NHS
The Shrewsbury and Telford Hospital
NHS Trust

Quality Account

The Shrewsbury and Telford Hospital NHS Trust

2020/21

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

CONTENTS

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 (VTE)
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 2021-2022

Priority 1: Learning from Events and Developing a Safety Culture
Priority 2: The Deteriorating Patient
Priority 3: Inpatient Falls
Priority 4: Best clinical outcomes
Priority 5: Right care, right place, right time
Priority 6: Learning from experience
Priority 7: Vulnerable patients
Priority 8: End of life care

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

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 Hospital 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, as are Acute Stroke and Stroke rehabilitation services.

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 at Ludlow Hospital
- Community services including audiology, therapies and maternity services

Purpose of the Quality Account

All NHS Trusts are required to produce a Quality Account to provide information on the quality of the services provided to patients and their families. This is an important way for trusts to demonstrate how they are performing and identify areas for improvements taking into account the views of service users, carers, staff and the public. Due to the impact of COVID-19, the routine external auditor assurance of this year's Quality Account, has been suspended.

Statement on Quality from the Chief Executive Officer

Welcome to the Quality Account for The Shrewsbury and Telford Hospital NHS Trust for 2020/2021. 2020/21 has been an incredibly challenging year for the Trust and the COVID-19 pandemic, which continued throughout the year, saw the Trust almost double its intensive care capacity, the redeployment of many of our staff internally and the redeployment of staff from across the health economy into new roles to support the care of patients in our hospitals. Throughout, we worked hard to continue providing care for our patients, including transferring surgery and treatments to other NHS providers and private hospitals who had capacity to assist us, and transforming our outpatient appointments into telephone and video consultations.

Despite the challenges, we have made progress in improving services for our patients and local communities, so that they can receive the high quality, safe, individualised care they need.

The Trust has remained in special measures and rated as “inadequate” overall by the Care Quality Commission (CQC). We have worked throughout the year to deliver our comprehensive Quality Improvement plan, delivering the majority of the actions detailed within the plan. In 2020/21, the CQC removed 2 conditions previously imposed against the maternity services.

In December 2020, the first report of the independent review into maternity services at The Shrewsbury and Telford Hospital NHS Trust was published. The report outlines the local actions for learning for the Trust and immediate and essential actions for the Trust and wider system that are required to be implemented now to improve safety in maternity services for the Trust and across England. The Trust has developed an action plan to address the required actions, and implementation is underway Progress will continue to be reported in public at the Ockenden Report Assurance Committee and Board of Directors meetings.

In last year’s Quality Account, we set out 9 key Quality Priorities for 2020/2021, identifying how each would help improve the quality of care and services for our patients. The Trust has undertaken a significant amount of focused work to drive these quality improvements throughout the year; this work is detailed within this Account. We share information on how sepsis management in the Emergency Departments has improved during 2020/2021; timely implementation of the sepsis bundle remains a key priority in 2021/2022. The recognition and escalation of deteriorating patients on the inpatient wards has also improved, although we acknowledge there is still more work to do. We have made good progress in improving our safety culture, including the timely completion and quality of our serious incident reporting. . We have also strengthened the Trust’s quality governance processes and have invested in the Patient Safety Team infrastructure, with the appointment of a Patient Safety Specialist Officer and a Human Factors Specialist to lead on our patient safety improvement, from a system perspective. This improvement work will continue in 2021/2022.

Throughout 2020/2021, we focused on improving the care provided for patients who are at risk of falling whilst in our care, and in particular reducing the number of falls which result in patient harm. Although the Trust did not see a reduction in the overall number of falls, the number of falls resulting in significant harm reduced in quarters 3 and 4 of the year. We saw an overall reduction in the number of pressure ulcers reported across the Trust; further work will continue in 2021/2022 to reduce the number of higher category pressure ulcers. I am also pleased to report that our Friends and Family Test results continue to be positive, above the national average for inpatients, maternity and outpatient services; this is one of the key mechanisms that our patients can use to share their experience of the quality of care they receive across our services.

In 2020, we developed our Trust Quality Strategy for 2021 to 2024. The Quality Strategy priorities were proposed, referencing known areas of risk, themes from the regulatory compliance work-stream and the NHS Patient Safety Strategy. The priorities within the strategy were agreed following consultation with our staff and after engagement with patient groups and Healthwatch, to ensure patient care, experience and concerns were incorporated. Our quality priorities for 2021/2022, included in this Quality Account, reflect the priorities outlined in the Quality Strategy. These eight priorities include: implementing ongoing improvements to recognise and respond to the deteriorating patient; falls management; learning from events; embedding our safety culture; delivering the best outcomes for patients including ensuring their care is delivered in the right place and at the right time; improving the care for vulnerable patients and patient at the end of life; and improving our patients’ experience. Delivering these priorities will ensure safe, high quality care is provided to all our patients, with the voice and experience of all our patients, including those who are most vulnerable, driving our improvements.

Whilst we have made considerable progress, we have further improvement to deliver and this report provides an account of the progress we have made in 2020/2021, as well as outlining where we still have significant challenges and work to do. Thank you to everyone who has helped us put together, and commented upon, the Quality Account including Healthwatch and our local commissioners, and to our staff who have continued to work tirelessly throughout the year to provide care to the population we serve.

Louise Barnett
Chief Executive Officer

Section 2: Priorities for Improvement and Statement of Assurance

This section outlines the detail behind each of the quality priorities for 2020/21 and provides a summary of our performance and achievements in relation to these priorities throughout the year.

It also provides a statement of assurance from the Board and a review of the Shrewsbury and Telford Hospital NHS Trust performance for core quality indicators. A summary of the priorities identified for 2021/2022 are outlined, why we have chosen these and the actions we will take to achieve these throughout 2021/2022.

2.1 Review of the Priorities for Improvement 2020-2021.

In the Quality Account for 2019/2020 the Trust set out nine Quality Priorities for 2020/2021. Of these nine priorities, one, in relation to the deteriorating patient was carried over from the previous year and eight were new priorities. These priorities were presented using the Darzi framework for quality: Patient Safety, Clinical Effectiveness and the Experience of Patients and within these priorities we identified how we aimed to improve the quality of care and services for our patients over the coming year. The nine priorities covered a number of clinical services as well as including cross cutting priorities across the Trust and are outlined below:

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
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)

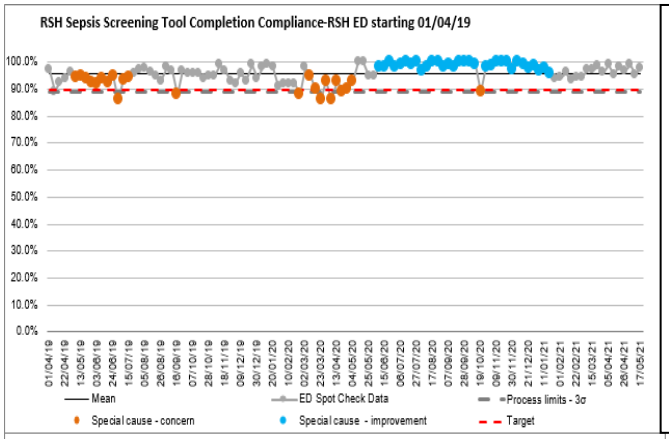
Recognising and responding to the deteriorating patient has remained a key priority for the Trust throughout 2020/2021.

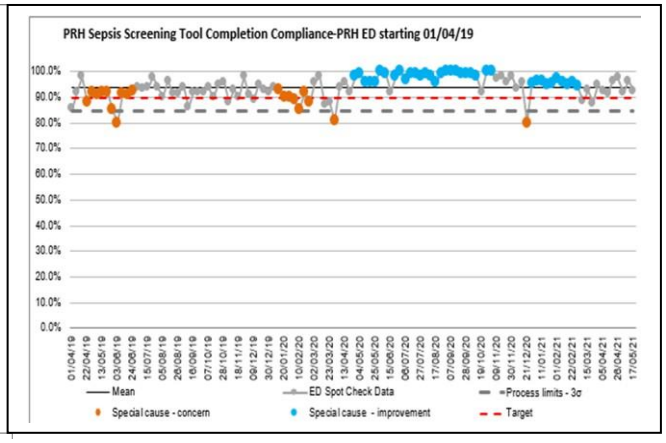
The aim and objectives in 2020/2021 included:

- 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

Compliance with Sepsis Screening in the Emergency Departments

The Trust priorities for 2020/2021 focused on recognition and management of sepsis in the acute entry points i.e. the Emergency Departments across both Shrewsbury and Telford sites. During this time we have been able to show that patients attending the Emergency Departments are consistently screened for sepsis using the Trust screening tool in over 90% of cases, indeed performance has often been above 95%. This demonstrates that we are consistently stratifying the potential risk of sepsis, which is fundamental in Sepsis management as it determines next steps.

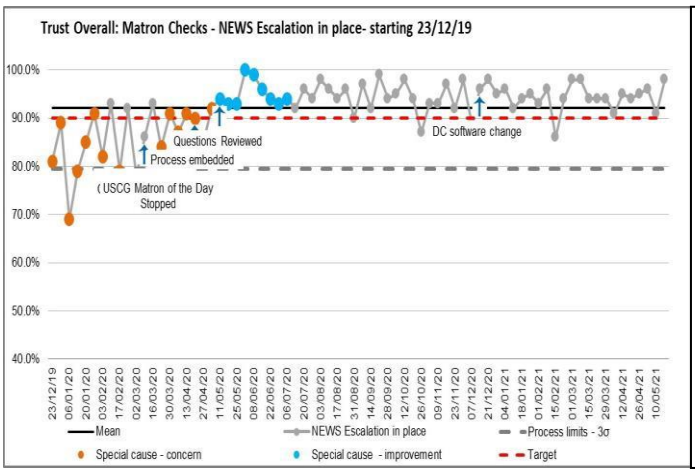


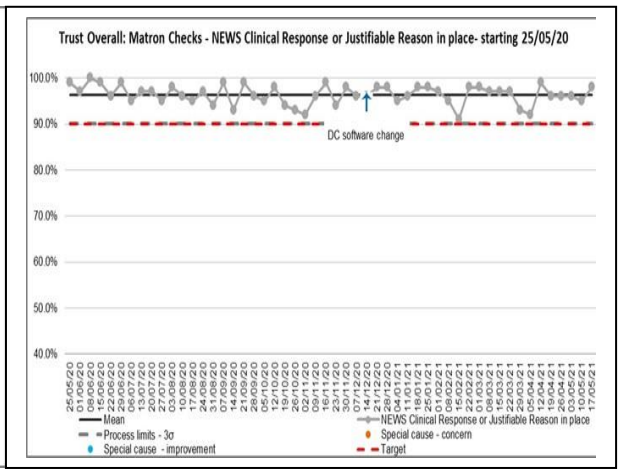


The delivery of sepsis management in the Emergency departments has shown a marked improvement during 2020 /2021 however there remain inconsistencies in relation to ensuring the “Sepsis 6” bundle for patients screened as high risk is implemented in a timely way and remains a focus for improvement works for 2021/2022. In 2020/21 Vitals, an electronic system for observation and decision support system, was implemented in the Emergency departments. The implementation of electronic Sepsis Screening tool via VitalPAC was delayed due to the COVID-19 pandemic but is planned for later in 2021/2022 which will further support the sepsis improvement work in the Departments.

Improvements in the recognition and escalation of deteriorating patients on the Inpatient Wards

Throughout 2020/2021 the matrons have been undertaking reviews of patients on the wards who have triggered a NEWS score of 5 (this score indicates deterioration). The audit results have consistently shown greater than 90% compliance with these patients having been escalated and a clinical response having been implemented.





Improvements in the use of the sepsis screening tool on the adult inpatient wards and timely treatment of Sepsis

During 2020/2021 implementation of the screening tool has taken place throughout all adult inpatient areas. This was further supported by the introduction of competence based Sepsis trainingfor all of our clinical facing staff. This process supports staff through the stratification process and timely clinical decision making.

The sepsis team have reviewed datix indicents regarding sepsis and deteriorating patients, and undertaken investigations to identify themes and share learning and improvements across the Trust. The Sepsis and Deteriorating Patient Policies have been revised to ensure they reflect best evidence-based practice. The appointment of a clinical lead for Deteriorating Patient and Sepsis in 2020/21 and the ongoing work of the Sepsis team have enabled closer working with our nursing leaders and clinical teams to support the implementation of standardised processes to ensure more consistent and timely management of patients identified at risk of Deterioration / Sepsis.

Recognising and responding to the deteriorating patient / sepsis remains a key priority which will continue in 2021/22. As part of the Trust's Improvement Alliance with University Hospitals Birmingham NHS Foundation Trust the "Getting to Good" Programme was implemented and a Quality Strategy developed which includes the deteriorating patient and sepsis as a key priority included in the strategy for the next 3 years and includes actions for 2021/22 such as:

- Replicate the work undertaken in the Emergency Departments in the inpatient areas across both sites, where we see a greater degree of variability in sepsis recognition and management.
- Ensure all clinical facing staff have completed the sepsis competence based training

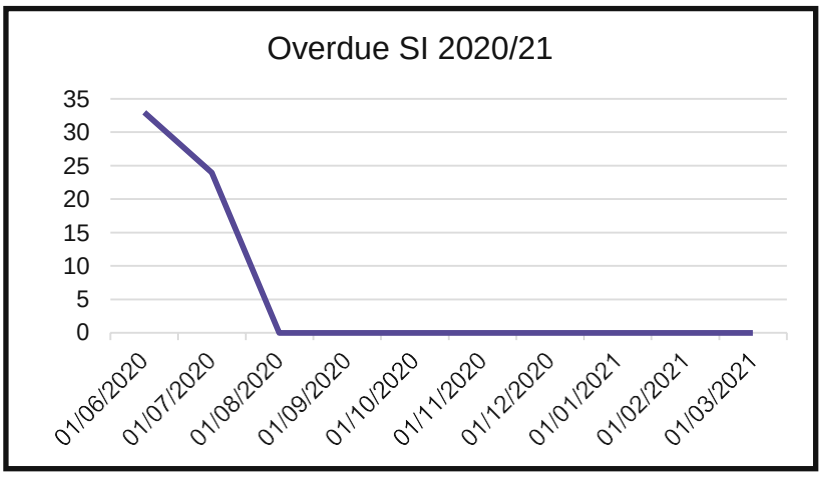
- Ensure standardise approach to Sepsis screening and response to escalations across all inpatient areas
- Work with clinical and nursing teams to ensure that performance against the quality standard drives improvement work at departmental level

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

As part of our improvement work in 2020/2021 we wanted to develop our safety culture to ensure that patient safety was a universal priority for all staff. We wanted to continue to focus our improvements on learning from incidents, delivering improved care and improve how we investigate,communicate and learn when things go wrong.

Improvements in the quality of serious incident investigations and the number of serious incident reports submitted on time

The Trust has focused on reducing the number of overdue serious incidents and since June 2020 has seen a significant improvement with no overdue serious incidents since August 2020.



The position with no overdue serious incidents means that learning identified through in-depth reviews can be shared in a timely manner and can influence quality improvement. The Trust has also received positive feedback from the Clinical Commissioning Group (CCG) in relation to the quality of the reports and the greater assurance provided. A duty of candour audit was conducted in 2020/2021, the results are currently pending but preliminary feedback was positive.

Increase the number of incidents reported as part of improving our open learning culture

A high reporting rate reflects a positive reporting culture. The Trust had seen an increase in incident reporting year on year since 2017, however, there was a decrease in overall incidents reported by the Trust in 2020/2021 (1st April 2020 to 30th September 2020). The impact of COVID-19 may be reflected in these figures as nationally the number of incidents reported in the same period also reduced. In 2020 (1st April 2020 to 30th September 2020) the number of incidents reported by the Trust on the NLRS incident system was above the national average; the percentage of patient safety incidents which resulted in severe harm or death was 0.21, which was below the national average.

Improving Governance Processes

In 2020/21 we continued to develop our 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 a serious incidents (SI) are reviewed at the weekly Review, Action and Learning from Incidents Group(RALIG) chaired by the Medical Director which was established in October 2020. Level 1 Serious Incidents, Falls, Pressure Ulcers and Hospital Acquired Infections are now reviewed at the Nursing Incident Quality Assurance Meeting (NIQAM) which again was established in October 2020. Incidents that are deemed to be serious incidents or never events then undergo an investigation which involves a 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.

To further support the embedding of the learning from incidents including serious incidents and never events in 2020/2021 a new patient safety and investigation team structure was implemented. The aim of the new team structure is to further support the Trust to undertaken timely and professional investigations into incidents and to support with embedding the learning to improve the quality of care and safety for our patients. A key role within the new team (a nationally mandated new role) is the Patient Safety Specialist Officer (PSSO) which is pivotal in the development of the new Patient Safety Incident Review Framework (PSIRF) which is due to be rolled out Nationally during 2022.

A programme of investigator training for serious incidents which incorporated human factors in the investigation process and action planning was delivered in 2020/21 and was attended by over 100 staff of various disciplines across the Trust.

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

A key priority for 2020/21 was ensuring we delivered the key requirements in relation to Infection Prevention and Control (IPC) 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 for 2020/2021 included:

- Achieve Health Care Associated Infection targets
- Reduce device related health care associated infections (HCAI)
- Ensure compliance with all core IPC standards
- 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

Health Care Associated Infections (HCAI) Performance

The Shrewsbury and Telford Hospital NHS Trust achieved a reduction in all HCAI in 2020/2021 with the exception of MRSA; although MRSA cases remained low the target was not achieved. All Clostridium difficile cases have a root cause analysis investigation with the relevant clinical team caring for the patient completed to determine if there was any learning that could be taken from them to prevent similar incidents happening again.

Health Care Associated Infection	Number of Cases 2020/2021	Number of Cases 2019/2020	Target
Methicillin Resistant Staphylococcus aureus (MRSA)	2 ↑	1	0
Clostridium Difficile	30 ↓	54	43 (locally agreed)
Methicillin Sensitive Staphylococcus Aureus (MSSA)	28 ↓	30	No Target
Pseudomonas aeruginosa	3 ↓	8	No Target
Escherichia Coli bacteraemia	36 ↓	51	No Target
Klebsiella bacteraemia	14 ↓	19	No Target

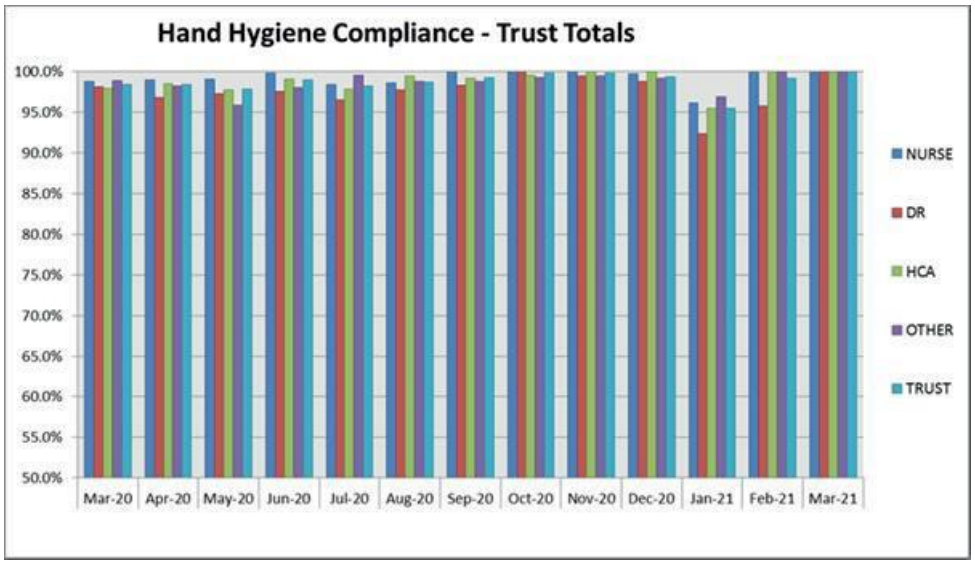
Reduce Device related Health Care Associated Infections (HCAI)

In October 2020 root cause investigations were also implemented for all cases of Escherichia Coli and Methicillin Sensitive Staphylococcus Aureus where the source of infection cannot be determined or is deemed to be device related again to ensure learning. In order to improve the care of patients with a catheter and reduce catheter associated urinary tract infections a new catheter insertion documents and care plan was introduced in 2020.

Ensure Compliance with all Core IPC Standards

1. Hand Hygiene Compliance

All wards complete an audit of their compliance with hand hygiene monthly and this is recorded on the Nursing Quality Metrics and ward dashboards. Hand hygiene audits are also conducted on the quarterly IPC Quality Ward Walks. In the event of an outbreak, the audit is conducted for, at least, three consecutive weeks as part of the outbreak control measures led by the IPC team. Overall compliance remains over 95% across all clinical staff groups, moving towards 100% by March 2021.



2. Monitoring Standards and Compliance

The IPC Nurses has undertaken a programme of monitoring within wards & departments throughout 2020/2021. The Quality Ward Walk concentrate on four main areas: Cleanliness, Equipment,Isolation & Management of Infected patients, and Invasive Devices. At the time of the Quality Ward Walk the IPC nurse verbally reports any areas of good practice and any concerns to the nurse in charge. A summary report including photos of areas of non-compliance is produced and emailed to the Ward manager, Matron and Head of Nursing. The IPC link nurse, Domestic services' supervisor and Estates advisor are informed by exception based on findings. In addition clinical areas that experienced periods of increased infection or outbreaks had spot checks undertaken in addition to the quarterly programme.

