) guidance has been reviewed is therefore an important step in a process to confirm the quality of care and services across the Trust. Without this confirmation, the Trust does not have assurance that current practices are compliant or non-compliant with the current best evidence base and we are unable to make a decision on whether changes in practice are required.

To ensure compliance with NICE guidance the Trust has established processes in place in accordance with our NICE Policy. This includes circulating all new NICE guidance to relevant clinical staff at the time of publication, as well as timely completion of benchmark assessment templates for NICE guidelines, Quality Standards and Interventional Procedural Guidelines. The system for ensuring availability of drugs recommended within Technology Appraisal Guidelines within the mandatory time frames, via the Drugs and Therapeutics Committee will be on-going. In 2019/20, to further support this process of NICE Guidance Reviews during the COVID 19 pandemic, the Clinical Audit Team piloted the delivery of additional support to clinicians to facilitate the completion of benchmark assessment templates, this pilot was positively evaluated.

**The aim and objectives, including the measures/metrics:**

- Improve clinical practice and effectiveness through complying with relevant NICE Guidance.
- Increase the number of NICE guidance compliance reviews undertaken in line with agreed timescales by 20% responses received in 28 days).

**The planned activity to achieve this:**

- Review the Trust NICE guidance management process to ensure that this is robust in order to deliver the improvements required
- The current standard is that the Clinical Effectiveness Department receives a response to a request for review within 28 days.
- To further enable the process of NICE Guidance Reviews, continue the provision of additional support to clinicians by the Clinical Audit Team to facilitate the completion of benchmark assessment templates during 2020-21.
- Relevant NICE guidance to continue to be added to the clinical audit forward plan, to ensure that case notes audits are carried out to provide on-going assurance in this area.

**How will progress be monitored and reported?**

- Regular NICE updates will be included in the agenda for Speciality and Care Group Clinical Governance Meetings, to ensure that outstanding issues are outlined, and leads identified to action these to ensure timely review and implementation.

- A quarterly report will be submitted to the Quality Operational Committee and then the Quality and Safety Assurance Committee to review achievements against the measures and the required actions to be undertaken
- The Trust will continue to keep its stakeholders informed by sharing information on progress throughout the year by providing a quarterly update to the commissioners on performance against the indicators at the Clinical Quality Review Meetings.

### Quality Priority 6: Focus on Referral to Treatment Times on the Cancer Pathways.

Shorter cancer waiting times can lead to earlier diagnosis, faster treatment, a lower risk of complications, an enhanced patient experience and improved cancer pathways. The 62 day cancer standard is from referral from a GP through to first definitive treatment. Whilst the Shrewsbury and Telford Hospital NHS Trust saw a small improvement in 2019/20 compared to the previous year's performance for the cancer target, performance remains significantly below the national target of 85%. A failure to achieve the national target is a pattern displayed across the region as capacity often struggles to meet demand and some cancer pathways have become more complicated in some specialities. Achievement of the national cancer waiting times (CWT) standards is considered by our Trust, the NHS, patients and the public to be an indicator of the quality of cancer diagnosis, treatment and care NHS organisations deliver. Improving our performance for the referral to treatment time for cancer pathways and therefore the quality of care for our patients is also a key priority for the Trust for 2020/21.

There was a clear impact on referrals in the early period of the pandemic but an increase in referrals to all specialities is expected as the Trust alongside the NHS continues with the restoration and recovery of services.

**The aim and objectives, including the measures/metrics:**

- To improve performance in line with national performance (85%) and maintain this performance against this standard
- Improve patient experience and outcomes through timely diagnosis and treatment standards being achieved

**The planned activity to achieve this in 2020/21:**

In order to improve and maintain performance against this standard, the following actions are being implemented:

- Appointment of Pathway Programme Managers in some cancer specialities including Breast, Colorectal, Gynaecology, Head and Neck, Upper GI and Urology to improve pathway timeliness
- To improve patient experience and ensure a smooth transition through the pathway, introduce Cancer Care Navigators
- Reducing the number of steps in the cancer pathway by increasing access to more one stop clinics, straight to test.
- Reduce time to first appointment. The earlier in the pathway a patient receives their first appointment, the less probability of breaching the 62-day standard.
- The Faster Diagnosis Standard will ensure that all patients who are referred for the investigation of suspected cancer find out, within 28 days, if they do or do not have a cancer diagnosis.

**How will progress be monitored and reported?**

- Performance against the 62 day standard will continue to be monitored on a weekly basis at the Cancer Performance and Assurance Meeting
- Performance is monitored at a system level at the System Planned Care Working Group.

**The Experience of patients**

Quality of care includes quality of the caring. This means how personal care is, the compassion, dignity and respect with which patients are treated. This can only be improved by analysing and understanding patient satisfaction from their own perspective of their experiences. Improving the experience of the patients and their loved ones cared for at the Shrewsbury and Telford Hospital NHS Trust is a key priority for us, we have therefore identified 3 key patient experience quality priorities for 2020/21.

## Quality Priority 7: Patient Experience and Community Engagement

Ensuring that each and every one of our patients receive high quality care and have a positive experience of the care received in our hospitals is a key priority for the Trust. To do

this, we must provide care that is responsive to individual patient preferences, needs and values. Obtaining insight into patients' experience and receiving feedback on both what was done well and what could be improved is critical to ensuring a high-quality, person centred service is provided to every patient who accesses services within the Trust. In 2020/21 improving the experience of our patients and increasing community engagement has been identified as a key priority for 2020/21.

The Trust works with a range of patient representative groups such as the Patient and Carer Experience (PaCE) Panel, Equality, Diversity and Inclusivity Community Advocates Group, local partner organisations and stakeholders who provide a voice of their lived experiences and help us to further understand individual needs, with the aim of improving accessibility and service equity.

**The aim and objectives in relation to improving the patient experience include**:

- To embed patient experience at every level and within every service within the organisation, enhancing overall patient experience
- Increase the opportunities available for patients, people close to them and carers to provide feedback on their experience and share how this is used to support improvement.
- Increase the Friends and Family Test (FFT) response rate for ED, Inpatients and Maternity by 20% compared to the response rates for 2019/20.

These priorities are fundamental in ensuring that the patient voice is heard and feedback is responded to. The priorities are a baseline and will support additional work streams within the Trust to facilitate the delivery of an improved patient experience.

**The planned activities to embed patient experience within the Trust will include:**

- Promote patient experience and engagement opportunities in the Care Groups through development of Care Group Patient Experience Groups
- Incorporate patient and staff stories into staff training
- Closer working and synergy between the Patient Experience Team and Complaints/PALS team to provide robust oversight of all of the patient experience
- Introduce quarterly local Inpatient surveys and Emergency Departments
- Increase accessibility to the Friends and Family Test (FFT) with availability in a variety of formats
- Support the introduction of focus groups to obtain feedback from people accessing services

**How will progress be monitored and reported:**

- Progress on patient experience improvements will be monitored and reported through the Care Group Patient Experience Groups and the Patient and Carer Experience Panel
- A combined Trust Complaints/PALS and Patient Experience Report will provide a robust overview of patient experience across the Trust and report quarterly to the Patient and Carer Experience Panel, Quality Operational Committee and the Quality and Safety Assurance Committee.
- FFT response rates by clinical area will be reviewed at the monthly nursing metrics meetings chaired by the Director of Nursing
- The published feedback on the Trust website sharing actions which have been taken in response to feedback

## Quality Priority 8: Responsiveness and Learning from Complaints

The Shrewsbury and Telford Hospital NHS Trust sees feedback from complaints as an important part of helping us to learn how to improve the quality of people's experience, improve safety, effectiveness and outcomes through the lessons learned from complaints.