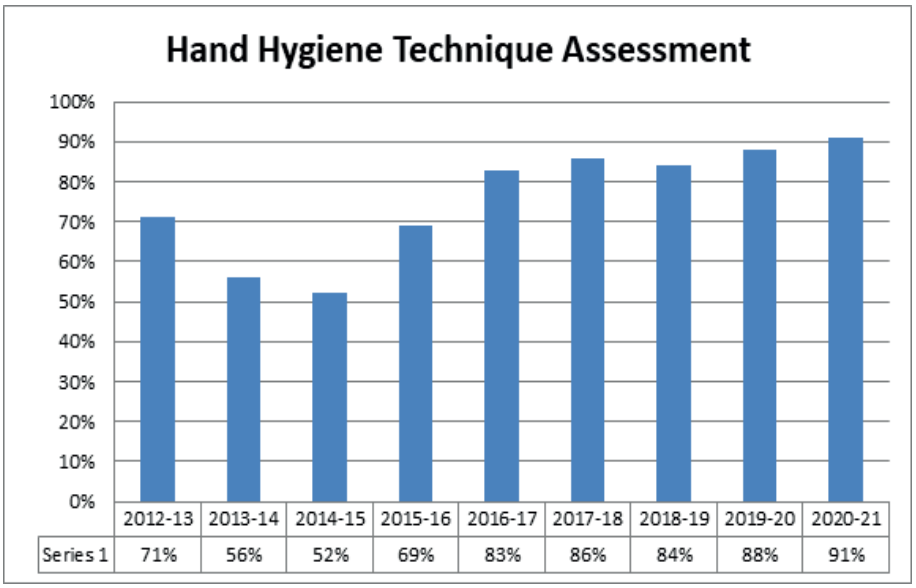
Improvements made in 2020/2021 included investment in a rapid response team for cleaning clinical spaces, additional cleanliness team hours to provide 24/7 cleaning to the clinical areas. The Trust also invested in additional isolation capacity by purchasing "pop up" Redi-rooms which enable an isolation facility to be set up in a bed space in a ward Bay, thus helping isolating patients more quickly.

In Quarter 1 of 2021/2022 the Trust will be preparing for its NHSE/I IPC reassessment. The Trust was RAG rated Green following an inspection for the NHSE/I Director of IPC in October 2019 but this was downgraded to red following the publication of the CQC report in April 2020 following their inspection of the Trust in November 2019 when they witnessed some examples of IPC non-compliance with staff. The Trust is hoping that the NHSE/I reassessment will result in an improved IPC rating.

Ensure all IPC Training is above 90%

1. Hand Hygiene Technique Assessments

The Trust Hand Hygiene Policy stipulates that all staff should have their hand hygiene technique assessed within one month of starting their employment and reviewed yearly.



The overall compliance rate for 2020/21 is 91%. This is an improvement regarding last year's 88%. It should be noted that these figures do take into consideration medical staffing.

2. IPC Training Compliance

The IPC team deliver numerous training sessions year round. These have included a programme of mandatory sessions and corporate induction days. Bespoke training sessions on wards and departments so staff do not have to leave their working environment to attending sessions have also been provided. Compliance with IPC training at the end of March 2021 was 84% against a target of 90%. Ongoing work to achieve compliance is monitored through the monthly IPC Operational Group.

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

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

Throughout the COVID-19 pandemic in 2020/21 the all Trust staff worked collaboratively to ensure that:

- COVID-19 IPC policies were updated as national guidance was revised
- Personal Protective Equipment and FFP 3 mask FIT testing was ongoing
- Implementation of measures to protect staff and patients including social distancing
- New Patient Pathways to separate infected, potentially exposed or unknown status patients from negative patients. These had to be changed again as elective activity was reintroduced.
- Management of COVID-19 outbreaks, investigations and implementing actions and learning
- Implementation of swabbing for patients on admission and throughout hospital stay as per national recommendations

Throughout 2020/2021 the NHSE/I Infection Prevention and Control Board Assurance Framework (IPC BAF) was used as a tool to monitor actions required to ensure continuous improvement during the COVID-19 pandemic. The Trust compliance with the IPC BAF was 88% with actions in place for items where the Trust was not fully compliant.

Clinical Effectiveness

Priority 4 - Ensure learning from deaths through clear mortality review processes

The National Quality Board Guidance on Learning from Deaths (2017) has driven a national endeavour to initiate a standardised approach to the way in which we review and learn from the care and treatment given to our patients prior to their death.

The aim of this priority for 2020/21 was to strengthen 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

Increase the total number of mortality reviews that take place across the Trust

By the end of March 2021, 827 (39.32%) case reviews had been carried out in relation to the 2103 patient deaths across the Trust; this is an improvement from the 35% reported for 2019/2020.
Of the 2103 deaths, 100% of deaths at the Royal Shrewsbury Hospital were subject to an initial scrutiny by the medical examiner and 100% of deaths were scrutinised by the Medical Examiner in the first instance at the Princess Royal Hospital from August 2020 when the Medical Examiner services was implemented there.

Improve the governance processes around mortality reviews ensuring the appropriate learning opportunities and improvements are actioned from these reviews

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. Improvements as a result of this learning will in turn provide better care for our living patients. To fully support this mortality agenda the Trust has continued to develop the wider mortality systems and processes to enable us to get a clear understanding of the care delivered to patients, their families and loved ones at what is a very emotional and difficult time. In 2020/2021 Learning from Deaths was included as a key component of the Trust overarching 'Getting to Good' Improvement Programme. Progress against the 'Getting to Good Learning from Deaths' Improvement programme was monitored in 2020/2021 through the Trust Learning from Deaths Group and a Learning from Deaths report was submitted to the Quality Operational Committee in March 2021 to provide assurance in relation to achievements against the measures and actions being undertaken.

Improvements made in 2020/2021 included:

Mortality Lead

A new Trust Clinical Lead for Mortality was appointed alongside a Trust Mortality Lead in 2020/21 to lead and oversee the mortality improvement works

Engagement with Bereaved Relatives and Medical Examiner Role

The Trust complies with the legal requirements of having a Medical Examiner Service following the enforcement of the Coroners and Justice Act 2009. A full Medical Examiner Service has been in place on the Royal Shrewsbury Hospital site throughout 2020/21 and has been active on the Princess Royal Hospital site since August 2020.The Medical Examiner has an independent role in the Trust but remains professionally accountable to the Trust Executive 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 Trust has an effective Medical Examiner and Bereavement Service in place and is the first opportunity to identify where there may have been potential lapses in care, initiating the first step to a more in-depth review. The Medical Examiner role at the Trust has enabled 100% of deaths to undergo an initial independent scrutiny. The purpose in the main is to identify the cause of death, complete the Medical Certificate on the Cause of Death (MCCD), liaise with HM Coroner where necessary and speak with bereaved families to further explain issues surrounding the death of their relative.

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 vitally important. This has been particularly difficult for bereaved families and clinical staff alike through the Covid-19 Pandemic. Bereavement Services have worked extremely hard through this most challenging year to provide the compassionate, caring and timely support, advice and guidance wherever possible. For much of the year there were less opportunities for families to be close to their relatives during those important last moments thus the contact and communication with the Bereavement Centre Team has been all the more crucial to guide them through this time

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

Regardless of whether the care provided to a patient who dies is examined using case record review or an investigation, the findings should be part of, and feed into, robust clinical governance processes and structures. The findings should be considered alongside other information and data including complaints, clinical audit information, mortality data, patient safety incident reports anddata and outcomes measures etc. In 2020/2021 the Trust started to implement a training programme for the Learning from Deaths Structured Judgement Review Tool across all clinical specialties to encourage standardisation of approach across the organisation.

The mortality improvement work will continue in 2021/2022 and will include:

- Continuing to improve the governance processes around learning from deaths reviewsworking closely with other teams – e.g. patient safety, complaints, patient experience, to optimise learning opportunities.
- Build on the effectiveness of the Trust learning from Deaths Group widening the remit to include contributions from partner provider organisations to improve the approach to learning from deaths from a system perspective.
- 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.
- Roll out the agreed structured judgement review tool developed by NHSE/I as part of their national learning from deaths programme. Further support the training with a series of master classes where experiences and issues are discussed to support continuous improvement.

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

NICE (National Institute for Health and Care Excellence) 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 care and improve efficiency, productivity, and safety. Confirmation that NICE guidance has been reviewed and any outstanding actions addressed is therefore essential in confirming the quality of care and services across the Trust. Without this confirmation, the Trust does not have assurance that current practices are compliant with the best evidence available, and is unable to make a decision on whether changes in practice are required.

In 2020/2021 the Trust aimed to:

- Ensure appropriate clinical practice and effectiveness throughout the Trust by reviewing and complying with relevant NICE Guidance.
- Continue to improve the number of timely NICE compliance reviews, aiming for 90% of these to be completed within specified timescales during 2021-22.

The Planned Activity to achieve this in 2020/2021	
Review and update the Trust NICE guidance management process to ensure that this is robust in order to maintain and deliver the improvements required.	√
Continue the provision of additional support to clinicians by the Clinical Audit Team to help with the completion of benchmark assessment templates during 2021-22.	√
Ongoing support and engagement from the Deputy Medical Director in facilitating implementation of the Trust NICE process	√
Clinical areas to prioritise relevant NICE guidance to be added to the clinical audit forward plan, to ensure that case notes audits are carried out to provide on-going assurance	√

During 2019/20 a pilot was carried out with the aim of further supporting the process of NICE Guidance Reviews during the COVID 19 pandemic. This involved the Clinical Audit Team providingadditional support to clinicians to help with the completion of assessment templates. This pilot was positively evaluated, and was rolled out across the Trust during 2020/21 enabling timely review and implementation of this important guidance. Implementation of this new initiative has resulted in an increase in the percentage of guidance completed within the target timescales from 65% in 2019-20 to 80% in 2020-21, and the overall percentage of guidance completed from 95% in 2019-20 to 99% in 2020-21. The tables below show the impact of this additional support to date.

Percentage of guidance published during the year completed within target timescale

	Percentage of guidance published during the year completed within target timescale (2019/20)	Percentage of guidance published during the year completed within target timescale (2020/21)
Clinical guidelines (NG)	59% (23/39)	93% (28/30)
Quality Standards (QS)	60% (6/10)	62.5% (5/8)
Interventional Procedural Guidelines (IPG)	75% (21/28)	67% (12/18)
Total	**65% (50/77)**	**80% (45/56)**

Overall percentage of all published guidance completed

	Percentage of all published guidance completed (2020/21)	Percentage of all published guidance completed (2020/21)
Clinical guidelines (NG)	91% (239/264)	97% (283/291)
Quality Standards (QS)	93% (176/189)	99% (195/197)
Interventional Procedural Guidelines (IPG)	98% (516/526)	99% (543/544)
Total	**95% (931/979)**	**99% (1021/1032)**

Throughout 2020/2021 regular NICE updates have been reported to the Quality Operational Committee, Divisional Management Meetings and to our Clinical Commissioning Groups.

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.

In 2020/2021 the Trust aimed to:

- 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

Performance against national target and timely diagnosis/treatment

The 62 day cancer standard is from referral from a GP through to first definitive treatment. The Shrewsbury and Telford Hospital NHS Trust saw a small improvement in 2019/20 and another small increase in 2020/2021 reporting 75.1% compliance compared to 73.34% the previous year. Even though the Trust did not hit the target of 85%, the Trust performance did show an improvement despite the restrictions resulting from the COVID-19 pandemic. The Trust 31 day performance (decision to treatment to treatment) also improved and we finished 2020/2021 on 98.4% against a target of 96%.

To improve patient experience and ensure a smooth transition through the pathway, Cancer Care Navigators roles were introduced in 2020/2021. The Trust also reinstated the “vague symptoms” pathway in the Autumn of 2020 to provide a pathway for patients with non-specific but suspicious cancer symptoms; this was linked to the rapid diagnostic work being undertaken by the Trust.

The Living with and Beyond Cancer Programme continued throughout the year. This is ensuring that all patients living with cancer, and those affected, have access to living well support. At the Trust this takes place virtually or face-to-face (COVID-19 social distancing permitted) as “Living Well Sessions”. Underpinning these is access to a “Living Well with Cancer” passport and access to living well videos accessible via the Trust’s website. The programme also ensures all patients are

offered holistic needs assessment to ensure their personal needs are met. Throughout 2021/22 we will be undertaking further work to ensure End of Treatment summaries are provided following all treatment modalities. These have already been successfully embedded in some areas and are in pilot form at present in others. We will be working to ensure a consistent, high quality approach to delivery over the next 12 months. We will also be working with Primary Care colleagues to improve the quality and quantity of Cancer Care Reviews which should be offered to all patients by their GP within 12 months of diagnosis. We are currently offering personalised stratified follow up in Breast and Colorectal services. Our aim in 2021/22 is to roll this out within Urology, Haematology and Gynaecology

The Experience of Patients

Quality Priority 7: Patient Experience and Community Engagement

Patient Experience

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. Obtaining insight into patients' experience and receiving feedback on both what was done well and what could be improved is therefore crucial to ensuring a high-quality, person centred service is provided to every patient within the Trust.

The Trust has continued to work with a range of patient representative groups including the Patient and Carer Experience (PaCE) Panel representatives and Healthwatch who provide a voice of their own or relatives live experiences and help us to further understand individual needs, with the aim of improving accessibility and service equity. Whilst face to face engagement was more limited in 2020/21 due to Covid-19, dialogues have continued to take place, and feedback received and acted upon

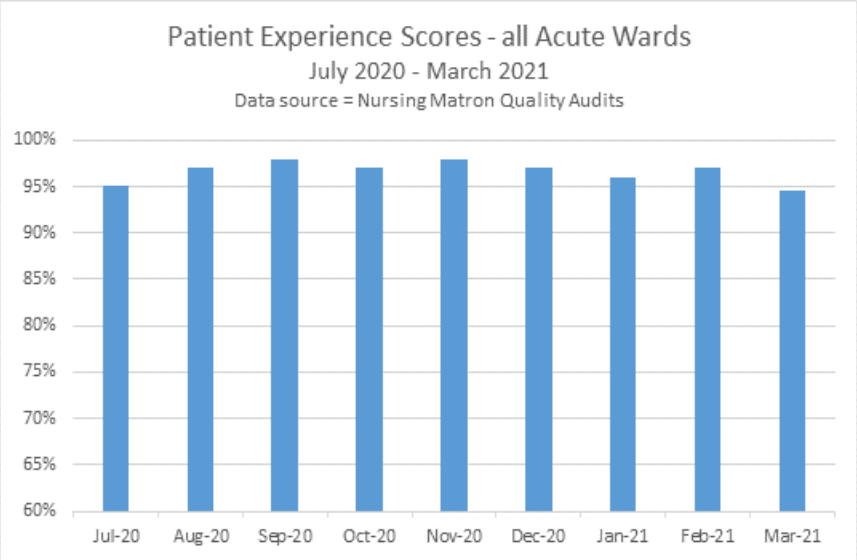
A key priority for 2020/21 was to ensure that we increased the opportunities available for patients, people close to them and carers to provide feedback on their experience and share how this is used to support improvement.

The actions we took to achieve this in 2020/21 included:

- A local inpatient survey was developed to give an overall picture of how the Trust isperforming throughout the year, as well as a breakdown by ward and Division in order togive more detailed and meaningful data at ward level. In summary 72.4% of patients rated their overall experience as 8 or higher out of 10, 96% reported being treated with dignity and respect.
- A Feedback Hub was also launched to centralise all feedback-collection methods, and increase accessibility, including: patient stories; electronic Friends and Family Test (FFT); surveys by topic (e.g. discharged, food, virtual visiting); comments, suggestions, compliments or 'thank yous'. The Hub directs users to the PALS and Complaints Team ifthey wish to raise a concern, complaint or compliment; and, to Healthwatch/Powys Community Health Council and Care Opinion if users wish to share feedback externally.

- A Children and Young Person's Hub is currently in development to provide child-friendly information on what to expect when you come into hospital and to seek direct feedback on how to improve the child/young person's patient experience.

Throughout 2020/2021 the matrons have undertaken monthly Quality Assurance Reviews of the wards which has included discussions with patients about the quality of the care and their experience, the results from these reviews has been constantly positive.



Community Engagement

Over the past year the Trust has continued to engage and involve our local populations in a meaningful and inclusive way. The Public Participation department are responsible for ensuring that we reach out and engage with all of our local communities across Shropshire, Telford & Wrekin and mid Wales. The Public Participation Department consists of three main inter-related public facing services (Community Engagement, Volunteering and Trust Charity). COVID-19 has impactedon the ways we engage with our local communities; however, over the past year we have developed new and innovative ways to engage our local communities virtually.

A range of virtual meetings and health lectures have been facilitated over the past year, including:

- Community Cascade – Delivered by our Director of Corporate Services, this meeting provides a monthly update on the Trust, and provides the opportunity for the public to ask questions
- Health Lectures – Virtual health lectures delivered by specialist Trust staff on a specific topic
- Quarterly Community Engagement Meetings – Agenda items focus on specific topics of interest.
- Drop in sessions – meet members of the public participation team and have an informal discussion.

The Department has provided support to the Divisions to ensure that they meet their Section 242 duties to engage the public around potential service changes; this has including facilitating focus groups, surveys, and completing Equality Impact Assessments.

Quality Priority 8: Responsiveness and Learning from Complaints

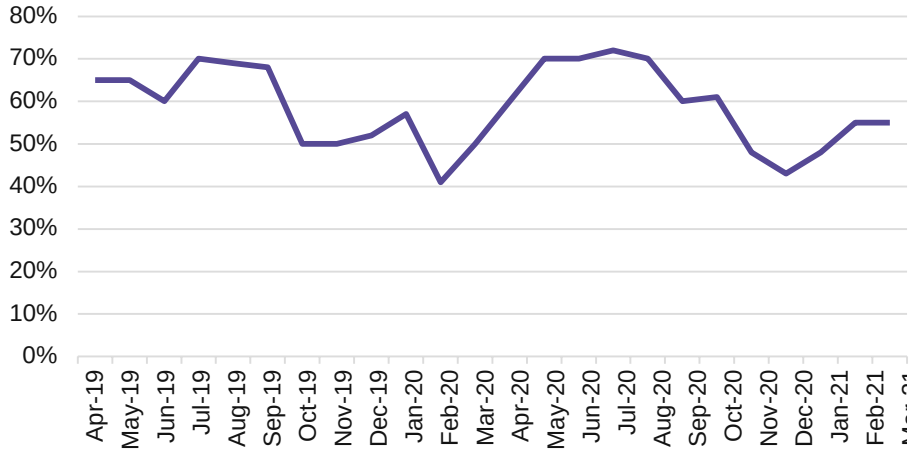
The Trust is committed to learn, change, improve and evolve in response to complaints. Thelessons learned and trends identified through monitoring data collected through complaints plays a key role in improving the quality of care received by patients and their experience. The Trust has identified that improving the timelines of our responses to complainants and embedding learning from complaints was 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 Speciality, Divisional, and Trust-wide level

In 2020/2021 improving the timeliness of our responses to complaints remained a challenge. Response rates remained low, and were impacted by the COVID-19 pandemic, with 60% of complaints responded to within timescale during 2020/21.

Response Rates



Each complaint may be multi-faceted, particularly where the complaint relates to inpatient care that may involve the multidisciplinary team or events over an extended period of time. The main themes from complaints include: communication, clinical care, admission/discharge issues, and appointments. Work has been ongoing to ensure that complaints investigations are carried out promptly, so that findings can be shared with the complainant. Weekly meetings are in place with senior managers within each of the Divisions, to identify where responses are late, and agree actions to complete the investigation. In addition, training has been provided to medical and nursingstaff on responding to complaints. During quarter 4 of 2020/21 a new sign-off process was introduced, to ensure that there is senior divisional sign-off of all complaint responses.

Although response rates remained low, the number of complaints that were re-opened in 2020/2021 was low, with 44 complaints re-opened in 2020/21. Only two cases were referred to the PHSO in 2020/21. In order to further strengthen the quality of responses, as well as improving divisional engagement.

Reduce the number of formal complaints by 10%:

Between April 2020 to March 2021 the Shrewsbury and Telford NHS Trust received 588 complaints.

Year	Number of Complaints
2017/2018	600
2018/2019	680
2019/2020	762
2020/2021	588

There was a 22% reduction in the number of complaints in 2020/2021 compared to the previous year, although it should be noted that activity was significantly reduced during the year, with the cessation of elective activity during the COVID-19 pandemic. The number of complaints per 1000 patients remains the same as in 2019/20 (0.78).

An internal review of complaints and processes commenced in quarter 4 of 2020/2021, this review will inform actions moving forward and aims to strengthen the links between Complaints, PALS and the Patient Experience Team, and develop a more proactive service to improve the patient experience. A new PALS role has been created, aligned with the Women & Children's Division, to provide a more agile and proactive service, with the role due to start during the first quarter of 2021/22.

Embed learning from complaints at Divisional and Trust-wide level

Details of learning from both complaints and PALS contacts are shared with the Divisions each month; these are then discussed at Divisional Board and Specialty Governance meetings, to ensurethat learning is cascaded and discussed at a variety of levels. Follow up of learning is also being built into the ward exemplar programmes.

Examples of learning from complaints includes:

- Following confusion over the process for patients who are exempt from wearing a face mask, which resulted in a patient not being able to have the procedure, additional checks have been implemented at the pre-op assessment and at the time of the pre-op swabbing. These patients are then placed last on the list so that additional measures can be put in place, and infection control guidance is available for all staff.
- Work in the Phlebotomy Department to improve the process for taking blood from children, including ensuring a clear pathway for the prescription of numbing cream prior to the appointment.
- Following concerns that a patient's cuts and grazes were not properly treated during the admission, staff were reminded that they must identify, document and treat all injuries, and that, in cases where the patient declines skin checks, this should be documented and the reasons for the refusal explored, so that support can be given as needed.
- As a result of a complaint about antenatal care, staff were reminded to use the 24-hour clock system, to avoid misunderstandings, and were reminded that they must ensure that the assessment process is clearly communicated. Staff were also reminded of the transfer process if there is a delay in the patient being assessed, or she is in obvious labour.

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

Ensuring a safe and effective transition of young people with chronic illness and disability from paediatric care to adult health services is a key quality priority for the Trust. Effective transition processes requires a whole trust approach, with appropriate clinical engagement across specialities 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.

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

Progress made in 2020/2021:

During 2020/2021, a named Transition Consultant Lead was established. The Trust made an application to the Roald Dahl charity in 2020 for the initial funding of a transitional nurse. Although this was unsuccessful a Trust business Case has been developed for both the transitional nurse and allocated sessions for transitional clinical leads for both Medicine and Surgery.

The Trust-wide Transition of Young People to Adult Services Policy was developed in 2020.Alongside this, in order to enable adolescents to have their journey into adult services mapped a review was also undertaken to identify the number of children for each identified services that were in the age range 13-19 age, this included 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. The review showed the Outpatient attendances by age in 2020.

Specialty	Age 14	Age 15	Age 16	Age 17	Age 18	Age 19	Total
Epilepsy	39	57	41	23	7	4	171
Gastroenterology	44	67	45	14	2	0	172
Endocrinology	26	47	24	39	6	0	142
Clinical Haematology	7	12	11	3	1	0	34
Clinical immunology	48	48	26	3	0	0	125
Respiratory	82	58	15	4	0	0	159
Nephrology	15	10	2	0	0	0	159
Medical oncology	33	15	20	8	2	2	80
Rheumatology	61	141	62	72	18	2	356
Diabetes	337	316	842	683	523	18	2719
Cystic fibrosis	9	10	7	1	0	0	27
Neurology	17	19	9	2	0	0	47

The Paediatric Diabetes service is funded to see young people up to their 19 birthday. Joint transition clinics with adult services are now well established in Diabetes, Rheumatology, Epilepsy and Gastroenterology with support from specialist nurses. Additional hours of specialist nurse in rheumatology transition clinics approved.

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 2020/21 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 2020/21 the Shrewsbury and Telford Hospital 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 £434109. In 2020/2021 the Shrewsbury and Telford Hospital NHS Trust provided or subcontracted NHS services which included:

- Accident and Emergency Services
- Acute Services
- Cancer Services
- Diagnostic, screening and/or pathology services
- End of Life Care Services
- Radiotherapy Services
- Urgent Treatment Centre Services

There were:

- 35,407 elective/day cases
- 50,901 non-elective cases
- 99,085 emergency attendances
- 333,762 outpatient attendances

The Trust has reviewed all the data available to us on the quality of care in these categories.
The income generated by the NHS services reviewed in 2020/21 represents 85% of the total income generated from the provision of NHS services by the Shrewsbury and Telford Hospital NHS Trust. The Trust has reviewed the data against the three dimensions of patient experience, patient safety and clinical effectiveness.

The data reviewed included:

- Clinical outcomes from local and national audits
- Performance against national targets and standards including those related to the quality and safety of services

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.

	Safe	Effective	Caring	Responsive	Well-led
Princess Royal Hospital	**Inadequate**	**Inadequate**	**Requires Improvement**	**Inadequate**	**Inadequate**
Royal Shrewsbury Hospital	**Requires Improvement**	**Requires Improvement**	**Requires Improvement**	**Requires Improvement**	**Requires Improvement**
Overall Trust rating	**Inadequate**	**Inadequate**	**Requires Improvement**	**Inadequate**	**Inadequate**

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

Further focused visits of the Medical Wards took place in June 2020. A focused CQC inspection of Children and Young People's (CYP) Services took place on the 24th February 2021 at the Princess Royal Hospital (PRH) related to the care of CYP with mental health needs and children's safeguarding resulted in services being downgraded to "inadequate".

The Trust currently has conditions in place in relation to its registration following enforcement action taken against the Trust in 2018/19, 2019/20 and 2020/21.

The 2 conditions imposed on Maternity Services in 2018/2019 were removed in 2020/2021.

Regulated Activity	Reason	Area
Regulation 31 **Section 31 of the Health and Social Care Act 2008** **Treatment of disease and injury**	Sepsis and Deterioration Paediatric pathway in the ED including triage within 15 minutes, left without seen and follow up Mental health risk assessment All Adults assessed within 15 minutes Environment safe for intended purposed Effective environmental risk assessment and management across ED Effective systems in place to account for patient acuity and location of patient in ED Effective monitoring of patient pathways through the Department Suitably qualified and competent staff to carry out their roles	Emergency Departments
	Deteriorating Patient and Sepsis Management of de-escalation and intervention holds Mental Capacity Assessment/Deprivation of Liberty safeguards Clinical risk assessment and care planning Learning from Incidents	Trust-wide
	Admission of under 18 year olds with isolated mental health needs Training for all staff who care for patients under 18 years with mental health and learning disability Continuous oversight of CYP with mental health needs by registered mental health nurse Children's Safeguarding	Trust-wide
Regulation 17 and 18 **Section 29A**		
Tissue viability, Nutrition and **Hydration assessment and risk** **assessments**	Risk assessments not being Documented	Ward 10 and 15 at Princess Royal Hospital
Staffing level is in ED, Critical Care **and EOLC and training requirements**	Staffing levels not meeting national requirements	ED , Critical Care and End of Life Care Team
End of Life Care	Specialist palliative care staffing levels not meeting national requirements System to identify EOLC patients across the Trust Syringe driver training	Trust wide
Safeguarding	Systems and processes , including training	Trust-wide
Children and Young People individual needs and preferences	Choice of location of Care in the Trust Individualised care plans	CYP Ward and wards caring for 16-18 year olds

CQC Improvement Action Plan

In order to address the concerns raised through the variety of visits an overarching Improvement Plan was developed and agreed by the Trust Board in May 2020. Weekly Confirm and Challenge sessions were set up with the Divisions, these weekly sessions aimed to monitor and provide assurance in relation to the completion of actions and support the Care Groups to deliver the improvements required. There were 403 individual actions identified, 94% of the actions were completed as illustrated below:

Action Plan Summary by Area

Total Number of Actions - -

Group	Scope	Total Actions	Embedded	Complete	In Progress	Off Track	Not Yet Started	Percentage Complete
Trustwide	Trust Wide	122	-	114	4	3	1	93%
Urgent and emergency care	Urgent and emergency care	157	11	136	2	8	-	94%
Medical care	Medical care	25	-	25	-	-	-	100%
Scheduled Care	Surgery	37	-	36	1	-	-	97%
	End of life care	10	-	8	1	1	-	80%
	Outpatients	2	-	2	-	-	-	100%
	Critical Care	3	-	3	-	-	-	100%
Women & Children	Maternity	34	1	31	2	-	-	94%
	Children and Young People care	13	-	13	-	-	-	100%
Total		**403**	**12**	**368**	**10**	**12**	**1**	**94%**

In order to ensure that the improvements made are sustained and embedded into business as usual processes they have been aligned to six key themes and will be monitored via the appropriate Trust Governance Forum.

The key themes are:

- Safeguarding
- End of Life Care
- Deteriorating Patient
- Training
- Safe Staffing
- Governance

An individual action plan has been developed for each of these themes that align to the relevant regulatory action/sanction. Each action plan is monitored through the appropriate group with a progress report presented at the Quality Operational Committee for oversight and assurance of the Director of Nursing and Medical Director.

Participation in clinical audits and confidential enquiries

The Trust aims to use clinical audit as a process to embed clinical quality, implement improvements in patient care, and as a mechanism for providing evidence of assurance about the quality of services. During 2020/21 **97** national clinical audits and **5** national confidential enquiries were prioritised by NCAPOP (the National Clinical Audit and Patient Outcomes Programme) for Trusts to participate in, where applicable. During that period the Shrewsbury and Telford Hospitals NHS Trust participated in **93%** (63/68) of the national clinical audits and 67**%** *(2/3)* of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that were prioritised for Trusts to participate in are listed in Tables 1 and 2 below. Examples of actions taken following participation in national audits are listed in table 3.

The Trust also undertook 125 local audits which are outlined in Table 4.

Table 1 – National Clinical Audits 2020-21 (97)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
Antenatal and newborn national audit protocol 2019 to 2021		✓	✓	100% of eligible cases
British Association of Urological Surgeons	*Management of the Lower Ureter in Nephroureterectomy Audit	✓	✓	100% of eligible cases
	*Cytoreductive Radical Nephrectomy Audit	✓	✓	100% of eligible cases
	*Renal Colic Audit	✓	✓	Auditing in progress
*British Spine Registry		×	×	Not applicable
*Case Mix Programme (CMP) - ICNARC		✓	✓	RSH – 710 PRH – 345
Chlorhexidine Gluconate versus Providone-Iodine Akin Antisepsis prior to upper limb surgery (CIPHUR).		✓	✓	Auditing in progress
*Cleft Registry and Audit Network (CRANE)		×	×	Referred to specialist centre
COVID-19 ACS Global Survey		✓	✓	Auditing in progress

Table 1 – National Clinical Audits 2020-21 (97)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
COVIDTrach; a UK national service evaluation of mechanically ventilated COVID-19 patients undergoing tracheostomy		✓	✓	100% of eligible cases
*Elective surgery (National Proms Programme)		✓	✓	340 questionnaires returned
Emergency Medicine QIPS (RCEM)	**Assessing Cognitive Impairment in Older People	✓	✓	100% of eligible cases
	**Care of Children	✓	✓	100% of eligible cases
	**Mental Health	✓	✓	100% of eligible cases
	*Fractured Neck of Femur	✓	✓	Currently in progress
	*Infection Control	✓	✓	Currently in progress
	*Pain in Children	✓	✓	Currently in progress
ENT UK COVID guidance for sore throat and epistaxis management		✓	✓	100% of eligible cases
Falls and Fragility Fractures Audit programme (FFFAP)	*Fracture Liaison Service Database	✓	×	
	*Inpatient Falls	✓	✓	9 cases submitted in 2020
	*National Hip Fracture Database (NHFD)	✓	✓	RSH – 490 PRH – 157
	*Vertebral Fracture Sprint Audit	×	×	Not applicable
Fragility fracture post-operative mobilisation		✓	✓	Currently in progress
Inflammatory bowel disease (IBD) Registry, Biological Therapies Audit		✓	×	Depleted workforce
Laparoscopic Common Bile Duct Exploration (P-ALiCE Study)		✓	✓	Currently in progress
*LeDeR - Learning Disabilities Mortality Review		✓	✓	100% of eligible cases
Management of children in the West Midlands with suspected & confirmed COVID-19		✓	✓	621 patients
Management of suprcondylar fractures		✓	✓	Currently in progress
*Mandatory Surveillance of HCAI		✓	✓	All applicable
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	*Maternal mortality surveillance and confidential enquiry	✓	✓	All applicable
	*Perinatal confidential enquiries	✓	✓	All applicable
	*Perinatal mortality surveillance	✓	✓	All applicable
Mental Health Clinical Outcome Review Programme	*Suicide by middle-aged men	×	×	Not applicable
	* Real-time surveillance of suicide by patients under mental health	×	×	Not applicable

Table 1 – National Clinical Audits 2020-21 (97)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
	care			
	*Suicide & Homicide	×	×	Not applicable
National Asthma & COPD Audit Programme (NACAP)	*Adult Asthma Secondary Care	✓	×	Lack of resources
	*Paediatric - Children and young people asthma secondary care	✓	×	
	*Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	✓	✓	338 to date
	*Pulmonary rehabilitation	×	×	Not applicable
*National Audit of Breast Cancer in Older People (NABCOP)		✓	✓	367 patients
*National Audit of Cardiac Rehabilitation		×	×	
*National Audit of Care at the End of Life (NACEL)		✓	✓	Start date delayed
*National Audit of Dementia (care in general hospitals)		✓	✓	Start date delayed
*National audit of Pulmonary Hypertension		×	×	Not applicable
*National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		✓	✓	All applicable 100%
*National Bariatric Surgery Registry (NBSR)		✓	✓	All applicable 100%
*National Cardiac Arrest Audit (NCAA)		✓	✓	All applicable 100%
National Cardiac Audit Programme (NCAP) - NICOR	*National Audit of Cardiac Rhythm Management (CRM)	✓	✓	April 2014 - March 2019. 562 cases
	*Congenital Heart Disease (CHD)	×	×	Not applicable
	*Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	2019-2020: PRH - 255 RSH - 301
	*Heart Failure Audit	✓	✓	18/19 data (2020 report) PRH - 570 RSH - 405
	*National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	×	×	
	*National Adult Cardiac Surgery Audit	×	×	
National Clinical Audit of Anxiety and Depression (NCAAD)	*Core audit	×	×	Not applicable
	*Psychological Therapies Spotlight	×	×	Not applicable

Table 1 – National Clinical Audits 2020-21 (97)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
*National Clinical Audit of Psychosis (NCAP)	*EIP audit 2019/2020	×	×	Not applicable
	*2020/21 Spotlight Audit	×	×	Not applicable
National Comparative Audit of Blood Transfusion programme	*2021 Audit of Blood Transfusion against NICE Guidelines	✓	N/A	Start date delayed
	*2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	✓	N/A	Start date delayed
	**Management of massive haemorrhage	✓	✓	2 cases identified
	***Re-audit of the medical use of blood	✓	✓	All applicable 100%
National Diabetes Audit - Adult	*Inpatient Audit Harms (NaDIA-Harms)	✓	✓	All applicable
	*Inpatient Audit NaDIA	✓	✓	PRH - 40 RSH - 69
	*National Diabetes in Pregnancy Audit (NPID)	✓	✓	All applicable 100%
	*Transition	✓	✓	Linkage audit from other NDA audits
	* NDA Integrated Specialist Survey	✓	✓	All applicable 100%
	*Core Diabetes Audit	×	×	Primary care audit
	*Foot Care Audit	✓	✓	241 cases
*National Early Inflammatory Arthritis Audit (NEIAA)		×	×	Not applicable
*National Emergency Laparotomy audit (NELA)		✓	✓	226 cases
National Gastrointestinal Cancer Programme	*Oesophago-gastric Cancer (NAOGC)	✓	✓	171 cases
	*National Bowel Cancer (NBOCA	✓	✓	379 cases
*National Joint Registry (NJR)		✓	✓	374 cases included
*National Lung Cancer Audit (NLCA)		✓	✓	All applicable 100%
*National Maternity and Perinatal Audit (NMPA)		✓	✓	All applicable
*National Paediatric Diabetes Audit (NPDA)		✓	✓	PREM report 27 CYP 32 Parent/carer
*National Vascular Registry		✓	✓	100%
*Neonatal intensive and special care (NNAP)		✓	✓	100%
*Neurosurgical National Audit Programme		×	×	Not applicable
*NHS provider interventions with		✓	N/A	Audit closed currently

Table 1 – National Clinical Audits 2020-21 (97)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
suspected/confirmed carbapenemase producing Gram negative colonisations / infections				due to covid
*Ophthalmology Audit		✓	✓	Apr19-Mar20: 2340 patients
*Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry		×	×	Primary care
*Paediatric intensive care (PICaNet)		×	×	Not applicable
*Perioperative Quality Improvement Programme		×	×	Not applicable
Prescribing Observatory for Mental Health (POMH-UK)	*Prescribing for substance misuse: alcohol detoxification	×	×	Not applicable
	Prescribing for depression in adult mental health services	×	×	Not applicable
	Prescribing high-dose and combined antipsychotics on adult psychiatric wards	×	×	Not applicable
*Prostate Cancer Audit		✓	✓	519 cases identified
*Society for Acute Medicine's Benchmarking Audit (SAMBA)		×	×	Not applicable
*Sentinel Stroke National Audit Programme (SSNAP)		✓	✓	982 for 2020
*Serious Hazards of Transfusion (SHOT): UK National haemo-vigilance scheme		✓	✓	All applicable
*Surgical Site Infection Surveillance Service		✓	✓	All applicable
Suspected scaphoid fracture - a national collaborative audit		✓	✓	Currently in progress
*Trauma Audit & Research Network		✓	✓	PRH - 128 RSH - 406
*UK Cystic Fibrosis Registry		×	×	Not applicable
*UK Registry of Endocrine and Thyroid surgery		✓	✓	67 cases submitted
*UK Renal Registry Acute Kidney Injury		✓	✓	All applicable

Table 2 – National Confidential Enquiries 20-21 (5)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
Child Health Clinical Outcome Review Programme (NCEPOD)	*Transition from child to adult health services	✓	✓	
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	**Physical Health in Mental Health Hospitals	×	×	
	**Dysphagia in Parkinson's Disease	✓	×	Lack of resources
	*Crohns disease	✓	N/A	Audit not yet

Table 2 – National Confidential Enquiries 20-21 (5)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
				commenced. Start date delayed due to COVID
	*Epilepsy study	✓	✓	

Examples of actions taken following participation in national audits are listed in table 3 below:

Table 3 - Examples of actions taken following National audits	
Title	***Action / Outcome***
Bowel obstruction (NCEPOD) (4043)	• Routine recording of frailty score for older patients and risk assessment for all surgical patients is now carried out
BTS Smoking Cessation Audit 2019 PRH (4304)	• Recording of smoking status better than national average • An aide memoire created and distributed to junior doctors. The NRT (nicotine replacement therapy) prescribing policy is now available to all staff on the intranet.
Cancer Patient Experience Survey 2019(4564)	• Demonstrated consistent improvements in areas of previous poor performance
Cataract Audit (Ophthalmology Database Audit 2020) (4699)	• Visual outcome is in keeping with the national outcome
College of Emergency Medicine: Care of Children in ED (PRH) (4338)	• There has been significant improvement since then. • In response to the audit a patient improvement action plan was produced • As part of this plan • All patients are now discussed with a senior prior to discharge • If over 16 years of age will be assessed by RAID and if under 16 years of age we now have direct access to a CAMHS consultant
College of Emergency Medicine: Care of Children in ED (RSH) (4337)	• This data is out of date and there has been significant movement since then. • There has been the patient improvement action plan that we report to the CQC which has improved most of this plan - All patients are now discussed with a senior prior to discharge - Patients over 16 years of age are now assessed by RAID and if there is direct access to a CAMHS consultant for patients under 16 years ofage Local audit has shown improvement in all areas

Table 3 - Examples of actions taken following National audits	
Title	***Action / Outcome***
	following implementation of the action plan
COVIDTrach; a UK national service evaluation of mechanically ventilated COVID-19 patients undergoing tracheostomy (4516)	• Tracheostomy for Covid positive patients is safe for both patients and surgeons • Timing of surgery has been changed to ensure the risk of delay is reduced
Epilepsy12 audit round 3 (3926)	• As the EEG facility is provided by different Trust, it is not possible to meet the criteria. Consultant will forward the Audit results to them and will come up with a plan to meet the criteria • SUDEP (sudden unexpected death in epilepsy) will be discussed in the epilepsy MDT. It will become policy that all epilepsy cases which are high risk for SUDEP are discussed.
Hip Fracture Audit Database (NHFD) - RSH National 2020 (2019 data) (4694)	• High proportion of patients waiting >4 hours in A & E. Work with the A & E team is underway to address this
ICNARC case mix programme – PRH 18-20 (4587)	• Outcomes of the audit are in line with Units of a similar type and size
ICNARC case mix programme – RSH 2018/19 (4036)	• On the 10 metrics measured the Trust is performing as expected or better • Kaplan Meier plot suggested we may have poorer outcomes compared to similar units. We have performed an analysis of the care of these patients which had not identified any causative factors.
ICNARC case mix programme – RSH 2019/20 (4646)	• Unit performance is good • Monitor Kaplan Meier curve. Advice requested from ICNARC
Management of patients that have a massive haemorrhage (4144)	• No actions required (small number of patients submitted – 2)
Cardiac Arrest Audit (NCAA) 2019-2020 (4422)	• Root Cause Analysis reviews (RCAs) are now carried out for all in hospital cardiac arrests so that trends can be identified and action taken if necessary • Focused teaching sessions around ReSPECT to try and prevent futile resuscitation attempts are now taking place.
National Children and Young People's Patient Experience Survey 2018 (4436)	• The introduction of a “Listening to you” leaflet to explain how to escalate concerns was a success • Introduction of Break Buddies to enhance team working while staff on breaks • A relevant post-operative leaflet is given to the parent/carer and this is documented in the child’s notes

Table 3 - Examples of actions taken following National audits	
Title	***Action / Outcome***
National Maternity Survey 2019 (4233)	• The findings are very positive, indicating that overall SaTH performing "Better" other trusts in 4 separate areas. • A Birth Choices Booklet has now been produced
Non Invasive Ventilation study (NIV) 2019 – BTS (4230)	• Long standing, satisfactory service
Peri operative diabetes study (NCEPOD) (3839)	• A national joint standard policy for multidisciplinary management of patients with diabetes who require surgery has been implemented • A new system is now up and running to identify high risk patients for elective surgery at a pre-operative clinic. If an urgent patient is identified, they are referred to diabetic clinic.
RCEM QIP - Cognitive impairment in older people (4576)	• A cognitive impairment tool is being embedded into a new IT system
UK Parkinson's audit 2019 (4299)	• A standardised clinic pro-forma has been developed to ensure required information is collected

Based on information available at the time of publication.

The Trust also undertook 125 local audits, shown in table 3 below.