The efficient and effective handling of complaints by the Trust matters to the people who have taken the time to raise their concerns with us. They deserve an appropriate apology for their experience alongside a recognition where care fell short of the standards expected and assurance that we will put actions in place to ensure other patients are not affected by a reoccurrence of the same concerns. Alongside this, it is important that complaints are managed in a timely and sensitive way to minimise the negative impact on the people involved.

A key objective of the Trust, and one we need to do better at, is to learn, change, improve and evolve in response to complaints. The lessons learned and trends identified through monitoring data collected through complaints plays a key role in improving the quality of care received by patients and their experience. The Trust has identified that improving the timelines of our responses to complainants and embedding learning from complaints as a key priority for 2020/2021.

**The aim and objectives, including the measures/metrics**

- Improve the timeliness of our responses to patient complaints, ensuring that patients receive a response to their complaint within the agreed timescales, with at least 85% of complaints responses completed within the agreed timescale
- Reduce the number of formal complaints by 10%
- Embed learning from complaints at Care Group and Trust-wide level

**The Planned Activities to Achieve this:**

- Develop a system for tracking the implementation of actions arising from complaints investigations and embedding of changes as a result of learning from complaints.
- Introduction of the Medical examiner role at the Princess Royal Hospital
- Implement an agile PALS service within the Women's and Children's Care Group
- Provide training to staff who are allocated to undertake complaints investigations
- Embed learning from complaints is embedded into the Care Group Governance structures
- Implement a new process of review and sign off of complaints by the Care Group Senior Leadership Triumvirate prior to Executive approval to ensure Care Group oversight and ownership

**How will progress be monitored and reported?**

- Complaints feedback at Care Group Governance Meetings
- Quarterly complaints report to Quality Operational Committee and Quality and Safety Assurance Committee
- Share progress being made and the learning shared from complaints with our commissioners through regular reports

## Quality Priority 9: Improving the Effectiveness of the Transitional Care from Children to Adult Services

Adolescents aged between 10 and 20 years make up 13–15% of the UK population, a similar proportion to the under 10s. While young people are generally perceived to be healthy, data shows that the adolescent years are associated with significant morbidity and mortality. The prevalence of chronic illnesses, such as asthma, diabetes (types 1 and 2), and obesity has increased, as has the burden of other chronic conditions in adolescence, such as cystic fibrosis, inflammatory bowel disease, chronic arthritis, metabolic diseases, and neuromuscular disorders. In England, it is estimated that there are more than 40,000 children and young people (aged 0-18) living with a life-threatening illness. The life-limiting or life-threatening category of illnesses includes more than 300 different conditions.

The Care Quality Commission National review in June 2014, "From Pond to Sea: Children's transition to adult health services" identified:

1. Identified significant shortfall between policy and practice of transition.
2. The system was found to be fragmented, confusing, sometimes frightening and desperately difficult to navigate.
3. Planning often started late, which sometimes delayed decisions and caused gaps in care. Health assessments were often out of date and there was a lack of regular review. There were often no transition plans at all; where they did exist they were of variable quality.

In 2016, NICE published its guideline: “Transition from children’s to adult’s services for young people using health or social care services; setting standards for health and social care providers”. (Nice.org.uk/guidance/ng43). Within paediatrics, there are certain agreed principles such as an accompanying adult during appointments, the opportunity for a carer to be resident during admissions and additional support to help navigate healthcare services which often end when the child reaches 16 years of age. The experience of young people transitioning to adult services is often variable.

Transition is now a key quality issue for paediatric services for two main reasons. Firstly, increased survival of children with complex or congenital conditions has produced cohorts of adolescents and young adults with diseases previously unseen by adult services. Secondly, and perhaps most importantly, poorly planned transition can be associated with increased risk of non-adherence to treatment and of lack of follow-up, with subsequent measurable adverse consequences in terms of morbidity and mortality as well as in social and educational outcomes.

Ensuring a safe and effective transition of young people with chronic illness and disability from paediatric care to adult health services is therefore a key quality priority for the Trust. Effective transition process requires a whole trust approach. This requires appropriate clinical engagement across the Trust in all Clinical Care groups to work alongside paediatrics focusing upon making transitional planning for all children effective. In order to achieve this there are 3 key elements which the Trust must ensure are in place to enable every child to make this transition in care in a seamless way. Firstly, a cultural shift in staff attitudes is required supported by training. Secondly, systems must change to ensure that all paediatric chronic illness and disability services have effective transition programmes to adult care in place. Thirdly, young patients need to be trained and empowered to allow them to be an effective partner in their own transition.

**The key actions in relation to this priority include:**

- A specialist nurse leading on paediatrics to adult transition be appointed at the Trust
- Clinical leads be identified in each of the relevant Clinical Care groups to drive the transitional Care agenda forward across the Trust
- Undertake a review to identify the number of children for each identified services that are in the 13-19 age range, including Diabetes, Epilepsy and asthma as well as those children with complex needs and/or children that have their first or an ad hoc encounter with healthcare during the 13-19 age range. This will enable these children to have their journey into adult services mapped
- The development and Implementation of a Trust-wide Transition of Young People to Adult Services Policy

**The aim and objective(s) (including the measures/metrics)**

- The aim of this priority is to ensure that as many children as possible have a seamless transition from children to adult services. The proposed activities to achieve this will vary depending on the pathway
- Where national recommendations are available, the Shrewsbury and Telford Hospitals NHS Trust should aim to meet these national recommendations. This may not be achievable in the first year but a measure of the Trust's progress against these recommendation should be undertaken

**The Planned Activities to Achieve this:**

- Implementation of a "Ready, Steady, Go" transition programme which commences for all children with a chronic long term condition at the age of 14
- The Trust will offer a staged approach to transition at different ages dependent on the feelings and wishes of the you person and appropriate to their underlying medical condition
- Development of metrics/audit to monitor the progress of children who transition into adult services
- Transition Care Task and Finish group to be established by Transitional care specialist nurse once appointed
- Links to be established and developed with the Regional Nurse Advisor for Young People's Healthcare and Transition within Burdett National Transition Nursing Network
- To include transition as a key priority on the Trust wide Paediatric Stakeholder Group to ensure engagement across the Trust and support and provide a forum for actions spanning across Care Groups to be discussed and monitored

**How will progress be monitored and reported?**

- Baseline data to be obtained where this is available on number of children by age range in key specialities
- Pathways in place for transition in key services
- Progress with this improvement priority to be reported through the Paediatric Stakeholders Group

## 3.0 Other Information Relevant to the Quality of Care

## 3.1 Performance against the Relevant Indicators and Performance Thresholds

The Shrewsbury and Telford Hospital NHS Trust aims to meet all national targets and priorities. All Trusts report performance to NHS Improvement (NHSI) against a limited set of

national measures of access and outcome to facilitate assessment of their governance. As part of this Quality Account, we have reported on the following national indictors.