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
CLINICAL SUPPORT - PATHOLOGY & RADIOLOGY AND THERAPIES		
1	Adequacy of magnetic resonance imaging of the shoulder - re-audit (4540)	• There was significant improvement in the Shoulder MRI examination coverage after the primary audit and hence no further concerns identified
2	Adequacy of magnetic resonance imaging of the shoulder (4501)	• MRI radiographers are now better aware of the recommended coverage and anatomical landmarks for MRI shoulder examination • Re-audit has also been done with much improved results
3	Adequate Contrast Enhancement of CT Pulmonary Angiograms (4500)	• Radiographers have started using a large cannula (ideal minimum of 20 gauge) in the antecubital fossa with appropriate arm positioning not too high above the head. • They are scanning in minimal rather than maximal inspiration
4	Audit on destination from hospital (4663)	• Goals are being achieved
5	Blood transfusion practice 2017 (NICE Guideline NG24 (4327)	• Specific training has been given to all new SaTH medical staff, including FY1s, about the need to

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
		document weight and assess all patients for TACO • Specific training has been given to all new SaTH medical staff, including FY1s, about the need to document informed verbal consent or sign in the "no" box on the Transfusion Record if they were unable to gain consent
6	Breast screening cases with a suspicious history (4289)	• The audit suggests our SH service is effective
7	Chest Xray reports at 12 months (4505)	• The audit showed Good inter radiologist agreement, therefore no need for further review for quality assurance for these CXRs
8	Plain Abdominal X-Ray (4499)	• AXR findings contributed to the diagnosis in 14% patients. To reduce the number of AXR performed, this has been fed back to the surgeons
9	Reporting Times for Major Trauma (4498)	• The problem with outsourced reports not going onto PACS has now been addressed
10	Shropshire Breast Screening Programme Client Satisfaction Survey 2019 (4410)	• Signs acknowledging parking problems and giving information on how to pay has now been put into practice.
11	TNM (tumour, nodes & metastases) staging on PET (positron emission tomography) reports of patients referred from the Upper Gastro intestinal MDT (multi-disciplinary team) in 2019 (4506)	• Lack of TNM staging to be communicated back to the listed Alliance PET reporters
CORPORATE – TRUST WIDE		
12	Bereavement feedback questionnaire 2019-2020 (4584)	• Thank you certificates now issued to wards each month • Improvements on the use of EOLC plan, asking for Preferred Place of Care (PPC) and distributing relative leaflets have been discussed at the EOLC Steering Group meeting & within the team for action
13	Care after Death 2019-20 (4261)	• The audit has identified that clinical staff are now making every effort to transfer the patient to the Swan Bereavement Suite within 4 hours • More ward sisters are to be trained in verification of death to further improve the time frames between the patient's death, and their arrival to the Swan Bereavement Suite
14	Catheter Prevalence (4714)	• The audit was taken to the CAUTI group , the urology nurse collaborated with the Quality Matrons has meant that a Catheter care plan / HOUDINI check list has been introduced to the wards. • The urology nurses have also devised a SOP for patient education and shared them with the Quality team for escalation.
15	End of life care plan Jan-20 (4521)	• More education / review date for plan review Dec-20, work has already been done but not finished due to

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
		Covid19
16	End of life care plan Jun-20 (4586)	• The audit showed good use of the plan during covid-19 • Champion training covers spiritual care needs in depth, and promotes swan scheme fundamentals
17	EOLC comfort chart versus EOLC plan (4610)	• The comfort chart showed that symptom management was assessed and reassessed more consistently • Decision made by EOLC steering group for Comfort Chart to be in the revised addition of the End of Life Care Plan
18	Policy for the use of the ReSPECT form - Jan-20 (4522)	• Promote e-learning package on ReSPECT to all clinical staff members is ongoing.
19	Policy for the use of the ReSPECT form - Jan-21 (4721)	•Focused teaching on wards with spot check audits with feedback documented. •Use of the updated concise MCA form 1+2 to be used when assessing capacity. An improvement has been noted since the last audit. •A clinical lead for ReSPECT would be beneficial to aid in the implementation and correct documentation and use of ReSPECT. The appointment of a lead is due to be discussed later in the year.
20	SaTH End of Life Care audit (4376)	• ReSPECT (DNACPR) documentation often completed on the day of death • Mandatory training for nursing staff on T34 syringe drivers is now in place
21	Trust Outpatient Survey 2018 (4382)	• Results satisfactory, no recommendations necessary.
SCHEDULED - ANAESTHETICS, THEATRES & CRITICAL CARE		
22	Epidural Cases 2019 (4550)	• Management & documentation around post dural puncture headache (PDPH) so much better thanprevious years
23	Handover of post op patients to recovery staff re-audit 2019 (4375)	• Only 60% had absolutely no concern • Discuss with team leader for recovery how to improve – e.g. posters next to beds
SCHEDULED - HEAD, NECK AND OPHTHALMOLOGY		
24	ENT Casenote Audit 2020 - Nov-19 & Jul-20 patients (4619)	• Operation documentation showed significant improvement. • Ward round proforma has been updated to include move of date request and include space for patient sticker
SCHEDULED - MSK		
25	Analysis of paediatric forearm plate removal (4471)	• The results were comparable with other studies, no concerns identified.
26	Ankle Fixation Outcomes (4636)	• Satisfactory results in line with results from large services and guidelines
27	Fascia Iliac Block Audit (4582)	• The Trust was found to be fully compliant with the NICE guidance

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
28	Fractured Neck of Femur Operative Delay: Its Reasons and Impact (4578)	• Theatre capacity has increased for trauma to all day list • A 'golden' patient board located on the wards has been created to ensure patient allocated by on-call team night before
29	Management of supracondylar distal humerus fractures in children (3403)	• Most elbows are fixed on the day, all within 24 hours
30	Neck of Femur documentation & Fascia Iliac Block Administration - re-audit (4625)	• There has been a significant improvement in documentation
31	OSCAR Distal Radius - re-audit (4641)	• Overall the results were satisfactory, however, Use of simple splints could be applied more frequently
32	Outpatient satisfaction survey - fracture clinic 2020 (4556)	• 86% had a "good experience", compared to 52% in 2017
33	Oxygen prescription & pre/post op neurovascular status quality improvement projects (4637)	• Overall good but could improve a little in O2 prescription and documentation of assessment of neurovascular status, therefore the audit confirms expected need to constantly educate, include in junior education and teaching
34	Patient Records Documentation Closed loop Quality Improvement Project (4638)	• Every member of MDT has responsibility to document accurately. A re-audit will be carried out to monitor this.
35	ReSPECT Audit (4583)	• During MDT meetings consultants are now assessing whether the ReSPECT form was completed with proper assessment of mental capacity
36	Role of Orthopaedic department to meet the four hour criteria to review patient in A&E - re-audit (4653)	• The audit confirmed prompt response of T&O teams
37	To Cement Or Not Cement: An audit on the Clinical Outcomes of Hip Hemiarthroplasties (4274)	• Results in terms of complications in line with large publications
38	Trauma services & workload during COVID-19 pandemic (4635)	• The effect of lockdown on the number of paediatric admissions requiring an operative intervention is apparent with 119 less operations
SCHEDULED - SURGERY, ONCOLOGY & HAEMATOLOGY		
39	Archeck measurement audit – 219 (4676)	• No issues identified. A follow up audit is planned.
40	Bladder CTV-PTV (202) (4497)	• Decision made to reduce the CTV-PTV growth based on national guidelines and local audit
41	Bladder margin re-audit – 227 (4684)	• Good compliance with the protocol. The team to continue bladder monitoring as part of treatment
42	Brain setup uncertainty – 218 (4675)	• This data suggests the margins are sufficient atpresent, and that the immobilisation is working adequately
43	Breast Telephone follow up call (212) (4574)	• Following the audit it seems that the majority of patients cope well physically with the 5# +/- 4# boost, treatment

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
		regime • Moved to a 2 week post RT telephone follow up rather than a 1 week follow up. Plan to re-audit to see if there has been any changes in the outcomes.
44	Casenote Oncology 2017 & 2018 (3962)	• Departmental teaching on INTERESTING REAL cases where failure in adequate/ good documentation had resulted in medicolegal issues
45	Cervical cancer patients receiving brachytherapy (206) (4568)	• The audit raised issues with provision at New Cross. Alternative to New Cross arranged for this specific patient group
46	Checks & Weeklies – 224 (4681)	• Good compliance • A re-audit is planned.
47	Chemo spill training – 230 (4707)	• Changes to the QA documents are planned to reflect change to storage of chemo spill kits • A re-audit will be undertaken
48	Compliance with the BSH Guidelines for screening and management of late and long-term consequences of myeloma and its treatment (4427)	• Existing patient assessment proforma has been modified to include late-effects section • New checklist for accurate documentation in use.
49	Current IGRT protocol of IMC Patients – 231 (4708)	• All patients receive appropriate imaging for individual treatments • Discussion with breast site specific team about whether move to daily cbct is justified, review of protocol needed
50	Daily CBCT gynae patients - re-audit (203) (4565)	• No issues from audit no need to repeat as has been done twice now with same result
51	Endoscopy Unit Patient Satisfaction Questionnaire (15) - re-audit (4527)	• Very positive that 100% were satisfied with the information given &/or the way a query was handled. • To ensure aftercare sheets are given to patients on discharge, this will be raised at huddles
52	Endoscopy Unit Patient Satisfaction Questionnaire (14) - re-audit (4480)	• Positive patient survey with the majority of our patients stating that they would recommend our service to family and friends
53	Erlotinib and gefitinib for treating non-small-cell lung cancer that has progressed after prior chemotherapy - TA374 (3960)	• As a Trust we are 100% compliant with the NICE TA 374: Erlotonib and gefitinib for treating non-small-cell lung cancer that has progressed after prior chemotherapy
54	Gulmay treatment process – 229 (4706)	• All treatment processes carried out appropriately
55	Gulmay use 2019 (211) (4573)	• Gulmay machine is a useful piece of equipment that provided treatment for cancer patients when surgical option was unavailable
56	Handover log – 225 (4682)	• Not all machines have achieved good compliance level. An email has been sent to staff
57	Histopathological correlation of magnetic resonance imaging-identified additional lesions detected	• The results are preliminary and promising, therefore no concerns identified.

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
	in 2nd read breast MRIs (4380)	
58	HN process audit – 220 (4677)	• Some documents will be updated to reflect the process better
59	IGRT General Audit 2020 (209) (4571)	• This audit has shown that overall; processes are being followed very well. All the patients in this audit have had the correct scheduling with appropriate action documented
60	Life after radical prostatectomy (EPIC) audit (4712)	• High patient compliant • Result similar to NPCA audit
61	Lower GI imaging – 215 (4672)	• CTV – PTV margin sufficient no changes to protocol required
62	Magseed Guided Excision of breast lesions (4211)	• Reduction in re-excision rate. • Improved patient experience • Cost savings
63	Metastatic spinal cord compression in adults: risk management, diagnosis & management - CG75 (4466)	• MRI scans are carried out effectively • Pain ladder is in good use • Dexamethasone was prescribed for those patients who needed it. • All cases had regular observations
64	MSCC patients treated Dec-18 - Jun-19 (210) (4572)	• Based on current evidence, MRIs are being performed and reported on quickly. There is no delay from diagnostic department. CT scans and radiotherapy treatment is delivered within 48hrs. • Majority of patients still being treated with 5#s, query whether needed as overall survival difference is minimal. Further audit later to investigate overall survival difference between multiple single fraction treatment vs 5# or more.
65	Non conformities Dec-19 to Mar-20 – 213 (4670)	• Bench mark well against national data • Planning error codes have increased slightly, these have been investigated further.
66	Non-conformities data Aug-19 – Nov-19 (204) (4566)	• Similar benchmarking against national data gives reassurance
67	Non-conformity reporting – 217 (4674)	• Radiographers have shown complete engagement with the reporting system
68	Palliative patients (excluding MSCC) 30 day mortality – 232 (4709)	• Acceptable mortality level witnessed for palliative radiotherapy excluding MSCC group
69	Pregnancy status – 223 (4680)	• Excellent compliance, no concerns identified
70	Pre-Treatment Head and Neck Patients with Immobilisation Shell – 2.6 – PTX QAP (205) (4567)	• The QAP is being followed and is still appropriate
71	Pro-biopsy prostate MRI (4628)	• No recommendations necessary, cancer detection outcome is similar to reported literature
72	Prostate cancer (metastatic, castration resistant) - abiraterone	• Abiraterone was being used in accordance with the NICE guidance

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
	(following cytoxic therapy) - TAG259 (3961)	
73	QC - MV Photons QMS audit (208) (4570)	• The documentation reflects the current QC practice, and all are up to date
74	Quality objectives – 233 (4710)	• Prostate data is now provided to the radiotherapy management team in an audit report
75	Quality Policy & Objectives (201) (4496)	• No issues were found the documents are correctly applied and managed
76	Radiotherapy CT audit – 216 (4673)	• Reassurance that CT doses (DLPs) for most patients are not excessive
77	Renal & Ureteric Stone audit (4654)	• 100% of patients in the sample presenting withsuspected renal/ureteric stones received a CT urinary tract within 24 hours
78	Review of percentage of QA docs beyond their review date – 228 (4705)	• Documents have been updated and reissued
79	Review of QA documents – 226 (4683)	• Documents that require an update and transfer are currently being reviewed
80	Single vs dual antiplatelet therapy in carotid endarterectomy (4167)	• Not enough data was collection to make any meaningful conclusions
81	Site & Laterality – 222 (4679)	• 100% compliance achieved
82	Timeliness of Plans – 221 (4678)	• Due to delays with pathways, site specific meetings have been arranged to address this.
83	Urology US for bladder – 214 (4671)	• The changes to the documents have been Successful
84	Vacbag audit write up (207) (4569)	• A way forward has been found for this tricky patient group which allows quicker treatment for the patient and reduces additional minor dose from imaging
85	Weekend On Call (200) (4495)	• No concerns identified from the audit
UNSCHEDULED – EMERGENCY ASSESSMENT & MEDICINE		
86	ABG's in COPD patients - NICE Clinical Guideline NG115 (4563)	• To ensure ABGs are performed on all patients with COPD who are requiring Oxygen or who are suspected to be in Type 2 Respiratory Failure, the medical clerking proforma will be updated
87	Audit of local diabetes foot ulceration (4698)	• A pathway will be devised to aid triage of urgency of need/capacity
88	Audit & QIP of Intravenous Iron in non-dialysis Renal SaTH (4553)	• The audit raised concerns with Use of iv iron in heart failure, therefore a further audit will take place
89	Cardiac Arrests in hospital (4469)	• No significant concerns found. Cardiac arrestsdecisions were appropriate for the time when the arrests are happening
90	Case for QIP VTE prophylaxis (4549)	• There is a plan to incorporate the complications of VTE prescription in a card which will have other details on it as well
91	Cinacalcet use in SaTH (NICE	• Cinacalcet use outside of NICE guidance has been

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
	TAG117) re-audit 2019 (4552)	addressed.
92	Coding compliance in the Emergency Department RSH (QIP) (4577)	• The action plan around this is already embedded in the IT action plan around Vitals and CAREFLOW ED
93	Compliance with minimum data content of discharge summaries for AKI patients (4420)	• Overall compliance is reasonable and areas where we are not performing well can be quickly improved with education of the medical team
94	DKA management on the acute medical unit (4053)	• Posters will be produced and placed in AMU doctor's office to reinforce prescribing long acting insulin for all patients presenting with DKA
95	Driving advice for cardiac patients – QIP (4470)	• Ensure written information is given to patients regarding driving after diagnosed with cardiac conditions, and any concerns are referred to DVLA guidelines
96	First Fit proforma (4536)	• First Fit referrals are now phoned through to the consultant as routine to facilitate prompt diagnosis • The Sath Seizure Patient Information leaflet is now hyperlinked to the Proforma on the intranet.
97	Inpatient Administration of Parkinson's Disease Medications (4532)	• The audit revealed numerous concerns, and these will be addressed in the near future.

98	Local Renal Registry (4555)	• Gaps remain in the transplant pathways. To address this, the following will be implemented:
		  • Monthly CKD QA with consultant and respective CKD nurse
		  • At least quarterly meetings with Transplant Sister and consultants to discuss patients in the Transplant Pathway
		  • Initiate Transplant preparation early in the CKD journey

99	Mental Health Audit at PRH (4575)	• The need to have Mental Health triage tool – this has been implemented and currently been use • Mental Health observation document – this has been produce and currently in use
100	Mood assessment in acute stroke – NICE Clinical Guideline NG128 (4349)	• The consultant will look for alternative methods of assessments of mood disorder in stroke patients
101	Needlestick Injuries (4702)	• To improve documentation, the process has been discussed at induction
102	Pilot in-patient Audit (4697)	• A SOP will be devised for podiatrists undertaking the service
103	Radiological follow up of patients discharged following hospital admission with community acquired pneumonia (4086)	• Discharge plan regarding follow up in patients with pneumonia is now included in respiratory junior doctor induction
104	RCEM Severe Sepsis and Septic shock local re-audit (4412)	• Compliance with sepsis screening and treatment – this has been addressed by the CQC action plan

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
105	Sleep apnoea - continuous positive airways pressure (CPAP) – NICE Technology Appraisal TAG139 (3628)	• To ensure documentation of the relevant fields are in one place, an A4 form to capture all information will be produced
106	Swabs and Antibiotic sensitivity in Diabetic Foot Ulcers (4658)	• The lead podiatrist for diabetes will devise a pathway for microbiological sampling
107	Stroke discharge summaries (4413)	• Modified Rankin Score is to be added to the discharge summary • A re-audit is planned
108	Tolvaptan Audit (4554)	• We are compliant with NICE Audit standards. The audit however, identified a need for Homecare delivery, but this is not possible at this time.
109	Transient loss of consciousness - RSH re-audit (4701)	• To address the issues of the audit, this will be discussed at future inductions.
110	Transient loss of consciousness in adults and young people – NICE Clinical Guideline CG109 (RSH) (4558)	• A flow chart has been produced to improve compliance with the NICE TLOC guideline
111	Tuberculosis – NICE Clinical Guideline NG33 (3832)	• Standards are being met in the TB service in PRH
112	Valproate use in women & girls of childbearing years (4687)	• Those patients identified in the audit not to have evidence of RAF within notes to be booked for outpatient review with relevant clinician
113	VTE Audit: Electronic VTE assessment; Exploring its correlation with VTE prescribing and barriers to its utility in clinical practice (4519)	• VTE assessments are not being performed using the existing Vitalpac electronic system. This was discussed at the relevant meetings, and escalated to the MD office
WOMEN & CHILDREN'S		
114	Admission temperatures in babies being admitted to the Neonatal Unit (4588)	• Overall, increased awareness and areas of good practice with multi-disciplinary working • 100% of babies have their temperatures measured within one hour of admission to the neonatal unit.
115	Case-note Audit - Paediatrics 2019 (4502)	• There is a session on documentation in the induction of junior doctors and during the session the importance of good and clear documentation is discussed and the results of the Audit are briefly discussed.
116	Deliberate Self Harm in Paediatric Patients 2020 (4711)	• Implementation of the HEEADS assessment tool – discuss during the induction and Discuss the need for CAMHS referral with patient/family (even if known to CAMHS) and document discussion within notes
117	Determining optimum investigation pathways for women presenting with post-menopausal bleeding plus audit of current practice (4511)	• Following this audit, the guideline and SOP have been updated.
118	Diagnosis and management of Gynaecology Cancers during Covid	• Good service, no concerns identified

Table 4 - Trust local audits 2020-21 (125)		
No.	**Audit Title**	**Key actions/improvements following audit**
	Pandemic (4615)	
119	Early endometrial cancer management re-audit (4235)	• Letters from tertiary care are now uploaded to portal. This ensures plan is available on the intranet for users
120	Head Injury Audit/ QIP (Paediatrics) 2020 (4639)	• Education is being provided on ward rounds to ensure guidelines are being followed.
121	Incident Debrief: neonatal unit team - availability and effectiveness (4292)	• An Incident debrief flowchart has been produced
122	Neonatal Long Line Audit (4547)	• Neonatal medical and ANNP staff need to documentthe catheter size on the LocSSIPs form. There is already a clearly prompt in the relevant box on the form.This has been reinforced via email.
123	Prescription audit 2020 (4631)	• Documentation issues have been raised at local induction
124	Term Respiratory Admissions to the Neonatal Unit (4503)	• No major concerns noted with improving trends and areas of good practice. Areas for further improvement highlighted in this audit
125	Urethral bulking agents - NICE Interventional Procedure IPG138 (4152)	• A business case is currently being devised to perform procedure under local anaesthetic

Examples of actions taken following participation in national audits are listed in table 4 below

Table 4 - Examples of actions taken following National audits	
Title	***Action / Outcome***
Bowel obstruction (NCEPOD) (4043)	• Routine recording of frailty score for older patients and risk assessment for all surgical patients is now carried out
BTS Smoking Cessation Audit 2019 PRH (4304)	• Recording of smoking status better than national average • An aide memoire created and distributed to junior doctors. The NRT (nicotine replacement therapy) prescribing policy is now available to all staff on the intranet.
Cancer Patient Experience Survey 2019(4564)	• Demonstrated consistent improvements in areas of previous poor performance
Cataract Audit (Ophthalmology Database Audit 2020) (4699)	• Visual outcome is in keeping with the national outcome
College of Emergency Medicine: Care of Children in ED (PRH) (4338)	• There has been significant improvement since then. • In response to the audit a patient improvement action plan was produced • As part of this plan

Table 4 - Examples of actions taken following National audits	
Title	***Action / Outcome***
	• All patients are now discussed with a senior prior to discharge • If over 16 years of age will be assessed by RAID and if under 16 years of age we now have direct access to a CAMHS consultant
College of Emergency Medicine: Care of Children in ED (RSH) (4337)	• This data is out of date and there has been significant movement since then. • There has been the patient improvement action plan that we report to the CQC which has improved most of this plan - All patients are now discussed with a senior prior to discharge - Patients over 16 years of age are now assessed by RAID and if there is direct access to a CAMHS consultant for patients under 16 years of age Local audit has shown improvement in all areas following implementation of the action plan
COVID Trach; a UK national service evaluation of mechanically ventilated COVID-19 patients undergoing tracheostomy (4516)	• Tracheostomy for Covid positive patients is safe for both patients and surgeons • Timing of surgery has been changed to ensure the risk of delay is reduced
Epilepsy12 audit round 3 (3926)	• As the EEG facility is provided by different Trust, it is not possible to meet the criteria. Consultant will forward the Audit results to them and willcome up with a plan to meet the criteria • SUDEP (sudden unexpected death in epilepsy) will be discussed in the epilepsy MDT. It will become policy that all epilepsy cases which are high risk for SUDEP are discussed.
Hip Fracture Audit Database (NHFD) - RSH National 2020 (2019 data) (4694)	• High proportion of patients waiting >4 hours in A & E. Work with the A & E team is underway to address this
ICNARC case mix programme – PRH 18-20 (4587)	• Outcomes of the audit are in line with Units of a similar type and size
ICNARC case mix programme – RSH 2018/19 (4036)	• On the 10 metrics measured the Trust is performing as expected or better • Kaplan Meier plot suggested we may have poorer outcomes compared to similar units. We have performed an analysis of the care of these patients which had not identified any causative factors.
ICNARC case mix programme – RSH 2019/20 (4646)	• Unit performance is good • Monitor Kaplan Meier curve. Advice requested

Table 4 - Examples of actions taken following National audits	
Title	***Action / Outcome***
	from ICNARC
Management of patients that have a massive haemorrhage (4144)	• No actions required (small number of patients submitted – 2)
Cardiac Arrest Audit (NCAA) 2019-2020 (4422)	• Root Cause Analysis reviews (RCAs) are now carried out for all in hospital cardiac arrests so that trends can be identified and action taken if necessary • Focused teaching sessions around ReSPECT to try and prevent futile resuscitation attempts are now taking place.
National Children and Young People's Patient Experience Survey 2018 (4436)	• The introduction of a “Listening to you” leaflet to explain how to escalate concerns was a success • Introduction of Break Buddies to enhance team working while staff on breaks • A relevant post-operative leaflet is given to the parent/carer and this is documented in the child’s notes
National Maternity Survey 2019 (4233)	• The findings are very positive, indicating that overall SaTH performing “Better” other trusts in 4 separate areas. • A Birth Choices Booklet has now been produced
Non Invasive Ventilation study (NIV) 2019 – BTS (4230)	• Long standing, satisfactory service
Peri-operative diabetes study (NCEPOD) (3839)	• A national joint standard policy formultidisciplinary management of patients with diabetes who require surgery has been implemented • A new system is now up and running to identify high risk patients for elective surgery at a pre-operative clinic. If an urgent patient is identified, they are referred to diabetic clinic.
RCEM QIP - Cognitive impairment in older people (4576)	• A cognitive impairment tool is being embedded into a new IT system
UK Parkinson's audit 2019 (4299)	• A standardised clinic pro-forma has been developed to ensure required information is collected

Based on information available at the time of publication.

Clinical Audit Outcomes

The reports of 124 clinical audits were reviewed by the provider and a compliance rating against the standards audited agreed. However, 12 (10%) local audits demonstrated moderate or significant noncompliance against the standards audited. The Shrewsbury and Telford Hospital NHS Trust intends to take actions to improve the quality of healthcare provided and will consider re-audit against these standards once actions have been appropriately embedded.

Audit title - score	Recommendations - actions
Adequate Contrast Enhancement of CT Pulmonary Angiograms (4500) - Moderate non complaint	• Ensure radiographers realise the importance of a large cannula (ideal minimum of 20 gauge) in the antecubital fossa with appropriate arm positioning not too high above the head. The preferred rate of contrast injection should be established • With faster scanners and appropriate patients, scanning in minimal rather than maximal inspiration can be encouraged (to avoid a negative intrathoracic pressure drawing unpacified blood in from the IVC) • The strength and volume of contrast can be adjusted and the use of a saline chaser explored • Utilise a different protocol: • Fixed timing e.g. 17s • Bolus tracking, generally performed from the main pulmonary artery, but different thresholds may be used and the time to first scan slice can be varied • A test bolus can be used to define the optimum timing using a preliminary bolus to define the peak enhancement and follow it with the diagnostic scan • The following has now been implemented Radiographers have started using a large cannula (ideal minimum of 20 gauge) in the antecubital fossa with appropriate arm positioning not too high above the head. They are scanning in minimal rather than maximal inspiration.
Blood transfusion practice 2017 (NICE Guideline NG24 (4327) - Moderate non complaint	• Patient's weight needs to be considered prior to transfusion, alongside a consideration of the risk factors or TACO - Specific training to all new Trust medical staff was provided in Jul/Aug 2019/2020, including FY1s, about the need to document weight and assess all patients for TACO • Informed verbal consent should be obtained and documented prior to transfusion for patients able to do so - Specific training to all new Trust medical staff was provided in Jul/Aug 2019/2020, including FY1s, about the need to document informed verbal consent or sign in the "no" box on the Transfusion Record if they were unable to gain consent
TNM (tumour, nodes & metastases) staging on PET (positron emission tomography) reports of patients referred from the	• Inclusion of formal TNM staging in report - Lack of TNM staging to be communicated back to the listed Alliance PET reporters

Upper Gastro intestinal MDT (multi-disciplinary team) in 2019 (4506) - Moderate non complaint	
Catheter Prevalence (4714) - significant non-compliant	• Increased awareness required re nursing requirements of catheter documentation and monitoring. - Urology nurses to follow through with Quality nurse Matrons • To revisit clinical areas regarding using catheter cards on discharge/ relaunch of catheter card information. - To be included in sop for patients being discharged with a catheter • To re-establish the CAUTI meetings during the COVID-19 pandemic (the LHE BSIR group) having been currently disbanded) so that the antimicrobial management , catheter care and catheter education can be highlighted to those specialists with their responsibility to action improvement - Quarterly meetings to be reintroduced • To highlight to clinical governance the need to improve discharge summary information by clinicians , this will be done by Microbiology as discussed in Catheter associated urinary tract infection (Cauti) meetings. Doctor to bring to the Clinical Governance meetings • For nurse educators and urology specialists nurse team to "spotlight" good catheter care and documentation on a staff learning collaboration throughout the trust and so to enhance good patient education on catheter care too. Urology nurses to develop an SOP to be distributed to wards showing best practise catheter care and documentation that should be included. - Urology nurses to follow through with Quality nurse Matrons. SOP developed by Urology nurses for TWOC and insertion of catheters. • Will be part of the online training and stat training now being provided by the urology nurses on Trust induction and preceptors awareness course • For the use of prophylactic antibiotics in catheter care to be reviewed and discussed by microbiology and pharmacy antimicrobial lead as part of antibiotic stewardship . - Brought to IPCC as part of Pharmacy antimicrobial stewardship. Discussed as part of RCA for 31/3/21 CDI/ ECOLI/ MSSA

Research and Development

The ambition is for research to be an integral part of patient care here at the Shrewsbury and Telford Hospital NHS Trust. To that end in 2020/2021 the Trust has been developing a research strategy to address the needs of our patients and wider community. It is recognised that research is an essential part of providing high quality care and that research active organisations have better patient outcomes. The Trust is committed to embedding a culture of research for the benefit of patients, staff and the population we serve.

The number of patients that have been recruited to participate in research during the financial year of 2020/21 was 1191 (for studies approved by a Research Ethics Committee and the Health Research Authority). The portfolio of trials available to recruit to, and their complexity change every year, as such our target for the 2020/2021 was 1896. Due to the COVID-19 pandemic a clear directive from the National Institute of Health Research (NIHR) and Public Health England (PHE) was to focus on Urgent Public Health Measures Studies. These studies are designed to answer questions concerning the current pandemic and require rapid set up and delivery. To this end usual Key Performance Indicators were suspended and replaced with alternatives.

During the 2020/21 the Trust was involved in a number of research grant applications, submitting to national funding bodies, led by staff employed by Trust. Our Research and Innovation department has been awarded a regional award from the NIHR for their collaboration with partners across the Shropshire region in study set up and delivery. They were awarded the West Midlands CRN 'EcoSystem' Award for their innovative approach to set up of the Urgent Public Health Measures study 'SIREN', alongside Midland Partnership Foundation Trust, Shropshire Community Trust, and Robert Jones and Agnes Hunt Orthopaedic Trust. This collaborative way of working has resulted in excess of 600 staff members participating in this important study from across the region within 6 months.

The Shrewsbury and Telford Hospital NHS Trust has been able to contribute to a number of Urgent Public Health Measures Studies including PRIEST, ISARIC, GENOMMIC and RECOVERY many of which have been able to provide answers and treatments for patients with COVID-19. The Trust has managed to achieve an 8% recruitment rate of all positive patients into the RECOVERY Trial since 'green light' date at site.

The Trust continues to be part of the West Midlands Research Training collaborative (WMRTC) providing free training sessions locally and across the region including Principal investigator Masterclass, an NIHR accredited course, Fundamentals of research, Good Clinical Practice and Investigator Site File Training. In addition we continue to host one of the NIHR 70@70 fellows whose aim is to develop training and opportunities for nurses, midwives and allied health professional.

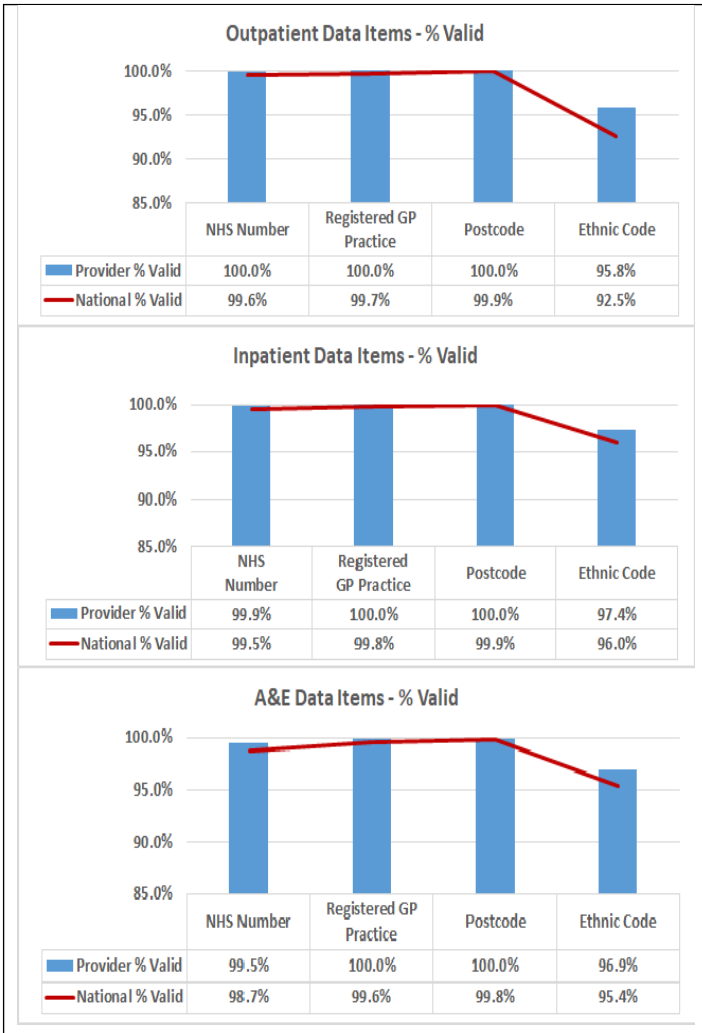
A summary of research activity for 2020/2021:

Research Activity 2020/2021	Number of Studies
New studies opened in 2020/2021	25
Total number of studies open during the period*	*112

**this includes research projects opened in previous years where patients can still actively enrol or are in follow up as well as the new research projects opened in this financial year*

NHS Number and General Medical Practice Code Validity

The Shrewsbury and Telford Hospital NHS Trust submitted records during 2020/2021 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.



Percentage of records which included valid NHS Number was:

- 99.5% for A&E
- 99.9% for Inpatients
  9% for Outpatients
  100%

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

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

All percentages were above national results and the results improved for Accident and Emergency (A&E) and were the same for Outpatients and Inpatients when compared to 2019/2020.

**NHS Number and General Medical Practice Code Validity updated as per month 12, 2020 to 2021 (data extracted on 20th May 2021).*

Data Security and Protection Toolkit Attainment Levels

The Data Security and Protection (DSP) 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 toprovide assurance that they are practising good data security and that personal information is handled correctly. The annual submission is the 31st March however due to the Coronavirus pandemic NHS Digital extended the submission date to the 30th September 2020. The Trustcompleted and submitted the self-assessment in September 2020 for 2019/2020.

For the 19/20 self-assessment our Trust status was Standards not fully met (plan agreed) and we are planning to submit our 20/21 in line with the NHS Digital timeline of submissions.

The Trust has put into place:

- Data quality reviews of records to make sure they are accurate, adequate and not excessive.
- Ensuring staff are aware of data quality issues following any incidents relating to data quality / reviews mentioned above, to prevent reoccurrence.
- A records retention policy and guidance to enable record leads to review / archive / dispose of records to reduce the risks of inaccuracies and excessive retention.

Learning from Deaths

During 2020/2021 2103 patients died within the Shrewsbury and Telford NHS Trust.

Number of Deaths included in the Learning from Deaths Process 2020/2021	
Time Period	**Number of Deaths**
April 2020 to March 2021	
Q1	499
Q2	409
Q3	544
Q4	651
Total	**2103**

By the end of March 2021, 827 (39.32%) of case reviews were carried out in relation to the 2103 deaths. In six cases a death was subject to a case review and an investigation in line with the Trust serious incident framework.

Number of Case Record Reviews in 2020/2021	
Time of Death	**Death Reviewed or Investigated**
April 2020 to March 2021	
Q1	234
Q2	85
Q3	251
Q4	257

Of the 2103 deaths in 2020/21 100% of deaths that occurred at the Royal Shrewsbury Hospital were subject to initial scrutiny by the Medical Examiner Service, with 100% of cases being scrutinised by a Medical Examiner in the first instance at the Princess Royal Hospital from August 2020 when the Medical Examiner Service was implemented there.

Through 2020/21 the Trust has reviewed the mortality review process to bring it in line with the National Quality Board Learning from Deaths Guidance (2017). This has included the move to replace the mortality review tool with a structured judgement review approach in order to increase the focus on learning from the care provided to patients prior to death rather than a focus on avoidability. The use of the structured judgement methodology is aimed at improving the care for living patients.

Number of Deaths reviewed or investigated in 2020/2021 and judged to be more likely than not to have been due to problems in the care provided to the patient	
Time Period April 2020 – March 2021	**Deaths reviewed or investigated 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	3.8%
Q2	1.1%
Q3	3.5%
Q4	1.1%

Six 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 has been a key priority for the Shrewsbury and Telford NHS Trust in 2020/21. The actions taken to achieve this are outlined on the Section 2.1 in Priority 4 when we have discussed the key priorities for 2020/21.

Implementing the Priority Clinical Standards for 7 Day Hospital Services

A 7 Day Services Working Group is in place at the Trust chaired by the Surgery, Anaesthetics and Cancer Divisional Medical Director, on behalf of the Medical Director. The 7 Day Services Working Group has representation from each Division, support services and relevant corporate functions. The purpose of this working group is to plan, identify workforce gaps, financial implications and develop business plans for each area to enable implementation of these four key standards. The Working Group is also required to keep sight of the additional 6 standards and work up plans to identify the gaps in resources and workforce to enable implementation.

The four priority standards:

- Standard **2**: Time to Consultant Review
- Standard **5**: Access to Diagnostics
- Standard **6**: Access to Consultant-directed Interventions
- Standard **8**: On-going Review

Standard 2: Time to Consultant Review
This standard is recognised nationally as challenging. The Trust saw a reduction in performance due to an increase in demand and instability of workforce. The Trust Board has committed to investment in the clinical workforce so we foresee an improvement in this area following recruitment. 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.
Standard 5: Access to Diagnostics
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. Currently, ultrasound can be provided within 1 hour for critical patients. MRI is also now available at weekends by formal arrangements. A business case to deliver overnight urgent MRI scans for patients with suspected cauda-equina syndrome is in progress.
Standard 6: Access to Consultant-directed Interventions
Interventional Radiology - discussions are progressing underway with a neighbouring Trust to establish a formal agreement to provide onsite interventional radiology
Standard 8: On-going Review
The most recent audit results have demonstrated a significant improvement in Clinical standard 8 with twice daily reviews achieving 100% at both weekdays and weekends. This is due to an improved staffing model of the critical care units at weekends, delivered as part of the CQC Quality Improvement Plan.

The Shrewsbury and Telford Hospital NHS Trust is partially compliant with the standards but still faces challenges in achieving these. The Trust has an expectation to fully deliver these standards once the Hospital Transformation Programme has been delivered but this is in contrast to the NHSE/I ambition which was to deliver this nationally by March 2020.

Progress has been limited with the onset of the COVID-19 pandemic. However, the workforce for general surgery has expanded by 4 consultants specifically to bolster the emergency service. The 7 day services group will be collating learning from the pandemic to support the implementation of a strategy to include 7 day service standards in conjunction with the Hospital Transformation Programme (HTP).

Encouraging Staff to Speak Up

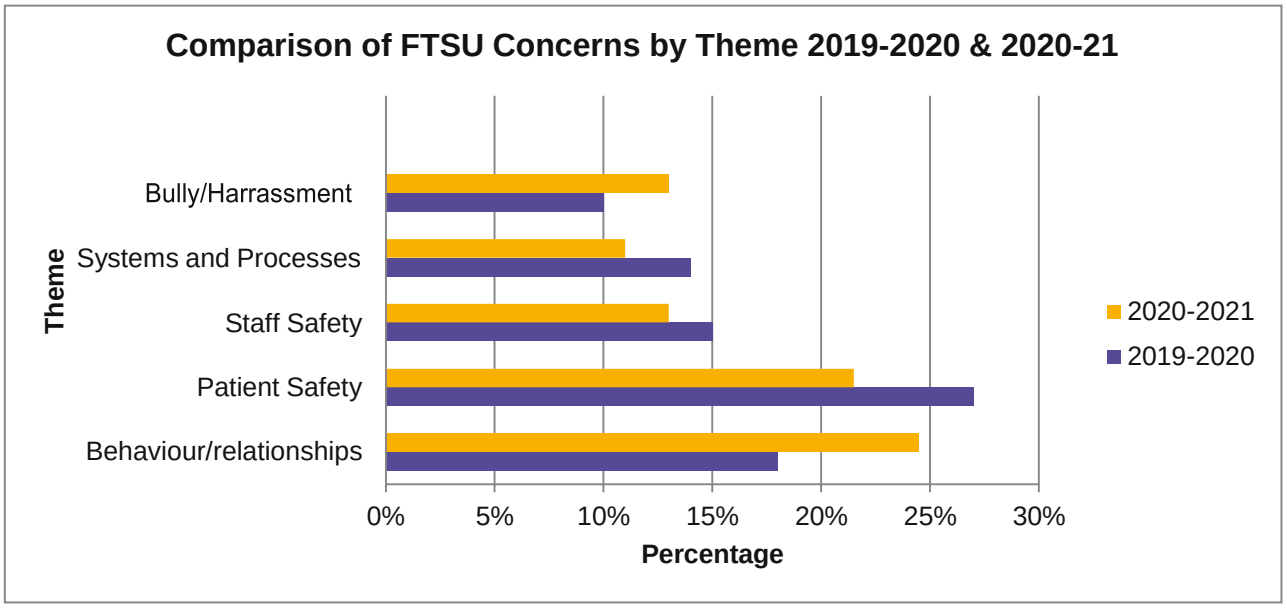
In 2020/21 Freedom to Speak Up (FTSU) arrangements at the Trust continued to be strengthened with the appointment of a Freedom to Speak Up Lead who joined the organisation in late 2020 and two FTSU guardians. To further augment the arrangement the Trust has a network of FTSU ambassadors who promote FTSU and sign post to the teams. In 2020/21 a refresh of the network was undertaken to better represent the diversity of the organisation with 39 ambassadors in total;

these ambassadors are from 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.

In 2020/21 the total number of concerns raised to FTSU Guardians was 302 compared to the year total of 145 in 2019/20. The increase in concerns was partly due to the pandemic which was mirrored nationally but also the increased visibility of the team who visit clinical and non-clinical teams. It is worth noting that nationally the increase was 33.7% up to Quarter 3 but at Shrewsbury and Telford Hospital NHS Trust the increase was 109%. A year on year comparator can be seen below.

	Q1	Q2	Q3	Q4	Total	Increase	National Avg Increase
2020/21	41	82	103	78	**302**	↑ 109%	33.7% Q1-Q3
2019/20	22	17	57	49	**145**	↑ 119%	32%
2018/19	10	18	18	20	**66**	↑ 106%	73%
2017/18	4	7	12	9	**32**	N/A	N/A

In 2020/2021 of the concerns raised 24.5% related to behaviours/relationships; 21.5% related to patient safety; 11% to systems and processes; 13% staff safety; 13% to bullying and harassment. Compared to the themes raised in 2019/20 there has been an increase in FTSU concerns related to behaviour/relationships and a decrease in concerns raised about patient safety in 2020/21.