| Performance against the NHS Oversight Framework | | | | | |
|---|---|---|---|---|---|
| | **2019/20** | **Improvement Threshold 2019/20** | **2018/19** | **2017/18** | **2016/17** |
| Maximum time of 18 weeks from referral to treatment in aggregate- patients on an incomplete pathway | 75.73% | 92% | 89.25% | 91.31% | 85.82% |
| All cancers- maximum 62 day wait for 1st treatment from urgent GP referral for suspected cancer | 73.34% | 85% | 70.85% | 89.5% | 86.82% |
| Maximum 6 week wait for diagnostic procedure | 77.57% | <=1% | 99.88% | 99.42% | 99.93% |
| A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge | 73.5% | 95% | 71.1% | 73.4% | 77.5% |
| Clostridium Difficile Variance from plan | Reported in Section 2.4 | | | | |
| Summary Hospital Level Mortality Indicator | Reported in Section 2.4 | | | | |
| Venous Thromboembolism (VTE) Risk Assessment | Reported in Section 2.4 | | | | |

**Emergency Department 4 hour Wait**

There were significant challenges throughout 2019/20 in providing timely care in the Emergency Departments at the Shrewsbury and Telford Hospital NHS Trust. The Trust has not met the target to treat and discharge a minimum of 95% of patients within four hours. Despite the high numbers of patients in the Emergency Departments at any time we have strived to deliver a consistent, high standard of care with the two Emergency Departments implementing new quality initiatives aimed at improving care and performance in the Departments as part of the Emergency Care Improvement Plans.

In Winter 2019/20, as with other acute trusts, the Shrewsbury and Telford Hospital NHS Trust experienced compromised emergency care performance and high levels of bed

occupancy, with a deficit in the beds required against the bed capacity. Winter planning will review patient pathways across the health economy for 2020/21.

The Trust continues to work with its partners across the health economy and with the support of the NHSi/E Emergency Care Intensive Support Team (ECIST) to improve our performance, the quality and experience of care provided in the Emergency Departments and throughout the hospital to ensure we have efficient plans in place to improve bed occupancy and facilitate flow.

**Referral to Treatment Time (RTT)**

The Referral to Treatment Time standard measures the percentage of patients actively waiting for treatment, the Shrewsbury and Telford Hospital NHS Trust did not achieve the RTT standard in 2019/20.

The increased emergency demand over winter and the changes in national pension contribution resulting in a reduction in non-contracted sessions resulted in reduced capacity across the Trust. This remains a key quality standard nationally and remains a priority for the Trust in 2020/21 but there will be a significant impact on elective activity as a result of the COVID-19 pandemic.

**All Cancers: 62 day wait for 1st treatment from urgent GP referral for suspected cancer**

Performance against this target improved in 2019/20 compared to the previous year but remains below the national target. There are national challenges associated with the urology cancer pathway capacity, oncology staffing and robotic surgery provision. The Trust continues to work with its partners across the region to ensure patients are treated in a timely manner. This is a trust priority for 2020/2021 and the work being undertaken in relation to this is outlined in Section 2.2 of this report.

## 3.2 Other Quality Information

**National Patient Safety Alerts Compliance**

Patient safety alerts are issued via the Central Alerting System, a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and other organisations. NHS trusts who fail to comply with actions contained within patient safety alerts are reported in monthly data produced by NHS Improvement and published on the NHS Improvement website. Compliance rates are monitored by Clinical Commissioning Groups and the Care Quality Commission. Failure to comply with actions in a patient safety alert may compromise patient safety and lead to a red performance status on the NHS Choices website. The

publication of the data is designed to provide patients and carers with greater confidence that the NHS is proactive in managing patient safety and risks.

With the Shrewsbury and Telford Hospital NHS Trust there is a robust accountability structure to manage patient safety Alerts. The Medical Director and Director of Nursing oversee the management of all patient safety alerts and the Care Group Senior management team take an active role in the management of these alerts within their services. Any alerts which fail to close within the specific deadline are reported to the Quality Operational Committee with an explanation as to why the deadline was missed and revised timescale for completion.

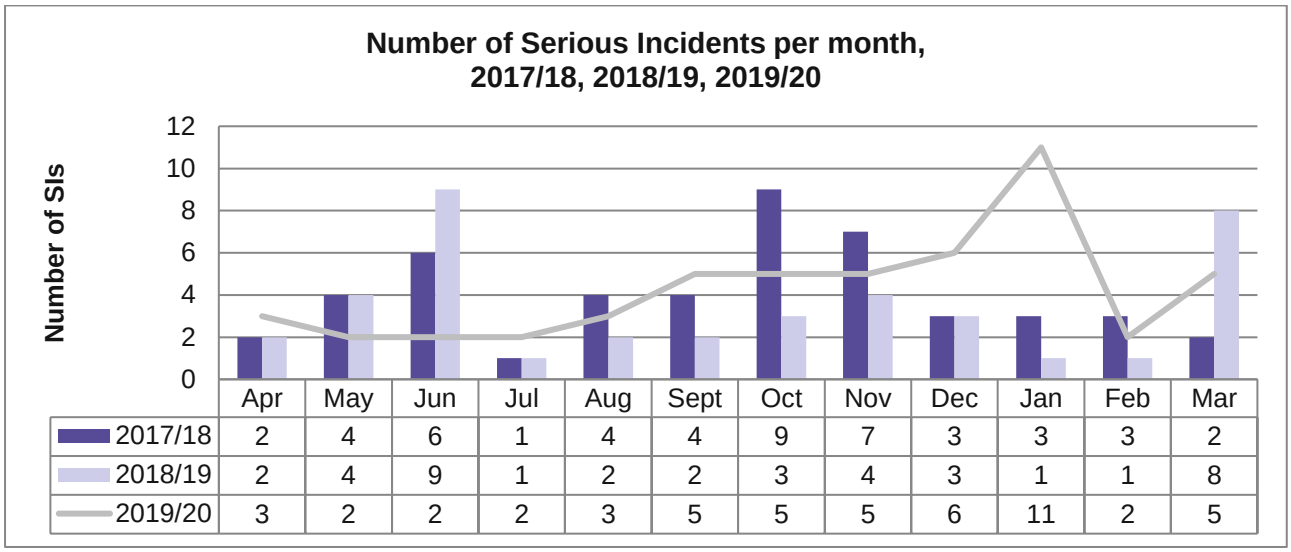
During 2019/2020 the Trust received five patient safety alerts. None breached their due date.

| Alert Identifier | Alert Title | Issue Date | Closure Target Date | Date Closed | Open/ Closed |
|---|---|---|---|---|---|
| NHS/PSA/RE/2019/002 | Assessment and management of babies who are accidentally dropped | 09/05/19 | 08/11/19 | 30/10/19 | Closed |
| NatPSA/2019/002/NHSP | Risk of death and severe harm from ingesting superabsorbent polymer gel granules | 28/11/19 | 01/06/19 | 29/05/20 | Closed |
| NATPSA/2019/003/NHSP | Risk of harm to babies and children from coin/button batteries in hearing aids | 13/12/19 | 11/09/20 | 22/07/20 | Closed |
| NATPSA/2020/001/NHSPS | Ligature and ligature point risk assessment tools and policies | 04/03/20 | 03/06/20 | 03/06/20 | Closed |