Of those speaking up 36% were Nurses, 23% Administrative/Clerical Workers, 11% Allied Health Professionals (other than pharmacists) 9% Healthcare Assistants; 7% Midwives; 6% Cleaning/Catering/Maintenance/Ancillary staff; and 6% Doctors.

In 2020/21 arrangements were further enhanced by closer working with colleagues such as the Senior Nursing Team; Staff Side; Equality and Inclusion Team; HR Business Partners; Education Team; Junior Doctor Forums. There have been monthly one to ones with the Chief Executive and Director of Workforce. As the Trust undertakes a robust cultural change programme FTSU continues to play an integral part in this and sits on the Cultural Steering Group. Reporting

arrangements were improved by bringing Board papers in line with NHSE/I guidance and increasing reporting to the Trust Board of Directors quarterly.

Planned improvements in 2021/22 include: a refreshed vision and strategy, communications strategy, a policy review, improved FTSU processes, triangulation of data with patient safety and Human Resources identifying hotspots and themes more readily, mandatory training for all staff on 'speaking up' and improved dissemination of learning from those speaking up.

The Guardian of Safe Working

The Shrewsbury and Telford Hospital NHS Trust Guardian of Safe Working (GoSW) continues to be a member of the 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
- Ensuring the well-being of junior doctors during the pandemic by keeping them up to date with the support available within the Trust via regular newsletters and our intranet pages.
- Providing weekly GoSW virtual meetings to ensure junior doctors get an opportunity to make contact in place of our face-to-face 'drop in' sessions, although the aim is to be reconvene these in July 2021. All forums have been held virtually to ensure social distancing during the pandemic.
- Improving rest facilities in line with the British Medical Association Fatigue and Facilities Charter that the Trust committed to in 2019. This has seen a new doctors' mess built on the Princess Royal Hospital site and a new kitchen area installed at the Royal Shrewsbury Hospital mess and 4 sleeping pods purchased.
- Ensuring compliance with reporting systems as mandated in the Junior Doctor Contract to enable junior doctors to report variations in their work schedule.

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 closelywith the NHS Outcomes Framework (NHSOF). The majority of core indicators are reported by financial year, e.g. from 1st April 2020 to 31st March 2021, however some indicators report on a calendar year or partial year basis. Where indicators are reported on a non-financial year time period this is stated in the data table. It is important to note that some national data sets report in significant arrears and therefore not all data presented are available to the end of the current reporting period.

Summary Hospital-Level Mortality Indicator

The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at Trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who died following hospitalisation at the Trust and the number that would be expected to die 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 2020/2021	**National Average 2020/2021**	**Best Performing Trust 2020/2021**	**Worst Performing Trust 2020/2021**	**SATH 2019**	**SATH 2018**	**SATH 2017**
110.83	100.72	*67.04 "lower than expected"*	121.22 *"higher than expected"*	101.64	99.83	102.84
Data Source CHKS, Insight for Better Healthcare, HES data used against peers						

The Shrewsbury and Telford Hospital NHS Trust considers this data is as described as it is taken from a well-established national source. The SHMI data for 2020/2021 shows that the index for the Shrewsbury and Telford Hospital NHS Trust is 110.83 which is in the "as expected" banding. The worst performing hospital index was 121.22 for 2020/2021 and the national average was 100.72

The Trust's overall mortality metrics for 2020/21 indicate that the Trust is generally within the expected range for the England average and comparable to the peer group. Crude mortality rate has been lower than most other peer groups and in line with the England average.

Mortality scorecard - mortality indicators for SaTH compared to the previous year and peer group

Description	Local Numerator	Local Denominator	Jan 20 - Dec 20	Jan 19 - Dec 19	Performance	Alert
Mortality Rate	1713	134763	1.27%	0.99%		-
Rate of Mortality in hospital within 30 days of elective surgery	2	1809	0.11%	0.06%		-
Rate of Mortality in hospital within 30 days of Non elective surgery	96	6905	1.39%	1.07%		-
% Mortality in hospital within 30 days of emergency admission with a hip fracture (age 65 and over)	5	133	3.76%	3.29%		-
Rates of mortality in hospital within 30 days of emergency admission with a stroke	92	955	9.63%	9.05%		-
% Mortality in hospital within 30 days of emergency admission with a heart attack (MI) aged 35 to 74	1	297	0.34%	1.18%		-
Deaths in Low Mortality CCS Groups	17	10457	0.16%	0.16%		-
% Still Births	10	4136	0.24%	0.41%		-
Mortality Rate - Admitted via A&E	1450	30304	4.78%	3.71%		-
HSMR (Hospital Standardised Mortality Ratio)	1343	1492.51	89.98	88.11		-
SHMI (Summary Hospital-Level Mortality Index)	1847	1698.74	108.73	101.55		-
RAMI (Risk adjusted mortality index) 2018	1713	1613.68	106.16	88.08		-
RAMI (Risk adjusted mortality index) 2018 without Confirmed or Suspected Covid-19	1408	1532.30	91.89	88.08		-

A new clinical lead for mortality has been appointed and a Trust Mortality Lead. The Mortality Review Group has met throughout 2020/2021 and routinely monitors mortality rates includingmortality rates by specialty, diagnosis and procedure.

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 2020/2021	**National Average 2020/2021**	**Highest Score Trust 2020/2021**	**Lowest Score Trust 2020/21**	**SATH 2019**	**SATH 2018**	**SATH 2017**
21.54%	34.69%	73.1%	3.39%	23.81	22.51	17.51
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 NHSpatients 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 2020/2021	**National Average 2019/20**	**Highest Score Trust 2019/20**	**Lowest Score Trust 2019/20**	**SATH 2019**	**SATH 2018**	**SATH 2017**
Hip Replacement	No data available	0.46	0.53	0.339	0.47	0.43	0.5
Knee Replacement	No data available	0.33	0.405	0.243	0.373	0.32	0.34
Data Source – HED. There is no data available for 2020/2021.							

The Shrewsbury and Telford Hospital NHS Trust considers this data is accurate as it is taken from a national source. PROMs figures reflect the average adjusted health gain (unadjusted average difference between pre- and post-operative scores), using the EQ-5D Index. All elective orthopaedic work previously undertaken by the Shrewsbury and Telford Hospital NHS Trust was re-located to the Robert Jones and Agnes Hunt NHS Foundation Trust from March 2020 due to the COVID-19 pandemic. Based on the data, the Trust scored above the national average for both procedures in 2019/20. No data is available for 2020/2021at the time of the Quality Account being collated.

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 2020/2021	**National Average 2020/2021**	**SATH 2019/20**	**SATH 2018/19**	**SATH 2017/18**
0-15	13.32%	9.56%	13.57	12.659	10.86
16 and over	8.82%	8.69%	8.44	8.872	8.17
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. Due to COVID-19 pandemic and lockdown, the activity coming into the Trust was affected from March 2020. The new Trust Quality Strategy has a priority in relation to “Right Care, Right Place” which aims to look at discharges processes and improvements to this.

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

The results for 2019/2020 are included in the Quality Account. Given the late reporting of last year’s (2019/2020) Quality Account due to the COVID-19 pandemic these results were also included in last 2019/2020 Quality Account. The next Survey results will be published on the 19th August 2021.

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	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 (see Section 3.2, National Survey 2019).

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 2020/21	**National Average 2020/2021**	**Best Performing Trust 2020/2021**	**Worst Performing Trust 2020/2021**	**SATH 2019**	**SATH 2018**	**SATH 2017**
61.4%	70.2%	89.4%	48.2%	53.6	52.6	60
Data Source – National NHS Staff Survey, provided by the NHS Survey Co-ordination Centre on behalf of NHSE/I. NHS employees in England were invited to participate in the survey during October and November 2020. Staff were eligible to take part if they were employed directly by an NHS organisation on 1st September 2020						

The Shrewsbury and Telford Hospitals NHS Trust considers this data accurate as it is produced by the NHS Survey Co-ordination Centre in accordance with strict criteria.

The Trust has continued to implemented actions to improve the quality of its staffs' experience of working at the Trust throughout 2020/2021. The new Trust Values were implemented in Quarter 2 of 2020/2021 and the implementation of the People Strategy continued in 2020/2021 and the implementation of a Behavioural Framework commenced.

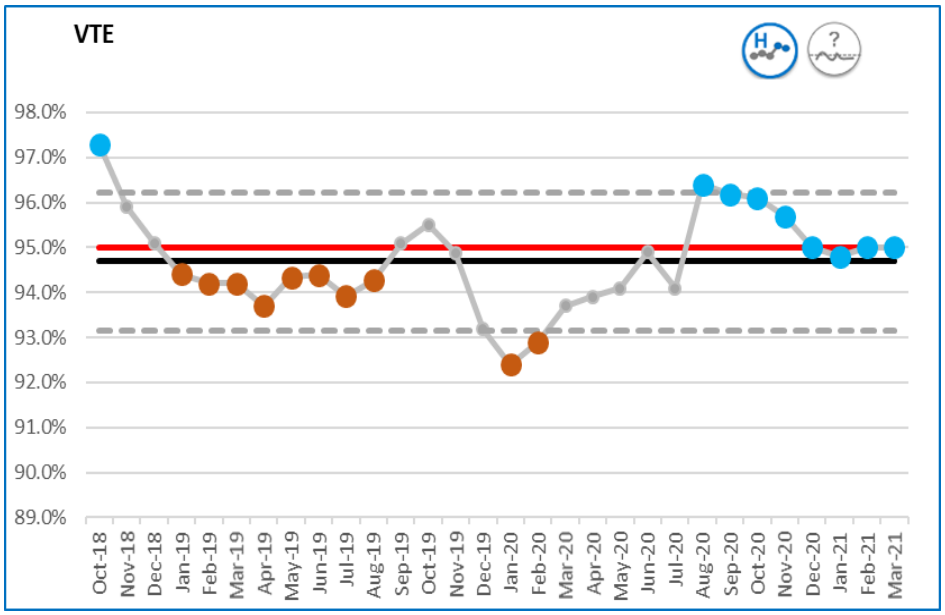
Venous Thromboembolism (VTE)

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.

The national submission VTE submission was paused in Quarter 4 of 2019/20 due to the COVID-19 pandemic and did not recommence throughout 2020/2021. The Trust made the decision to continue to collect this data and validate this information internally; these figures are included in the Quality Account alongside previous years' performance as a comparison.

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 2020/21	**National Average 2020/21**	**Best Performing Trust 2020/21**	**Worst Performing Trust 2020/21**	**SATH 2019/20**	**SATH 2018/19**	**SATH 2017/18**
95.06%	No National data available	No National data available	No data available	94.37% (Apr-Dec 2019)	95.81%	95.58
Data Source - https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201920/. Previous years' data represents the benchmarking performance nationally. As of December 2019, the national VTE return was stopped. The Trust however reinstated the monitoring of VTE. The 2020/21 figure is provided using SemaHelix and Vital Pack.						

The VTE data is routinely monitored and scrutinised in the monthly Integrated Performance Report presented to the Quality Operational Committee, Quality and Safety Assurance Committee and Trust Board.



The recording of VTE assessment has improved to the 95% target as a result of an education programme and interventions. The next phase for the coming year will be ensuring that no patients leave assessment areas without an assessment having taken place.

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 of patient safety incidents reported within the Trust during 2020/2021 and the percentage of such patient safety incidents that resulted in severe harm or death are shown.

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 (1st April 2020 to 31st Sept 2020)	**National Average** (1st April 2020 to 31st September 2020)	**SaTH** (1st October 2019 to 31st March 2020)	**National Average** (1st October 2019 to 31st March 2020)
Number of Patient Safety Incidents	5776	4393	7199	6575
Percentage of Patient safety incidents which resulted in severe harm or death	0.21	0.27	0.22	0.33
Data Source - For incidents occurring in England from 1st April 2020 to 31st September 2020 submitted to the National Reporting and Learning System (NRLS). Please not comparison data for				

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). NRLS comparison data for October 2020 to March 2021 is not available as NRLS are in the process of transferring to a new system.

A daily report of all incidents across the Trust is circulated to all Executive Director and Divisional Management Team. All patient incidents reported as moderate or above are validated by the Patient Safety Team and Divisional Senior Clinical Team/Governance Leads at the weekly Rapid Review Meeting. The Review, Action and Learning from Incidents Group (RALIG) chaired by the Medical Director meet weekly to review all incidents which potentially meet the threshold for a Serious Incident (SI) or Never Event and make the decision in relation to the level of investigation and the reporting of the incident as a SI.

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 is shown, this is the most recent national data available. The Clostridium difficile rate per 100,000 bed days for 2020/2021 is also shown but this figure is based on the Trust data rather than externally validated as this was not available at the time of collating the Quality Account.

Indicator	**The rate per 100,000 bed days of Trust apportioned cases of C.Difficile Infection that have occurred 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 2020/2021	**National Average 2019/20**	**Best Performing Trust 2019/20**	**Worst Performing Trust 2019/20**	**SATH 2019/20**	**SATH 2018/19**	**SATH 2017/18**
13.64 (Trust Data)	15.34	3.39	34.68	19.44	7.03	11.74
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

There was no nationally agreed target set by NHSE/I for the Trust for 2020/2021. At end of 2020/2021 there were 30 cases of Clostridium difficile apportioned to the Trust against a locally agreed target of no more than 43 cases; this was a significant improvement from the 54 cases reported in 2019/2020.

All Clostridium Difficile cases attributed to the Trust have a Root Cause Analysis (RCA) Investigation undertaken. Antibiotics usage, timely obtaining of stool samples and isolation continue to be the most commonly attributed issues associated with Clostridium difficile cases and the Trust sees very few cases that suggest transmission in hospital.

2.4 Looking forward to our Priorities for Quality Improvement 2021-2022

In September 2020 an improvement alliance with the University Hospitals Birmingham NHS Foundation Trust and the Shrewsbury and Telford Hospital NHS Trust was developed. As part of this a "Getting to Good" Programme was implemented with the aim of supporting the Trust to progress its improvements and move towards achieving an improved rating with the CQC and out of special measures. One of the "Getting to Good" programme work-streams was the development of a Quality Strategy.

The priorities for the Quality Strategy were proposed based on known areas of risk, themes from the regulatory compliance work-stream, and the NHS Patient Safety Strategy. These were consulted on with staff using a Survey Monkey, focus groups, existing meetings and forums. Additional previous feedback provided from engagement champions, non-clinical areas, the CCG, patient groups and Healthwatch in relation to patient care, experience and concerns were incorporated. The Quality Strategy for 2021-2024 was agreed by the Trust Board in March 2021. The eight priorities within the Quality Strategy are the priorities agreed for the Quality Account for 2021/2022 and the following year. These eight priorities for 2021/2022 are outlined:

Quality Priorities	
Priority 1:	**Learning from Events and Developing a Safety Culture**
Priority 2:	**The Deteriorating Patient**
Priority 3:	**Inpatient Falls**
Priority 4:	**Best clinical outcomes**
Priority 5:	**Right care, right place, right time**
Priority 6	**Learning from experience**
Priority 7:	**Vulnerable patients**
Priority 8	**End of life care**

Priority 1: Learning from Events and Developing a Safety Culture

We will aim to:

We will work to embed a forward thinking patient safety culture across the organisation which is focused on systems learning and genuine quality improvement. We will work to base our safety culture round the key principles outlined in the 2019 National Patient Strategy and make that strategy reality in the day to day delivery of care in our hospitals.

We will continue to report and investigate incidents that could have or did cause our patients harm in a timely way, and inform patients, their carers, families and our staff when we make mistakes and share any lessons we learn to prevent future harm. Also we will look to systematically learn from when we do well and feedback learning from both where we have made mistakes and where we have done well.

We will embed principles from human factors and ergonomics into how we learn from incidents and use these same techniques to understand areas of high risk to our patients and proactively redesign systems to improve safety.

We will embrace new ways of sharing learning across teams more effectively and using this learning to improve the way we deliver care and make our care safer.

How will we achieve this?

- Use information from incidents, complaints, and patient and staff feedback to identify themes to focus detailed investigation and improvement work on the most urgent and important areas for our patients care;
- Train and support our staff in human factors insights and tools and techniques and to better identify causes and contributory factors of incidents so we can focus improvementin the right areas;
- Monitor actions to reduce harm, both in response to serious incident investigations and following thematic analysis of incidents the serious incident review group will receive updates on progress of improvement work
- Establish new ways of communicating learning from both positive and negative incidents,
- Review the use of safety huddles in our wards and departments and share best practice to optimise how safety learning and awareness is shared
- Continue to monitor how Duty of Candour is delivered sharing best practice examples across teams
- Develop and introduce 'learning from excellence', for sharing learning from when things go well and seeing this as a key source of learning;
- Embed a comprehensive Mortality Review process, including Learning Disability Mortality (death) Review (LEDER) in line with national guidance and utilising the structured judgement tool methodology

How will we know if we have succeeded?

- Reduction in Never Events
- Reduction in avoidable harm
- Systematically annually reviewing at least two key areas of known patient safety risk using human factors and ergonomics principles and have clear quality improvement plans in place to reduce safety risk. Our first priority will be the deteriorating patient;
- Compliance with Duty of Candour via monthly checking, quarterly audit and an annual audit
- Proportion of reported patient safety incidents that cause no or low harm reported to NRLS to be above national average
- Increase patient safety incident reporting ratio per 1,000 bed days
- The % of patient safety incidents that result in severe harm or death to be below the national average
- Achieve 100% of deaths reviewed for patients with a known Learning Disability and achieve the Learning from Deaths Mortality Review Standard of >90% of deaths having been reviewed within 8 weeks of the death occurring;
- Reduction in the number of stillbirths, neonatal deaths and maternal deaths measured by MBRRACE
- Reduction in the incidence of Hypoxic-ischaemia encephalopathy (HIE)
- Maintain Hospital Standardised Mortality Ratio within / below expected range in Trust peer grouping.

Priority 2: Deteriorating Patient

We will aim to:

Recognise deteriorating patients at the earliest opportunity and identify the most appropriate course of treatment for them to give them the best possible outcome we can. This includes identifying all aspects of deterioration and treating sepsis and Acute Kidney Injury (AKI) and Diabetic ketoacidosis (DKA) at the earliest opportunity to prevent avoidable deaths.

How will we achieve this?

- The deteriorating patient will be the first high risk safety areas we subject to systematic review using human factors principles and develop a longer term improvement plan to reduce the risk of not responding to deterioration
- Work in partnership with the West Midlands Patient Safety Collaborative and Deterioration Network to share insights, innovation and best practice to improve our response to deterioration
- Undertake regular themed analysis of how we respond to deteriorating patients to ensure learning from both where we do well and where we can do better is captured and acted upon
- Introduce and implement learning around identification of deteriorating patients including 'soft signs' of deterioration
- Review and monitor internal protocols regarding escalation that is shared across staff groups
- Monitor pathways, processes and systems across clinical specialties that support the recognition and early intervention for septic and deteriorating patients, supported by better education and training for all staff members within multidisciplinary teams
- Develop and deliver an e-learning programme and deterioration competency assessments to all relevant clinical staff
- Further embed the use of sepsis screening tool and Sepsis Six bundle and pathway arrangements across the Trust;
- Ensure all identified patients receive full antimicrobial review at 72 hours following prescribing of antibiotics
- Develop and implement a training and assessment programme for staff in recognising AKI and DKA
- The same improvement processes will be implemented for DKA and AKI to include:
    i) Timely identification of patient suffering AKI using the AKI care bundle
    ii) Timely identification of patient suffering DKA using the DKA care bundle;

How will we know if we have succeeded?

- Improved compliance with NEWS 2, MEOWS and PEWS escalation criteria
- Reduction in avoidable inpatient cardiac arrests in hours and out-of-hours
- Improved compliance with the Sepsis screening and sepsis six bundle
- Reduction in unplanned Intensive Care Unit admissions
- Reduction in readmissions to Intensive Care Unit within 48 hours
- Reduction in avoidable term admissions to Neonatal Unit
- Reduction in Serious Incidents linked with failing to recognise the deteriorating patient
- Increased compliance with antimicrobial review within expected time frames
- Ongoing improvement in Sepsis mortality as measured by the Suspicion of Sepsis dashboard
- Ongoing monitoring of CHKS mortality data for AKI to ensure we are not an outlier
- Compliance with AKI Screening and post discharge monitoring
- Ongoing review of incidents involving DKA and thematic of incidents related to DKA

Priority 3: Falls

We will aim to:

Keeping patients safe from harm whilst in our care by reducing the risk of a fall is all our responsibility. Reducing both the number of patient falls and the level of harm associated with a fall whilst in our care is a priority. We aim to deliver high quality, safe and person centred care, which provides people who are at risk of falling and their carers with the most up to date evidence- based care and advice.

How will we achieve this?

- Ensure that our staff are equipped with the knowledge, skills and tools to be able to assess, plan, implement and evaluate preventative measures that help to reduce patient falls, and manage them appropriately when they do occur
- Ensure ALL patients have a multifactorial Falls Risk Assessment on admission, on transfer to another ward or if their condition changes.
- Ensure all patients who are assessed as at risk of a fall have a “Falls Prevention Care Plan” implemented
- Ensure every patient who falls has a “Post Falls Care Bundle” completed and that the post falls management procedures and pathways reflect national and local specialist recommendations
- 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)
- Educate our patients on their risk of falls and the risk of sustaining a severe harm if they do fall.
- Ensure patients are discharged with the appropriate onward referrals and support in place
- Ensure that all Trust Policies and Procedures relating to Falls are based on the most recent evidence base and are compliant with national recommendations
- Ensuring that all staff have access to the appropriate equipment to enable them to implement falls prevention interventions
- Ensure robust governance processes are in place for the reporting and investigation of falls incidence and embed a culture of learning from falls incidents

How will we know if we have succeeded?

- Ratio of falls per 1000 bed days below the national average
- Reduction in the number of patients who sustain a significant injury, e.g. hip fracture as a result of a fall in hospital
- Consistent completion of falls risk assessments and implementation of falls prevention care plans.
- Improvements in the results of local and National (National Audit of Inpatient Falls) audits.
- All staff working on the adult inpatient wards and the Emergency Departments to have completed the Falls Safe training programme.

Priority 4: Best Clinical Outcomes

We will aim to:

We will aim to provide outcomes that equal or exceed the best in the NHS, across all the services we provide. We will do this by doing the right things in the right way, by the use of innovation and ensuring our teams base their practice on the best available evidence including GIRFT recommendations, clinical outcome monitoring, audit, and NICE compliance The four central key themes of effectiveness for us are:

- Ensure our practice is based on the best available evidence
- Use our clinical audit programme as a force for sustained performance and improvement across all services
- Use outcome measures to inform us, our patients, the public and commissioners on our performance
- Innovate to improve outcomes in a safe and sustainable way.

How will we achieve this?

- As a first step we will implement a programme to develop a clear set of clinically owned standards for each of our clinical specialties. In order to do this we will:

    - Develop concept of Trust clinical standards with the clinical workforce
    - Consult on overarching clinical standards and map these to CQC domains
    - Outline individual specialty standards and map these to Trust clinical standards
    - Review and further develop specialty and divisional governance framework to implement and monitor standards
    - Consistently review and monitor clinical standards and identify areas for improvement;
    - Focus on delivery of improvements in divisional performance review meetings

- Assess our performance against NICE guidance within 28 days of issue of the guidance and meet or exceed the requirements of NICE quality standards
- Ensure that locally developed guidelines align to best practice and that we develop a clear governance process for sign off of clinical
- Use outcome measures from national and local clinical audits to inform us, our patients, the public, and commissioners on our performance
- Utilise other measurement tools, e.g.CHKS, Hospital Standardised Mortality Ratios (HSMR), Summary Hospital Level Mortality Indicators (SHMI), to inform and improve the provision of services
- Invest in innovation with regard to equipment, processes and technologies to improve clinical effectiveness and efficiency and demonstrate these innovations have been embedded in clinical practice

How will we know if we have succeeded?

- Year on year improvement in compliance against NICE baseline standards
- A 20% improvement in the review and return to the clinical audit department of NICE guidance compliance within 28 days of issue
- Year on year effectiveness evidenced by the result of re-audits and compliance against Best
- Practice Standards
- Increased and timely participation in national audits and NCEPOD returns
- Improvements in the outcome measures as identified by Dr Foster and national audits, aiming to be within the top 25% of organisations in the NHS (peer groups where available).

- Demonstrable improvement each year in the clinical indicators selected by each service.
- Reduction in readmissions
- Positive patient satisfaction survey result

Priority 5: Right Care, Right Place, Right Time

We will aim to:

There is recognised evidence that patients treated as outliers in specialty wards not related to their presentation have poorer outcomes and increased lengths of stay. Our aim is that all of our patients are located in the most appropriate place from admission to discharge. The patient, upon entering our care, will be cared for in the correct clinical location at the earliest opportunity. We will work with other local health and care providers to ensure that patients are able to be go directly to the right place of care at the right time.

How will we achieve this?

- Ensure that patients are assessed and referred to the most appropriate place for treatment at the earliest opportunity in all our care settings
- Improve bed capacity so that patients are cared for on the most appropriate wards following admission
- Ensure patients have accurate estimated date of discharge
- Through multidisciplinary ward rounds, ensure robust timely, safe discharge plans before lunch are in place for every inpatient discussed with the patient and family as appropriate
- Further develop weekend working to improve discharges
- Reduce the number of 'super stranded' patients with regular review
- Improve emergency planning to ensure that peak pressure times can be managed well
- Work with partners to reduce Delayed Transfers of Care
- Work to ensure patients are discharged safely and efficiently and all appropriate treatments, medication and clinical discharge information are in place before discharge;
- Provide patients with reasonable choices when booking appointments and enabling this will streamline administrative processes
- Improve communication for handover and transfers of care throughout the Trust
- Executive Medical Director to lead twice weekly review of all patients in hospital over 21 days

How will we know if we have succeeded?

- Bed occupancy of <90%
- <10% of inpatients 'super stranded' and <20% of inpatients 'stranded'
- Patients receiving their care in the most appropriate environment
- Reduction delayed discharges and transfers of care
- Reduction in the number of patients moved more than 2 times across wards during their stay in hospital unless clinical indicated
- Compliance with national standards e.g. SSNAP/TARN/CNST
- Audit to measure numbers of patients who are discharged with appropriate medication and a fully completed and accurate discharge summary
- Reduction in complaints linked to patient discharge
- Every patient to receive a daily review by a senior decision maker (ST3 or above) by 12 noon
- 30% of patients who are being discharged to have left their bedded area by 12 noon, 80% by 5pm (for patients without an identified right to reside)

- There is a clear medical plan and anticipated discharge date for all patients; the process for clinical criteria for discharge in the notes should be in place to enable rapid discharge
- Aim to have less than 10% of the hospital bed base with patients over 21 days length of stay.

Priority 6: Learning from Experience

We aim to:

We aim to create a positive experience for both our patients and service users, those closest to them, and staff who deliver the care. We also aim to deliver excellent, compassionate, clinical care which involves working with patients, their families and carers and involving them in every step of their journey.

How will we achieve this?

- Supported by our Patient Engagement Group, Community Engagement Forum, Patient and Carer Experience panel, and Patient Safety partners, identify key areas of focus
- Develop and implement a Patient Engagement Strategy, creating more ways for patients to share their experiences
- Align listening to staff experience as part of this engagement and the People Strategy
- Redesign the patient complaint process;
- Analyse, report and learn from patient surveys, complaints, concerns and compliments
- Develop and implement improvement plans in response to patient surveys and feedback
- Increase the prominence of patient stories at key committees or training opportunities across the organisation.

How will we know if we have succeeded?

- Improve on positive responses to national and local surveys
- Reduction in formal complaints that identify specific themes, particularly in identified categories such as staff attitude, dignity and respect, and communication
- Decrease in time taken to respond to formal complaints so that 85% are responded to within 30 days
- Increase in early resolution of concerns
- Decrease in complaints not answered first time
- Increase in compliments received
- Increase in staff and patients recommending services as a place to receive care including through Friends and Family scores and National Inpatient, Emergency Department, Children and Young People Surveys

Priority 7: Vulnerable Patients

We will aim to:

We aim to improve the care for vulnerable patients to improve their quality of life and the support we offer to them throughout their care in the Trust; this includes patients with mental health conditions, patients with safe-guarding needs, Learning Difficulties (LD) and Dementia. We also aim to havearrangements in place to safeguard and promote the welfare of adults and children in line with national policy and guidance. We aim to be recognised as a Dementia Friendly Organisation and ensure our patients with dementia, LD and mental health conditions have the best experience possible.

How will we achieve this?

- Deliver the Trust's Safeguarding Strategy through the use of robust Adult Safeguarding, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (LPS) policies and procedures and ensure we meet the national Prevent agenda responsibilities
- Have in place a comprehensive training offer encompassing face to face, multi- media and blended learning approaches for Safeguarding, MCA/DoLS, Mental Health Act (MHA), Dementia and LD
- Develop the Safeguarding team to support staff through safeguarding supervision and enable prompt recognition of emerging themes and trends
- Deliver the Trust's Dementia Strategy and the Dementia Friendly Hospital Charter
- Champion improvements in dementia care at all levels within the organisation which includes Dementia screening
- Deliver excellent patient care supporting those with Dementia and their carers by diagnosing dementia and delirium promptly and providing the right support at the right time
- Create Dementia friendly areas with secure, safe, comfortable, social and therapeutic environments that facilitate all types of functioning
- Improve our work with dignity and respect through early completion of the patient passport (About Me)
- Development of a Mental Health, Learning Disability (LD) Strategy and Charter which will include expectations in relation to admission and care of LD patients throughout their stay
- Work in collaboration with partner organisations and involve, support and engage carers as partners in care, to meet the care needs of all vulnerable patients
- Work with Mental Health partners to develop a Core 24 liaison service, which will enhance the mental health provision in the Trust by providing more nursing, psychiatry and psychologists input.
- Actively participate in audits to maintain and improve standards for vulnerable patients
- Develop appropriate literature for both inpatient and outpatient attendances.

How will we know if we have succeeded?

- Improve Dementia screening rates
- Increase in positive responses to surveys and audits for LD, Dementia and Mental Health care
- Low numbers of formal complaints relating to Dementia care, LD and patients with mental health needs
- Show improvements in Patient-led assessments of environment (PLACE) scores relating to Dementia-friendly environments
- Increase Dementia friendly environments
- Evidence based audit outcomes to support embedded safeguarding and MCA practice across the trust
- Improved and early recognition of patients with learning disabilities and collaborative working at earliest opportunity across system.
- Dignified, person-centred care and treatment throughout care pathway within the Trust
- Multi- agency involvement and ownership for patients with LD throughout hospital stay and discharge.
- Improvements in mental health risk assessments and in the quality of the mental health liaison assessments from a wider multi-disciplinary perspective.

Priority 8: End of Life Care

We will aim to:

We aim to ensure that patients at the end of their lives are treated in line with their wishes and with the utmost dignity and respect. We seek to ensure that an individualised approach is provided to our patients and those closest to them.

How will we achieve this?

- Deliver the Trust's End of Life Care Strategy
- Ensure clear and timely identification of patients
- Ensure timely decision making with patients who is approaching the end of their lives
- Have a clear understanding of the patient's condition, wishes and preferred place of care, ensuring this is always discussed with the patient and with their relatives as appropriate.
- Using the End of Life Care plan to deliver individualised (personalised) care and ensure that all patients approaching the end of life have anticipatory medications prescribed
- Implement a 7 day nursing specialist palliative care service across the Trust and the provision of 24 hour advice for palliative care
- Ensure there is clear staff training to deliver End of Life Care (including syringe driver training on wards)
- Increase the number of patients who are cared for in their preferred place of care at the end of their life.
- Work with stakeholders across the health economy to reduce the number of patients admitted to hospital from home and are homes in the last days of life
- Implement an audit program which includes both local and national audits

How will we know if we have succeeded?

We will develop Key Performance Indicator Dashboards which are continually monitored and will include:

- Evidence of advanced care planning
- Evidence of clear conversations have taken place with the patient and documentation of preferred place of care and in line with this fast track discharges home for end of life care.
- Bereavement feedback data
- Improve the results from the Annual Palliative Care Survey
- Improvement in the percentage of patients who are in the last days of life and are cared for on the end of life care plan.
- A reduction of complaints relating to end of life care.
- Improving uptake of mandatory training.

A Quality Strategy dashboard, key performance indicators and a delivery plan for each priority will be developed in Quarter 1 of 2021/2022. The Quality Strategy will be monitored through the Trust governance structures reporting to the Quality Operational Committee, Quality and Safety Assurance Committee and "Getting to Good" Committee on a quarterly basis.

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							
	SaTH 2020/21	**National Average 2020/21**	**Best Trust 2020/21**	**Worst Trust 2020/21**	**2019/ 20**	**2018/1 9**	**2017/1 8**
Maximum time of 18 weeks from referral to treatment in aggregate- patients on an incomplete pathway	56.1%	65.1%	85.7%	47.6%	75.73%	89.25%	91.31%
All cancers- maximum 62 day wait for 1st treatment from urgent GP referral for suspected cancer	75.1%	75.2%	94.1%	39.2%	73.34%	70.85%	89.5%
Maximum 6 week wait for diagnostic procedure	71.8%	79.2%	99.5%	41.8%	77.57%	99.88%	99.42%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	73.4%	84.8%	95.6%	67.9%	73.5%	71.1%	73.4%
Clostridium Difficile Variance from plan	Reported in Section 2.3						
Summary Hospital Level Mortality Indicator	Reported in Section 2.3						
Venous Thromboembolism (VTE) Risk Assessment	Reported in Section 2.3						

Emergency Department 4 hour Wait

There were significant challenges throughout 20202/2021 due to the COVID-19 pandemic and the requirement to develop “high risk” red pathways within the Emergency Departments in order to keep our patients safe during their attendances to the departments during the COVID pandemic.

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 2020/2021. The COVID-19 pandemic has meant there has been a significant impact on elective activity throughout 2020/2021. The Trust is working with its partners across the health economy in relation to the restoration and recovery of elective activity following the pandemic in 2021/2022.

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

Performance against this target in 2020/2021 has remained below the national target. Whilst there are national challenges associated with the urology cancer pathway capacity, oncology staffing and robotic surgery provision the Trust has continued to work with its partners across the region to ensure that suspected and diagnosed cancer patients received their treatment in a timely and safe way throughout the pandemic. (see Section 2.1 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 anactive 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 2020/2021 the Trust received seven patient safety alerts. None breached their due date.

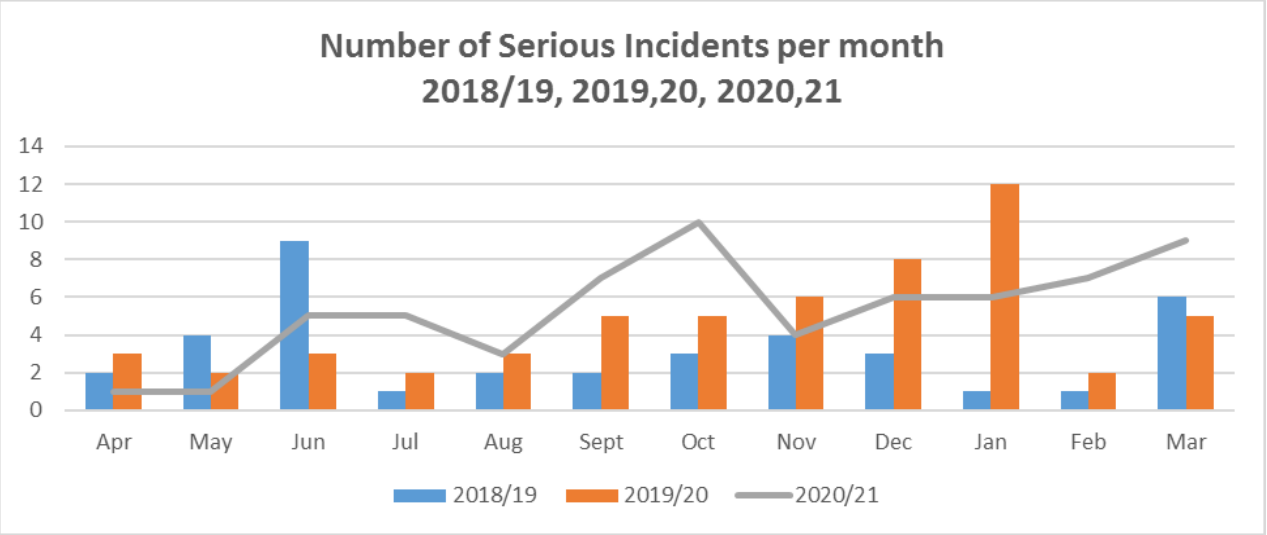
Alert Identifier	Alert Title	Issue Date	Closure Target Date	Date Closed	Open/Closed
NatPSA/2020/002/NHSPS	Interruption of high flow nasal oxygen during transfer	01/04/2020	08/04/2020	08/04/2020	Closed
NatPSA/2020/003/NHSPS	Blood control safety cannula & needle thoracostomy for tension pneumothorax	02/04/2020	09/04/2020	09/04/2020	Closed
NatPSA/2020/004/NHSPS	Risk of death from unintended administration of sodium nitrite	06/08/2020	06/11/2020	06/11/2020	Closed
NatPSA/2020/005/NHSPS	Steroid Emergency Card to support early recognition and treatment of adrenal crisis in adults	13/08/2020	13/05/2021	13/05/2021	Closed
NatPSA/2020/006/NHSPS	Foreign body aspiration during intubation, advanced airway management or ventilation	01/09/2020	01/06/2021		Open
NatPSA/2020/008/NHSPS	Deterioration due to rapid offload of pleural effusion fluid from chest drains	01/12/2020	01/06/2021		Open
NatPSA/2021/001/MHRA	Supply disruption of sterile infusion sets and connectors manufactured by Becton Dickinson (BD)	11/03/2021	31/03/21	31/03/2021	Closed

Serious Incidents

All patient safety incidents are reported on the hospital electronic incident management system (Datix). All patient safety incidents are reported, monitored and reviewed to identify learning that will help prevent reoccurrence. During 2020/2021 the Trust saw an increase in the number of serious incidents reported compared to previous years, this may demonstrate that staff have increased confidence to report incidents and concerns. In 2020/21 we were in the top quartile of reporting organisations as measured by the National Reporting and Learning System data.

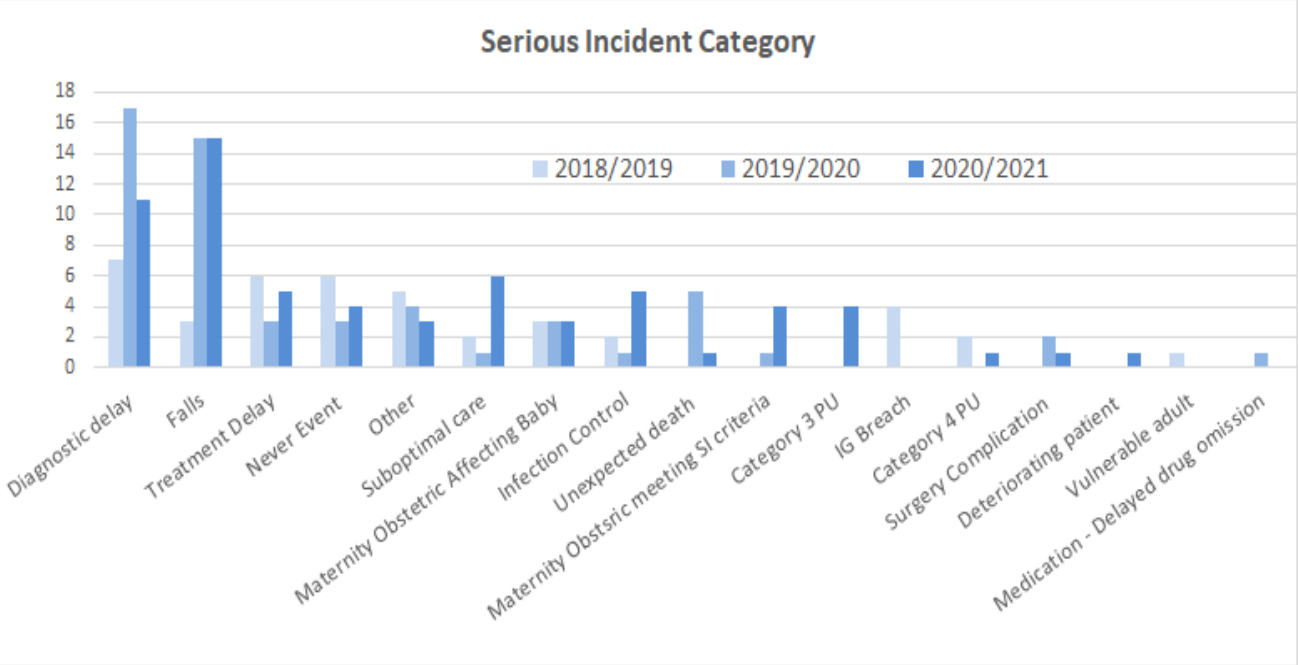
In November 2020 a new Review, Action and Learning from Incidents Group (RALIG) replaced the previous Executive Serious Incident Review Group (ESIRG). Chaired by the Medical Director this multidisciplinary group meets weekly to review all incidents which potentially meet the threshold for

a Serious Incident (SI) or Never Event and make the decision in relation to the level of investigation and the reporting of the incident as a SI. Level 1 Serious Incidents which include Falls, Pressure Ulcers and Hospital Acquired Infections are reviewed at a newly established Nursing Incident Quality Assurance Meeting (NIQAM), with cross Divisional representation, which is chaired by the Deputy Director of Nursing.



	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2018/19	2	4	9	1	2	2	3	4	3	1	1	6	38
2019/20	3	2	3	2	3	5	5	6	8	12	2	5	56
2020/21	1	1	5	5	3	7	10	4	6	6	7	9	64

The incidents reported as Serious Incidents (SIs) are monitored via the Quality Operational Committee and Quality and Safety Assurance Committee and reported to Board as part of the Integrated Performance Report. In 2020/2021 the Trust saw an increase in the number of incidents reported as Serious Incidents, with 64 SIs reported compared to 56 in 2019/20 and 38 in 2018/19.



Never Events 2020/2021

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In 2020/2021 the Shrewsbury and Telford Hospital NHS Trust had 3 incidents which met the definition of a Never Event. Thorough investigations are undertaken for Never Events and robust action plans are developed to prevent similar occurrence.