**Serious Incidents**

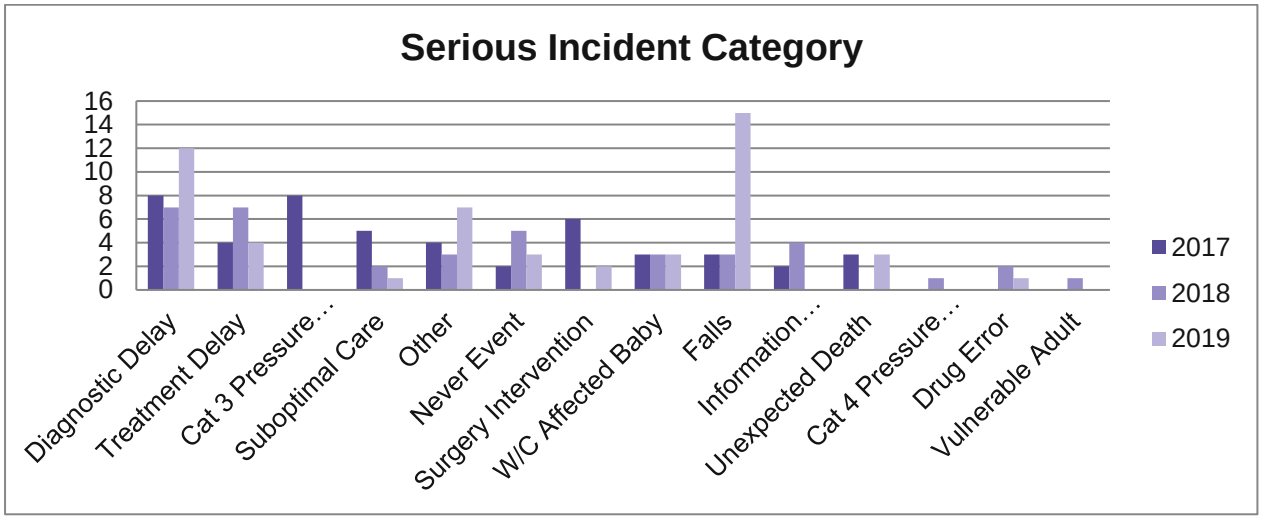
All patient safety incidents are reported on the hospital electronic risk management system (Datix). All patient safety incidents are reported, monitored and reviewed to identify learning that will help prevent reoccurrence. During 2019/2020 the Trust saw an increase in the number of incidents reported compared to previous years, this may demonstrate that staff has increased confidence to report incidents and concerns. In 2019/20 we were in the top quartile of reporting organisations as measured by the National Reporting and Learning System data.

In September 2019 a new Executive Serious Incident Review Group (ESIRG) was instigated. Chaired by the Medical Director this multidisciplinary group meets weekly to review all incidents which potentially meet the threshold for an SI or Never Event and make the decision in relation to the level of investigation and the reporting of the incident as a SI.




| | Apr | May | Jun | Jul | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/18 | 2 | 4 | 6 | 1 | 4 | 4 | 9 | 7 | 3 | 3 | 3 | 2 |
| 2018/19 | 2 | 4 | 9 | 1 | 2 | 2 | 3 | 4 | 3 | 1 | 1 | 8 |
| 2019/20 | 3 | 2 | 2 | 2 | 3 | 5 | 5 | 5 | 6 | 11 | 2 | 5 |

In September, the ESIRG made the decision that all falls resulting in significant harm such as a fractured neck of femur or head injury should be reported and investigated as Serious Incidents, this resulting in an increase in the Sis reported for the 3rd and 4th Quarter of 2019/20. The incidents reported as Serious Incidents (SIs) are monitored via the Quality Governance report to the Quality Operational Committee and Quality and Safety Assurance Committee and reported to Board as part of the Integrated Performance Report. In 2019/2020 the Trust saw an increase in the number of incidents reported as Serious Incidents, with 51 SIs reported compared to 40 in 2018/19 and 48 in 2017/18.




**Never Events 2019/2020**

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In 2019/2020 the

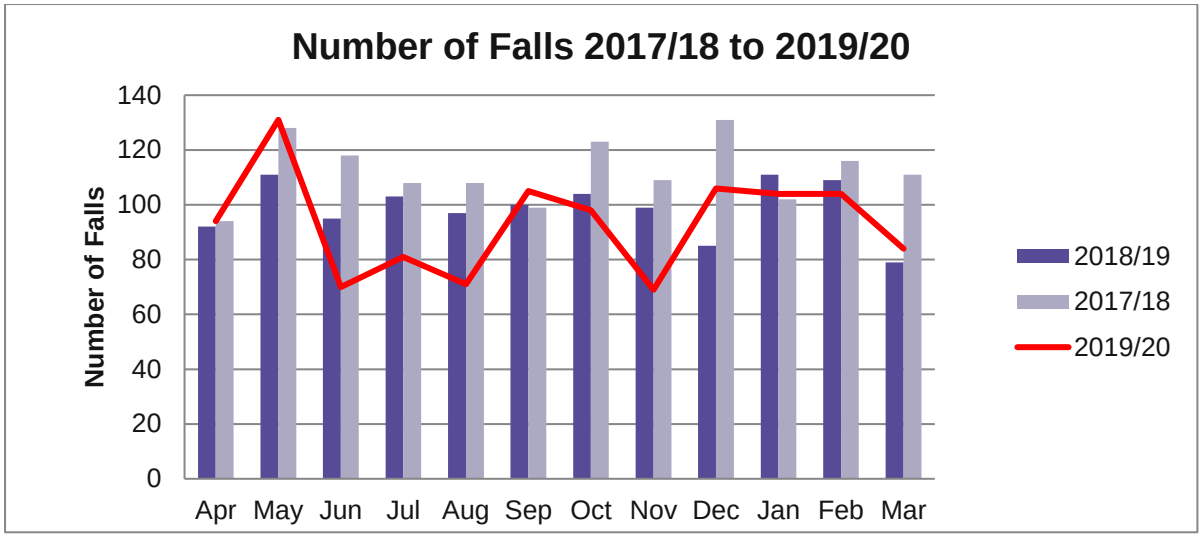
Shrewsbury and Telford Hospital NHS Trust had 3 incidents which met the definition of a Never Event. Thorough root cause analysis are undertaken for Never Events and robust action plans are developed to prevent similar occurrence.

The following table gives a description of the 3 incidents. Patients and families were informed of the investigation and kept informed throughout the investigation and offered the opportunity to discuss the investigation findings and recommendations

| **Never Event** | | | |
|---|---|---|---|
| SATH 2019/20 | National Average 2019/20 | Best Performing Trust 2019/20 | Worst Performing Trust 2019/20 |
| 3 | 1 | 1 | 7 |
| **Date** | **Description of Never Events 2019/20 at SATH** | | |
| November 2019 | Never Event - Wrong implant/prosthesis | | |
| December 2019 | Never Event - 2nd procedure on incorrect patient | | |
| January 2020 | Never Event - procedure on Incorrect patient | | |

**Falls Prevention**

Falls amongst inpatients are the most frequently reported safety incident in NHS hospitals. Approximately 30-50% of falls result in some form of injury and fractures occur in 1 to 3% of incidents. No fall is harmless, for a patient who has a fall this can lead to a loss of confidence, delays in recovery and a prolonged hospitalisation. Reducing the number of patients who fall in our care and reducing the risk of harm associated with a fall is a key quality and safety issue and priority for improvement for the Trust.




| Falls | 2017/2018 | 2018/2019 | 2019/2020 |
|---|---|---|---|
| Total Number of Falls | 1347 | 1185 | 1117 |
| Falls per 1000 bed days | 5.08 | 4.62 | 4.02 |
| Falls per 1000 bed days resulting in moderate harm or above | 0.08 | 0.09 | 0.11 |

There has been a reduction in the number of falls and the ratio of falls per 1000 bed days year on year since 2017. The Trust saw a 5.7% reduction in the overall number of falls in 2019/20 compared to the previous year. There has been a small increase in the number of falls resulting in moderate harm or above.

All falls which result in significant harm are raised as a serious incident and a full root cause analysis investigation is carried out. Common themes from these investigations have included: falls risk assessments not consistently completed on admission to hospital, on transfer to another ward or when the patient's condition changes, lack of falls prevention care planning, and lack of enhanced patient supervision. I

Following a review of the falls investigations, taking the themes and learning from these we have commenced our programme of improvement to reduce inpatient falls across the adult inpatient wards.

In 2020/2021 we aim to:

- Ensure ALL patients have a falls risk assessment completed on admission, on transfer to another ward or if their condition changes
- Ensure every patient who falls has a "Post Falls Care Chart" completed and the Falls risk assessment repeated
- Ensure the Trust has the correct equipment to help reduce the risk of a patient fall
- Ensure patients are educated about the risk of falls

- Embed the principles of “cohorting” (patients at high risk of a fall cared for in a ward bay providing greater visibility and “tagging (when a nurse/HCA is allocated to always stay in the ward bay with the patients)
- Ensure staff have the knowledge and skills to assess, plan , implement and evaluate the care for patients who are at risk of falls
- Embed a culture of learning from falls incidents

We will achieve this through:

- Implement a new multifactorial Falls Risk Assessment and Falls Prevention Care Plan across all adult inpatient wards
- Develop a Post Falls Check List to be completed by staff following a fall and inserted into patient’s notes.
- Deliver the Fallsafe training programme to staff on all adult inpatient areas and the emergency departments
- Roll-out a Falls Information Leaflet for Patients
- Pilot the use of falls equipment, Sensor Mats for our High Risk areas
- Revise our Trust Falls Policy and develop a Falls Prevention Strategy

We will monitor the delivery of these improvements and the outcomes through the matron’s quality assurance metrics audits which will be undertaken monthly in each clinical area and reported through to the Nursing Quality Assurance meeting, the Falls Steering Group and reporting monthly to the Quality and Safety Assurance Meeting.

## Patient Complaints Service and Patient Advice and Liaison Service (PALS)

Between April 2019 and March 2020 the Shrewsbury and Telford NHS Trust received In 2019/20 the Trust received 762 formal complaints, a 12% increase from 2018/19.

| Year | Number of Complaints | Number of PALS Contacts |
|---|---|---|
| 2017/2018 | 600 | 1491 |
| 2018/2019 | 680 | 1545 |
| 2019/2020 | 762 | 1951 |

The main area of concern raised in complaints relates to communication, with the main issues in this area being communication with families and patients receiving conflicting information. The second biggest area is around clinical treatment, with the main issues relating to delays in diagnosis, misdiagnosis and delays in treatment.

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. To assist with this, all staff asked to comment on a complaint, are asked to

consider what learning has arisen from the complaint and what actions are needed to implement that learning. 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. To assist with this, all staff asked to comment on a complaint, are asked to consider what learning has arisen from the complaint and what actions are needed to implement that learning. Learning from complaints is also discussed at Care Board meetings, and at ward and departmental meetings.

Some examples of learning and changes in practice that have arisen from complaints are set out below:

- A patient raised concerns that drinks were left out of reach, 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 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 consultation. She has changed her approach to history-taking and has carried out research to understand better the various conditions that increase pain during internal examination.

Of the 661 complaints closed in 2019/20, 22% (144) were upheld, 58% (385) were partially upheld and 20% (132) were not upheld. Performance in relation to patients receiving a response to their concerns within the agreed timescales in 2019/20 was between 65 to 70%. In addition, in 2019/20, six cases were referred to the Parliamentary and Health Service Ombudsman (PHSO). The PHSO concluded four investigations; one of these was not upheld and three were partially upheld.

**Pressure Ulcers**

The Shrewsbury and Telford Hospital NHS Trust has seen a year on year reduction in the category 3 and 4 pressure ulcers. In 2019/20 there was an overall rise in pressure ulcers compared to the previous year due to an increase in the number of hospital acquired category 2 pressure ulcers.

| Hospital Acquired Pressure Ulcers | 2019/20 | 2018/19 | 2017/18 |
|---|---|---|---|
| Category 2 | 195 | 146 | 206 |
| Category 3 | 10 | 34 | 31 |
| Category 4 | 1 | 2 | 1 |
| **Total** | **206** | **182** | **238** |

Eliminating hospital acquired category 3 and 4 pressure ulcers remains a key quality improvement for the Trust alongside reducing the number of hospital acquired category 2 pressure ulcers. Several improvements were initiated in 2019/20 aimed at improving the care of pressure ulcers and the learning from cases of hospital acquired pressure ulcers. These included:

- The introduction of the Tissue Viability Leading Change Annual Competency Programme for link workers
- Bespoke training for Maternity and the Emergency Department
- Introduction of “Pressure Ulcer Prevention” training days over the year
- Wound management pathways available on Tissue Viability intranet page
- The establishment of a Root Cause Analysis Pressure Ulcer Panel for all category 3 and above pressure ulcers, attended by senior nurses, matrons and ward managers. This enables greater scrutiny and challenges as well as facilitating learning across the clinical areas.

Ongoing themes from the completed RCAs for hospital acquired pressure ulcers in 2019/20 include incomplete assessment and documentation (33%) and lack of care planning (17%). In 2020/21 we will continue improvements in relation to pressure ulcer prevention to include:

- Extend Root Cause Analysis Pressure Ulcer Panel to include category 2 pressure ulcers to ensure thorough investigation and learning from all hospital acquired pressure ulcers
- Introduction of a new skin assessment, pressure ulcer prevention and wound care booklet
- Ensure all patients have a Waterlow risk assessment completed within 6 hours of admission (NICE 2015) and a pressure ulcer care plan in place. Ongoing monitoring of risk assessments and care planning via the matrons assurance audits and exemplar baseline review programme for clinical areas

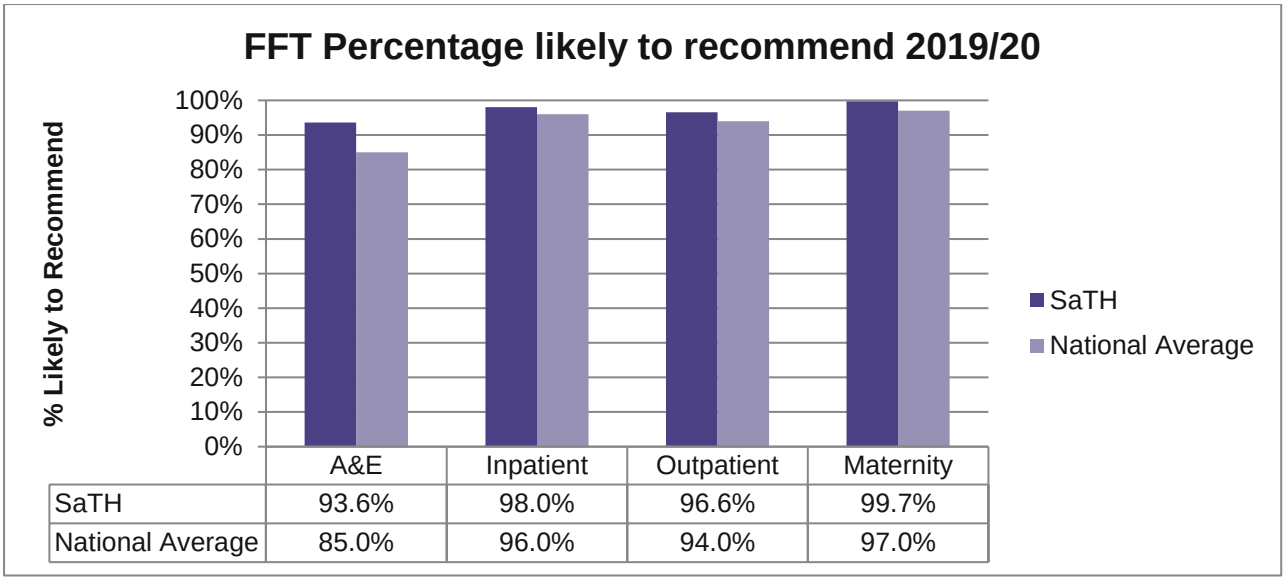
**Friends and Family Test**

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

A national standardised question is asked;

‘***How likely are you to recommend our ward (or department) to friends and family if they need similar care or treatment?***’

A total of 43,094 Friends and Family Test cards were completed and returned during 2019/20. The response rate increased on the previous year by 1.4% for inpatient areas and by 16.8% in Maternity (birth only). Within A&E the response rate decreased in comparison to the previous year by 5.5%. The Trust performed higher than the national average for Maternity (birth only) responses however the inpatient and A&E response rate were both lower than the national average. The Trust presently use paper based forms and volunteers to collect FFT feedback and do not have a text messaging facility to support FFT collection. It has been demonstrated that Trusts which use digital feedback systems have a higher response rate, which should be considered when comparing to national data.




| | A&E | Inpatient | Outpatient | Maternity |
|---|---|---|---|---|
| SaTH | 93.6% | 98.0% | 96.6% | 99.7% |
| National Average | 85.0% | 96.0% | 94.0% | 97.0% |

Of the cards completed, 97.1% of respondents said they would be “extremely likely” or “likely” to recommend the Trust’s services to their family and friends. The Trust performed higher than the national average in all categories; Inpatient, Outpatient, A&E and Maternity (April 2019 – February 2020 available comparison data).

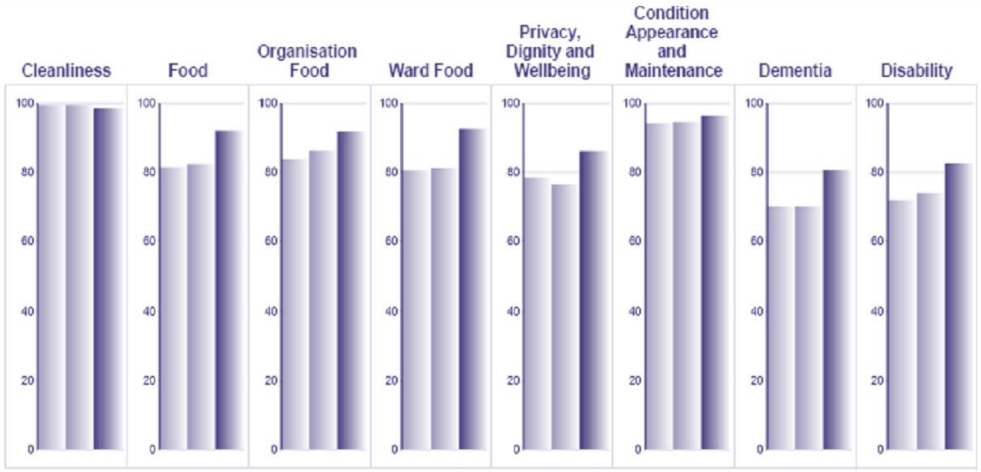
**Patient Led Assessment of the Care Environment (PLACE)**

Patient Led Assessment of Care Environment (PLACE) reviews are an annual appraisal of the non-clinical aspects of NHS and independent healthcare settings, undertaken by teams made up of staff and members of the public (known as Patient Assessors). They provide a framework for assessing quality against common guidelines and standards in order to quantify the environment's cleanliness, maintenance and condition, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or disabilities.

PLACE Assessments were undertaken throughout September 2019. The Patient Assessors were recruited from the Trust’s Patient and Carer’s Experience (PACE) and graduates of the People’s Academy, which gave a good, diverse group of assessors. The Patient Assessors were trained before the assessments and were given complete choice on the areas they wanted to assess.

The scores achieved for both the Royal Shrewsbury Hospital and the Princess Royal Hospital for each domain can be seen in the graphs; these also show the Trust average and the national average.

**ROYAL SHREWSBURY HOSPITAL- Collection: 2019**




| | Cleanliness | Food | Organisation Food | Ward Food | Privacy, Dignity and Wellbeing | Condition Appearance and Maintenance | Dementia | Disability |
|---|---|---|---|---|---|---|---|---|
| Achieved Score (Actual) | 1848.0000 | 262.5000 | 75.5000 | 187.0000 | 364.0000 | 693.0000 | 514.5000 | 351.5000 |
| Available Score (Actual) | 1856.0000 | 322.0000 | 90.0000 | 232.0000 | 464.0000 | 736.0000 | 734.0000 | 488.0000 |
| Site Score | 99.57% | 81.52% | 83.89% | 80.60% | 78.45% | 94.16% | 70.10% | 72.03% |
| Organisation Average | 99.60% | 82.34% | 86.26% | 81.22% | 76.58% | 94.66% | 70.11% | 73.98% |
| National Average | 98.60% | 92.19% | 91.92% | 92.62% | 86.09% | 96.44% | 80.70% | 82.52% |

**PRINCESS ROYAL HOSPITAL- Collection: 2019**


| | Cleanliness | Food | Organisation Food | Ward Food | Privacy, Dignity and Wellbeing | Condition Appearance and Maintenance | Dementia | Disability |
|---|---|---|---|---|---|---|---|---|
| Achieved Score (Actual) | 2160.0000 | 398.1667 | 80.1667 | 318.0000 | 398.6667 | 804.0000 | 510.5000 | 387.5000 |
| Available Score (Actual) | 2168.0000 | 478.0000 | 90.0000 | 388.0000 | 536.0000 | 844.0000 | 728.0000 | 508.0000 |
| Site Score | 99.63% | 83.30% | 89.07% | 81.96% | 74.38% | 95.26% | 70.12% | 76.28% |
| Organisation Average | 99.60% | 82.34% | 86.26% | 81.22% | 76.58% | 94.66% | 70.11% | 73.98% |
| National Average | 98.60% | 92.19% | 91.92% | 92.62% | 86.09% | 96.44% | 80.70% | 82.52% |

The organisation average score for Cleanliness in 2019/2020 PLACE assessments was 99.60% against a national average of 98.60%.

The organisation average score for food tasting, food organisation and ward food were all below the national average for the 2019/2020 PLACE assessment. The organisation average score for Ward Food this year was 81.22%; this had declined from the previous year and was below the national average of 92.62%.

Improvement Actions Taken:

- A new food service is being implemented at the Royal Shrewsbury Hospital, similar to the system implemented at the Princess Royal Hospital. This will address the temperature issues as meals will be kept in a heated trolley. This is being implemented in September 2020
- Products that were poorly rated have been replaced
- A new menu at both Hospitals is being introduced in September 2020
- The Catering Management Team have set up regular food tasting sessions involving Patient Representatives so that they can ensure that the standard is maintained and any issues can be addressed.
- Questions relating to patient food have been included in the Matrons Quality Audits undertaken monthly on all Adult wards

The organisation average score for Privacy, Dignity and Wellbeing this year was 76.58% against a national average of 86.09%. The poorer scores were reflected by the hospital buildings which included a lack of day rooms, separate treatment rooms on the wards and no private rooms on the wards to have private conversations with patients.

The organisation average score for Dementia this year was 70.11%, this was an improvement for the 2018/19 score of 67.51% but lower that the national average of 80.70%. This related to the clinical areas often not meeting the Dementia Friendly Standards such as toilet doors in a single distinctive colour which is a contrast to the walls, colours not being used to enhance patients orientation, toilet seats that were not in contrasting colours, lack of toilet and bathroom pictorial signage.

The PLACE disability average score in 2019/20 was 73.98%; whilst this was similar to last year it remains below the national average of 82.52%. Many of the disability requirements are similar to the dementia areas for improvement including bathroom / toilet facilities needing to be improved for access including more suitable pop up bins, signage and where there is no natural light the clinical areas should have brighter and bigger lighting and paint walls a brighter colour.

The improvement actions required have been collated and prioritised as part of a task and finish group with members of PACE Group and relevant Trust Manager.

# Annex 1: Statements from external organisations

1. HealthWatch Shropshire
2. HealthWatch Telford and Wrekin
3. Shropshire, Telford & Wrekin Clinical Commissioning Group
4. Powys Teaching Health Board

## 1. Healthwatch Shropshire response to the draft SATH Quality Account 2019-20

Healthwatch Shropshire (HWS) welcomes the opportunity to comment on the Quality Account. We are pleased to see the inclusion of some of the suggestions we made in last years response. During 2019-20 we received more slightly more negative feedback (53%) about patient experiences at the Trust than positive (47%). The main themes of the negative feedback were general service delivery, communication between staff and patients and waiting times & lists for treatment. The main themes raised in the positive feedback were general service delivery, quality of staffing, quality of treatment and quality of care.

### Priorities 2019 - 20

### Emergency Department (ED)

HWS acknowledges the issues, particularly around staffing, that have continued to hamper the sought-after improvements in the time taken to see patients. The achievements in the two priorities around learning from incidents are encouraging and the re-prioritsation of sepsis for the coming year is welcomed.

### Maternity

While acknowledging the success in reducing the rate of smoking through pregnancy and the improvements in safety it would be helpful to see how the Maternity Improvement Plan has progressed since November 2019. Although not key quality priorities for 2020/21, the fact that both the implementation of the Saving Babies lives care bundle and the Maternity Improvement Plan both remain priorities in 2020/21 is welcomed.

### Improving the experience of staff

The improvement shown, although not meeting the target, reflects the welcomed slight overall improvement in the responses from staff to the Quality of Care questions in the National NHS staff survey after several years of decline. We look forward to further improvements in the areas highlighted, Safety Culture, Staff Engagement and Health and wellbeing.

### Patient Access to services

The reduction in stranded patients is welcomed from not only from the point of view of improving the flow of patients through the Emergency Department but also from that of the medically fit patients who spend less time in hospital with the risks that can entail.

### Infection Prevention and Control (IPC)

The aligning of IPC staff with individual ward areas seems to have made an impact in meeting the NHS Improvement rating of the Trust. It would be supported by comments we receive suggesting the need for an individual to be responsible for overseeing hygiene and cleanliness at ward level. We welcome the continued focus on IPC in the coming year's priorities especially given the rise in Clostridium difficile infection rates.

### Quality Indicators

### Learning from Deaths

We are very concerned to see that the number of deaths reviewed or investigated and judged "to be more likely than not to have been due to problems in care provided to the patient" rose to 58 from 5 in 2018-19 and 2 in 2017-18. There is no account given for this rise or of the learning that has been taken from these incidents, however it is encouraging to see that it will be a priority for next year.

### Mortality Indicators

Although the Trust performs 'as expected' in the Summary Hospital-Level Mortality Indicator the figures seem to show that it is below the national average for identifying patients, who subsequently die within 30 days of discharge, as needing Palliative care. This lack of recognition has been raised in feedback received by Healthwatch Shropshire.

### Patient Safety Incidents

Disappointingly the level of safety incidents has risen again compared with previous years but encouragingly the rate of increase has slowed. We welcome the focus for the coming year.

### Serious Incidents (SIs)

The number of SIs has increased to a three-year high. Following patient and family feedback to HWS we would like to see an indication of how patients and families are supported and communicated with through the process of the SI investigation.

### Falls Prevention

We hope the measures set out to reduce the number of falls will continue the encouraging decline in cases seen over the last 3 years and will help the Trust meet the three 'High Impact Actions to Prevent Hospital Falls CQUIN' (Commissioning for Quality and Innovation Payment Framework)

### Implementing the Priority Clinical Standards for 7 Days Services

It is accepted that the Trust still faces challenges to meet the national expectations of being fully compliant by March 2020 however it is difficult to judge how the Trust is performing

against these standards. We would like to see the inclusion of more detail as has been done in previous Quality Accounts.

### Patient Reported Outcome Measures

The improvement in these measures and the fact that the Trust is above the national average for health gains after hip and knee replacements is encouraging.

### The Percentage of Patients Readmitted to Hospital within 28 Days of Discharge

The Trust readmission rate for adults sits at the national average for adults but is higher than the national average for under 16s and continues the upward trend for the last 4 years. HWS has been working with the Trust and other health care partners to gather the experience of patients when being discharged from hospital to hopefully inform the process and help to reduce avoidable readmission to hospital.

### Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)

The Trust continues to run slightly below the national average for this measure but we are pleased to see the action plan set out and look forward to seeing the results of it's implementation.

### Rate of Clostridium Difficile

Although it is difficult to understand how much of the significant rise in the rate is due to changing definitions any rise is concerning and the focus on Infection Control and Prevention next year is welcome.

### Pressure Ulcers

The significant reduction in Category 3 pressure ulcers is promising but the significant increase overall is of concern. We look forward to seeing the outcomes of the extension of the Root Cause Analysis to cases of Category 2 pressure ulcers and the other measures being put in place.

### Encouraging Staff to Speak Up

The work of the Trust to encourage staff to speak up about concerns is supported. The number of concerns raised with Freedom to Speak UP guardians has increased from 70 in 2018-19 to 145 in 2019-20. This could be, as the Trust asserts, due to increased staff confidence in reporting concerns or it could be due to a higher incidence of events that cause concerns or a mixture of the two. It is noted that the staff survey figures for 2019 around the area of reporting concerns, while still below the national average, show an improvement on last year.

### Guardian of Safe Working (GSW)

The inclusion of the GSW in the Senior Medical Team, thus ensuring that issues around safe working are represented at the highest levels within the Trust, is welcomed.

### Percentage of Staff who would recommend the Trust to a Friends or Family needing Care

This figure has fallen sharply since 2016 and now sits well below the national average. The slight uplift this year is encouraging, we look forward to seeing this rise as the measures set out in the Quality Accounts take effect and reassure staff.

### The Trust Responsiveness to the Inpatients' Personal Needs

There were no indications in last year's Quality Accounts of actions that would be taken in face of the year on year decline in the indicator for this measure. It is encouraging to see that actions have been put in place, we would like to see more detail and an indication of how the further decline is to be addressed.

### Friends and family test

The results are encouraging and show patient satisfaction in the care they receive across the Trust is higher than the national average. Last year the Trust believed there were ways in which they could improve the response rate, this seems to have worked in some areas and not others.

### Patient Complaints Service and Patient Advice and Liaison Service

The main areas of concern identified reflect the main themes that are reported to HWS. With the increase in the number of complaints there appears to have been slight decrease in the proportion of patients receiving a response in the agreed timescale. From our experience of providing the Independent Health Complaints Service for Shropshire we can attest that not meeting agreed timescales prolongs the patient and family distress in what are often very difficult circumstances. Complainants appreciate being contacted in advance of the response date if the Trust know they will not be able to give a substantive respond in time, it is much more stressful for people when they are expecting a response and it doesn't come.

### Place based care

The improvement the Trust has achieved in the score it receives for the environment being able to support the care of those with dementia is to be welcomed however the score it receives for the environment being able to support the care of those with disabilities reduced slightly this year. Both these areas are below the national average and we look forward to further improvements. The fall in the score for ward food is quite dramatic, from 96.22% in 2018-19 to 81.22% in 2019-20, we hope that the measures identified will quickly bring the improvements needed for patients.

### Data Security and Protection Toolkit Attainment

In 2018-19 the Trust failed to meet four of the ten standards set out in the NHS Digital 'Data Security and Protection Toolkit' and were working with NHS Digital to improve performance. We hope that when the results from 2019-20 were submitted in September there were improvements.

We welcome the inclusion of a summary of the Information Governance breaches reported to the Information Commissioners office and hope this transparency will continue.

### Priorities 2020 – 21

Overall the choice of priorities for the coming year would be supported by the feedback we have received at Healthwatch Shropshire and they pick up on the significant quality issues described in this Quality Account. We are pleased to see a detailed explanation of the aims, how they will be achieved and how progress will be measured and monitored. We look forward to hearing how the Trust progresses against their targets.

**Lynn Cawley**
Chief Officer

healthwatch

## 2. HealthWatch Telford and Wrekin

My Apologies for the delay in replying to your email

Having read the document, we are impressed with the report and the tremendous amount of work staff at all levels have put into maintaining and improving the Quality of services provided.

From our perspective. It is reassuring to see the emphasis being placed improving those targets which have been highlighted by the CQC with support of the UHB team and others.

We welcome a further staff review being considered and this initiative should ensure Bank and Part time staff in involved the process. It is also pleasing to see that staff are being encourage to "Speak Out" in promoting cultural change within the Organisation.

The report highlights positive developments in engaging and Patient feedback. Together with collaboration with other stakeholders. Healthwatch Telford and Wrekin who have a Statutory role to engage with Patients and Service users are keen to support Sath in this work.

In Conclusion. It is important when commenting on the Quality report that we recognise the Herculean efforts of our colleagues in the Shropshire and Telford Hospitals are undertaking during these difficult time

Barry Parnaby
Interim Chair

Healthwatch Telford and Wrekin

## 3. Shropshire, Telford & Wrekin Clinical Commissioning Group

NHS Shropshire Clinical Commissioning Group

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*Tel:* 01743 277500

NHS Telford and Wrekin Clinical Commissioning Group

Halesfield 6
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Date: 25th November 2020

Shropshire, Telford & Wrekin CCG response to SaTH Quality Account 2019/20

Shropshire CCG acts as the coordinating commissioner working closely with Telford & Wrekin CCG for Shrewsbury and Telford Hospital NHS Trust (SATH). We welcome the opportunity to review and provide a statement for the Trusts Quality Accounts for 2019/20. Both CCGs remain committed to ensuring with partner organisations, that the services it commissions provide the highest of standard in respect to clinical quality, safety and patient experience.

In doing so, the Quality Account has been reviewed in light of key intelligence indicators and the assurances sought and given in the monthly Clinical Quality Review Meetings (CQRM) attended by commissioners. This evidence is triangulated with information and further informed through Quality Assurance visits to the Trust to gain assurance around the standards of care being provided for our population.

We recognise the work undertaken by the trust to improve the quality of patient care and patient experience through 2019/20 however the trust has highlighted a number of issues that continue to be a challenge

- There were significant challenges throughout 2019/20 in providing timely care in the Emergency Departments at the Shrewsbury and Telford Hospital NHS Trust. The Trust has not met the target to treat and discharge a minimum of 95% of patients within four hours. The Trust continues to work with its partners across the health economy and with the support of the NHSE/I Emergency Care Intensive Support Team (ECIST) to improve performance, the quality and experience of care provided in the Emergency Departments and throughout the hospital to ensure efficient plans in place to improve bed occupancy and facilitate flow.
- All Cancers: 62 day wait for 1st treatment from urgent GP referral for suspected cancer Performance against this target improved in 2019/20 compared to the previous year but remains below the national target. There are national challenges associated with the urology cancer pathway capacity, oncology staffing and robotic surgery provision. The Trust continues to work with its partners across the region to ensure patients are treated in a timely manner
- In 2019/2020 the Shrewsbury and Telford Hospital NHS Trust had 3 incidents which met the definition of a Never Event. Thorough root cause analysis are undertaken for Never Events and action plans are developed to prevent similar occurrence

Commissioners look forward to seeing further progress and with continued improvements in 2021/22

Whilst reviewing the Quality Account we were pleased to note many of the specific actions that the Trust has taken during 2019/2020 to improve its services and the quality of care that it provides. The Trust has worked hard to address key areas to improve patient safety and has continued to strengthen learning from incidents, complaints and feedback; however, the CCG's would like to commend the trust for the following key achievements achieved during 2019/2020:

- For achieving a reduction in the number of overdue incident responses.
- For strengthening the trust sepsis team capacity to help drive early recognition and management of sepsis at ward level and support a cultural shift across the organisation and contribute towards reducing the number of preventable deaths due to sepsis
- On-going work has continued across the Care Groups supported by the IPC team to ensure all issues identified from the most recent visit are addressed and that IPC standards are maintained, the most recent visit undertaken by NHSI in November 2019 rated the Trust as 'green'.
- Congratulations to the Radiotherapy and Physics team who were awarded 'Team of the Year' in the West Midlands Clinical Research Network annual awards, in recognition of the work and contribution they have made to cancer clinical research.

There are notable areas of success as well as areas that continue to require focus and improvement. 2020/21 will be a year that will bring further change and challenge for the Trust, as commissioners we believe that the Trust's values will drive forward the objectives

and they will continue to improve quality across the breadth of services we commission, their continuous improvement will benefit our patients in the care they receive.

Yours sincerely,

**Mrs Zena Young**

**Executive Director of Quality**

**NHS Shropshire and Telford & Wrekin CCG's**

## Feedback Form

We hope you have found the Quality Account useful.

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

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

**Return to:**

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