The following table gives a description of the 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 2020/21	National Average 2020/21	Best Performing Trust 2020/21	Worst Performing Trust 2020/21
3	2.8	1	12
Date	**Description of Never Events 2019/20 at SATH**		
May 2020	Never Event - Bed Rail Entrapment		
July 2020	Never Event – Wrong site procedure		
December 2020	Never Event – Misplaced NG Tube		

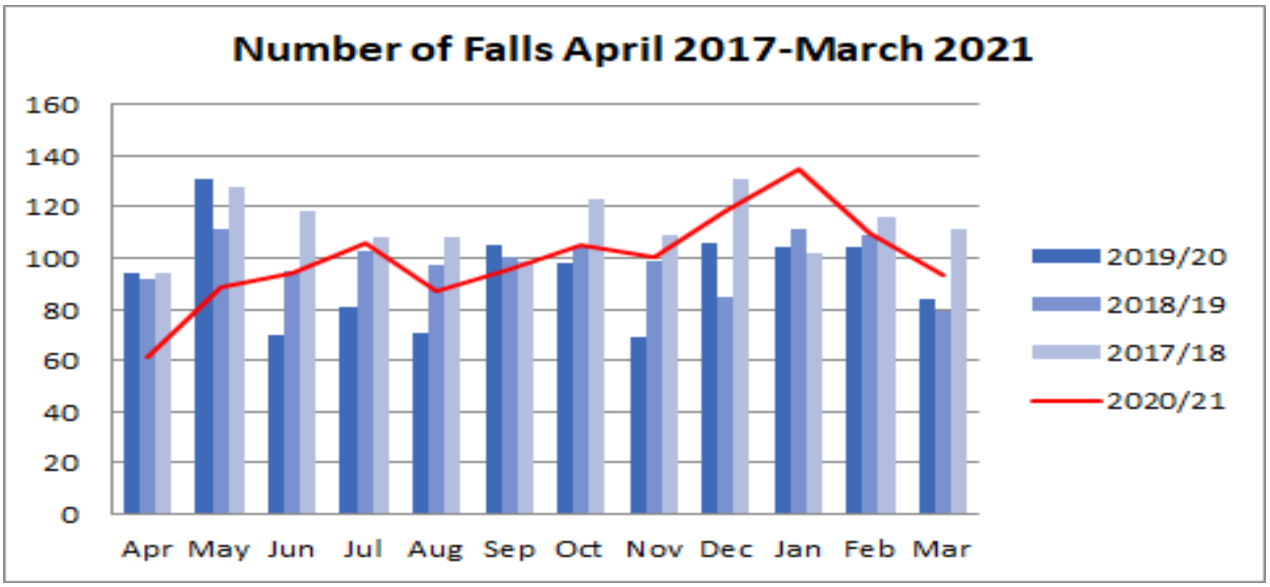
Learning from Never Events in 2020/2021 included:

- Reinforcing to staff the importance of compliance with WHO Surgical checklist at all times.
- Review and update of LocSSIPP policy
- Designated LocSSIPP Clinical Lead
- Review of Bariatric bed contract including training in the use of bariatric beds
- Production of" Bariatric Bed User Folder"
- Risk assessment produced for the use of bariatric beds
- Rolling programme of Bariatric bed training in place

Falls Prevention

Falls amongst inpatients remains the most frequently reported safety incident at the Trust and nationally in NHS hospitals. A fall can result in some form of injury, a loss of confidence, a delayed recovery and a prolonged hospital stay. Fractures occur in 1 to 3% of incidents. Reducing the number of patients who fall in our care and reducing the risk of harm associated with a fall was akey quality and safety priority for improvement for the Trust in 2020/2021, it has also been included as a priority for the next 3 years in the Quality Strategy developed as part of the "Getting to Good" improvement alliance work with University Hospitals Birmingham NHS Foundation Trust.

A summary of falls in 2020/21 and a comparison with previous years is shown.



Falls	2017/18	2018/19	2019/20	2020/21
Total Number of Falls	1347	1185	1117	1194
Falls per 1000 bed days	5.08	4.62	4.02	5.42
Falls per 1000 bed days resulting in moderate harm or above	0.08	0.09	0.11	0.123

There has been an increase in the number of falls and the ratio of falls per 1000 bed days in 2020/2021. Throughout 2020/2021 there was an increase in the number of falls reported each Quarter. Falls per 1000 bed days also increased during the first wave of COVID-19 in Quarter 1 and after a decline in Quarter 2 increased again in Quarter 3 as the 2nd wave of COVID progressed. A comparison with 2 other acute hospitals shows a similar pattern in relation to falls per 1000 bed days in 2020/2021.

There was also a small increase in the number of falls resulting in moderate harm or above. After an increase in Quarter 2 of 2020/2021 falls with moderate harm or above fell in Quarter 3 and Quarter 4. The number of falls resulting in severe harm and reported as serious incidents (SI) reduced in Quarter 3, and no falls were reported as SIs in January and February 2021 and one case in March 2021.

A Falls Prevention Plan was developed in Quarter 1 of 2020/21. This included the development and roll out of new multi-factorial risk assessments and care plan, a post falls care bundle, trial of falls equipment, patient information leaflets and strengthening the governance processes around falls. There has also been a focus on Falls Training being delivered to all ward staff which has increased to 81% by the end of March 2021. The Falls Prevention Plan includes the Falls “Always Events” and is a dynamic plan with actions being reviewed and added to. The Plan is monitored monthly at the Falls Steering Group attended by multi-disciplinary staff in the Trust. Falls are also discussed for each ward as part of the monthly Nursing Quality Assurance Metrics Meetings attended by the Ward Manager, Matron and Head of Nursing

As part of the Falls Improvements the Quality Team undertake a daily review of falls in the previous 24 hours on the adult inpatient wards at both hospital sites. The pre-fall documentation and care is

reviewed alongside the post falls interventions. The team provide immediate feedback to the team to raise areas of good practice and improvements. Areas of ongoing improvement work are:recording of lying/standing BP, repeat risk assessments, medication reviews and recording of neuro observations for unwitnessed falls.

Pressure Ulcers

The Shrewsbury and Telford Hospital NHS Trust saw a reduction in the overall number of pressure ulcers in 2020/2021. However, the number of category 3 pressure ulcers i.e. those deeper ulcers which cause more harm to the patient increased significantly compared to 2019/2020. There was an increase in category 3 pressure ulcers from December 2020 as the 2nd wave of the COVID-19 pandemic developed, critical care capacity increased and the acuity of patients increased.

Hospital Acquired Pressure Ulcers	2020/21	2019/20	2018/1
Category 2	139	195	146
Category 3	28	10	34
Category 4	2	1	2
Total	**169**	**206**	**182**

Summary of actions reduce number and severity of acquired pressure ulcers.

- Tissue Viability training reinstated for 2021/22 (paused during pandemic)
- Approval gained for trial on ward 26 of SEM scanner (sup-epidermal moisture) scanner to detect PU damage to underlying tissues as early as 5 days before any redness even being visible on the skin.
- Root cause analysis panels now well established which enable more robust process of pressure ulcer reporting and investigation for all category 2 or above pressure ulcer which allows identification of deficits in care and shared learning
- All pressure ulcers which meet the threshold for reporting as serious incidents are fully investigated and presented at the new Nursing Incident Quality Assurance Meeting
- New Skin assessment booklet was launched in July 2020
- Lead Tissue Viability nurse is working with nurse specialist from mattress company who is delivering teaching on mattresses and how to order to ward areas
- Pressure Ulcer Prevention leaflet now provided to all patients admitted to hospital
- Review of tissue viability documentation and care is reviewed monthly by the matrons as part of their Nursing Quality Metrics Reviews in each adult inpatient area.

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 Division and for the Trust which allows for comparison to be made both locally and on a national scale.

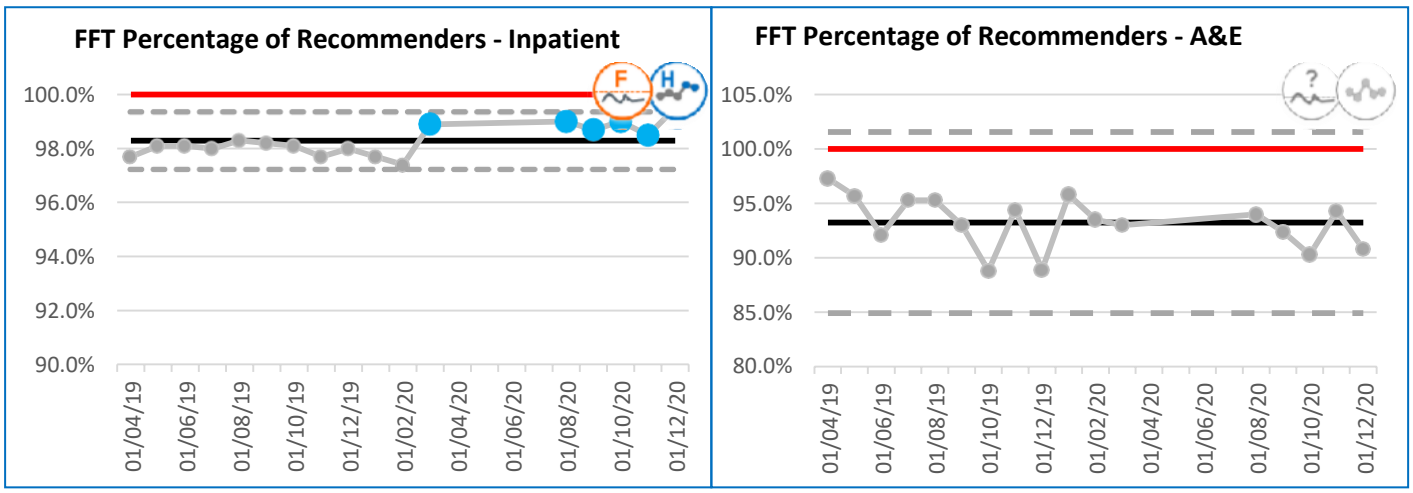
A national standardised question is asked:

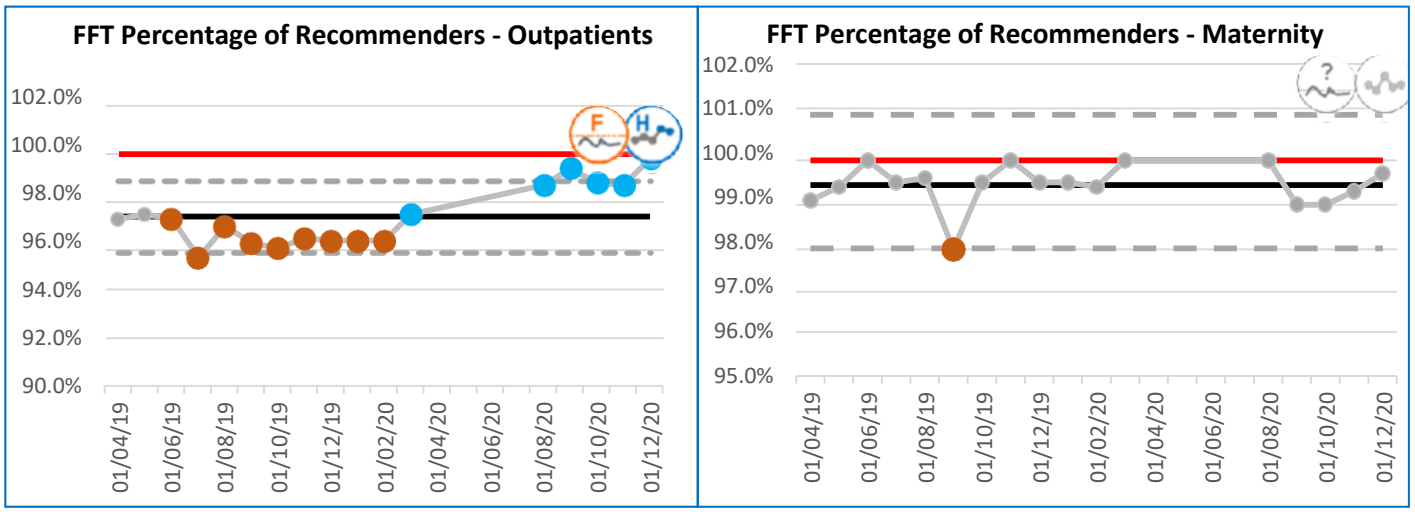
"How likely are you to recommend this service to friends and family if they need similar care or treatment?"

A total of 29,359 Friends and Family Test cards were completed and returned during 2020/21, this was a reduction from the previous year when of 43,094 Friends and Family Test cards were completed and returned. Whilst national reporting of the response rate ceased from 1st April 2020, the Trust response rate continued to be monitored closely to provide assurance that patients are being provided with an opportunity to provide feedback on their experience. The response rate decreased in comparison to the previous year by 6.1% for inpatient areas and by 4.7% in Maternity (birth only). Within A&E, the response rate increased in comparison to the previous year by 8%. Theoverall decrease in cards completed and response rate is likely to be affected by the pause and recommencement in reporting due to Covid-19.

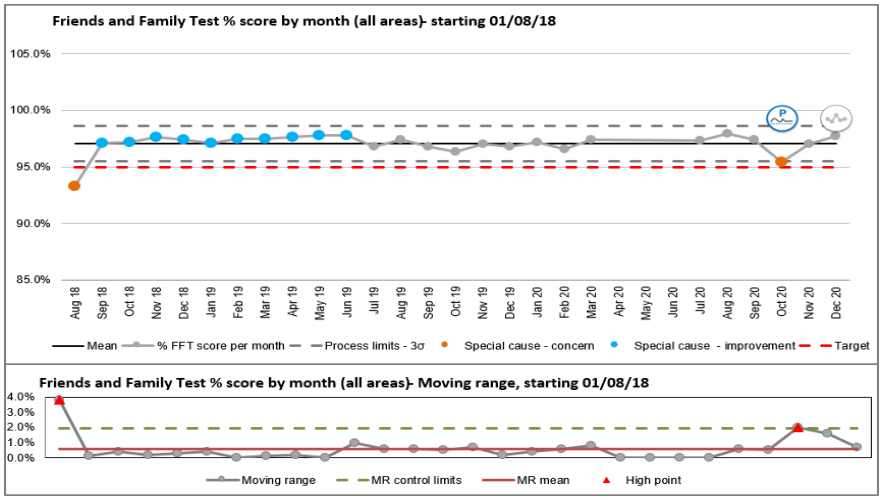
There was a gap in the Trust data from April 2020 to June 2020 as reporting was temporarily postponed due to COVID-19. Internal data collection resumed in July 2020 within A&E and August 2020 within inpatient and maternity areas. National reporting of the friends and family test paused in March 2020 and resumed in December 2020 for reporting in January 2021.

The Trust presently use paper based forms to collect FFT feedback. Within the Emergency Departments, volunteers were introduced to support the collection of FFT feedback over the telephone, which has demonstrated an improvement in response rate for the service. FFT surveys are also available online for patients to complete; and, easy read FFT surveys have been developed and published on the website to support accessibility. The Trust does not have a text messaging facility to support FFT collection.





The overall combined Friends and Family Scores for all areas has remained above the 95% target throughout 2020/21.



Of the FFTs completed, 97.2% of respondents said they would be “extremely likely” or “likely” to recommend the Trust’s services to their family and friends compared to 97.1% in 2019/20.

National Inpatient Survey (2019)

The National Adult Inpatient Survey was undertaken between September and December 2019, and included patients treated at the Trust during July 2019. The results were published by the CQC in July 2020.

The Trust had a response rate of 51.16%, which was 6.16% above the national average; and, performed ‘about the same’ as other Trusts for the majority (59) of questions. Five questions scored lower than the national average and four questions demonstrated a statistically significant decline from 2018 to 2019.

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

These five questions which scored lower, both in comparison to the national average and on the previous year related to the discharge home from hospital, and the quality and choice of hospital food as areas for improvement.

A Trust workshop on the survey results, incorporating key actions for improvement, was delivered to senior nurses to support the Divisions in developing patient experience action plans in response to the results.

Discharge Home From Hospital – Improvement Actions Taken:

- The number of Patient Journey Facilitators within the Trust increased to provide a visible presence at ward level to educate and support home first decision making.
- Patient pathways to provide specialised rehabilitation in community hospitals, and enhanced discharge summaries to improve communication with GPs, have been introduced.
- A discharge survey has been published on the Trust website to provide patients with an opportunity to provide feedback on their experience.
- Increased focus on identifying and supporting carers, to ensure they have the relevant information about when and how the person they care for will be discharged from hospital. The Patient Experience Team organised for carers awareness training to take place throughout Q4.
- Improving discharge from hospital is a key quality priority for 2021 to 2023 and improvements will be coordinated through the Tranfer and Discharge Group chaired by the Deputy Chief Operating Officer to oversee the improvements required over the next 2 years

Quality and Choice of Hospital Food – Improvement Actions Taken:

- A new food service was introduced on the wards as of September 2020, incorporating a new menu and hostess service.
- An increased range of meal options is now available, with four main courses at lunch and dinner, and the ability for patients to select a small, medium or large portion.
- Patients can now make their selections the same day, rather than the day before, which enables their individual needs and preferences to be catered for.
- Patient feedback continues to be monitored through Quality Assurance Metrics Audits completed by the matrons monthly in in the clinical areas, these audits were updated to incorporate questions on food choice and quality. A food survey has also been published on the Trust website to capture on-going feedback.

Section 4: Statements from External Organisations

1. HealthWatch Shropshire

Healthwatch Shropshire (HWS) welcomes the opportunity to comment on the Quality Account. The feedback we received predominantly concerned general service issues, communication, quality of care and treatment. Overall, the feedback raised more negative experiences (78%) than positive (22%).

Priorities 2020 - 21

Recognise and Respond to the Deteriorating Patient (sepsis)

HWS supports the focus that the Trust is placing on this priority and the commitment to do so for 3 years. It is difficult to understand how much progress has been made against the target of screening 95% of patients in both Emergency Departments. The implementation of the electronic sepsis screening tool, delayed by the pandemic, will hopefully add to the 'marked improvements' they have seen. It is unclear if the target of improving the recognition of deteriorating patients on adult inpatient wards has been met although the audit does show that the target for escalation (90%) has been met. The Trust has taken a number of measures to improve the use of the sepsis screening tool across the adult inpatient areas but it is unclear how this has affected the timely treatment of sepsis.

Learning from Serious Incidents (SIs) and Development of a Safety Culture

HWS welcomes the improvement made with the quality and timeliness of Serious Incident reporting. The Trust has put into effect a number of governance processes to address the issues around safety but it is disappointing to see that the overall number of Serious Incidents has continued to rise this year, on reduced patient activity. The Trust aimed to reduce commonly occurring SIs and Never Events, this has been achieved in the 'diagnostic delay' category. It has not been achieved in the 'Falls' category and we welcome the focus on inpatient falls in the coming year.

We look forward to the anticipated positive results of the duty of candour audit. We would have liked to see an indication of how the Trust supports and communicates with patients and families through the SI process, as raised in our response to the Quality Account last year, in a similar way that the Trust does for Never Events.

Deliver the Key Requirements for Infection Prevention and Control (IPC)

During the pandemic the issue of IPC has achieved heightened status and it would be useful to understand which areas of the NHSE/I IPC Board Assurance Framework the Trust is not meeting. The fall in the number of cases of all types of Health Care Associated Infections, with the exception of MRSA, is welcomed although it should be noted that was on reduced patient activity. It is disappointing to see that overall IPC mandatory training compliance is below the target of 90% at 84% and that the staff group with the lowest compliance is 'Medical and Dental' at 78%.

Ensure learning from deaths through clear mortality review processes

The introduction of an independent Medical Examiner at both sites is very welcome as is meeting the aim of increased number of mortality reviews, implementation of a standard approach and improved governance processes. However it is unclear if the aim of 'ensuring the appropriate learning opportunities and improvements are actioned from these reviews' has been achieved.

Improving Compliance with National Institute for Health and Care Excellence (NICE) Guidance

Although short of the target the significant improvement in the timeliness of the Trust's review and compliance with relevant NICE guidance is encouraging.

Focus on Referral to Treatment Times on the Cancer Pathways

It is encouraging to see the small improvements against the 62 day 'referral to treatment' performance given the restrictions that the pandemic has brought with it and we hope this will continue to gain pace. The improvement in performance against the 31 day 'decision to treatment totreatment' target is also welcomed. We would like to compliment the Trust on the 'Living with and Beyond Cancer Programme' and the efforts made to support patients through the pandemic restrictions on face to face contact.

Patient Experience and Community Engagement

We strongly support the Trust's efforts to embed patient experience in their efforts to improve patient care and increase the opportunities for patients, families and carers to share their experience. The introduction of the new methods to collect feedback are welcome. It would be useful to see a breakdown by ward and department of the inpatient survey and feedback in general. There is no mention of the performance against the Trust's target to 'increase the Friends and Family Test (FFT) response rate for ED, Inpatients and Maternity by 20% compared to the responserates for 2019/20.'

We were pleased to see the use of virtual community engagement methods during the year.

Responsiveness and Learning from Complaints

It was disappointing to see that the relative number of complaints to patients seen remained the same as the previous year and the hoped for reduction was not achieved. We appreciate how the pandemic will have affected the speed at which the Trust can respond to complaints however the failure of the Trust to respond to complaints in 40% of cases within the timescale they agree withthe complainant is worrying. We hope the Trust is in contact with these patients to keep them informed and updated about the delays. From our experience of providing the Independent Health Complaints Service for Shropshire we know that not meeting agreed timescales prolongs the patientand family distress in what are often very difficult circumstances. They appreciate being contacted in advance of the response date if the Trust know they will not be able to give a substantive response in time, it is very stressful for people who are expecting a response and it doesn't come.

We were pleased to see some examples of the learning that followed from a complaint.

Improving the Effectiveness of the Transitional Care from Children to Adult Services

It is encouraging to see the start that has been made in this area with the identification of the patients who need support in the transition and the development of a policy. It is unclear if the aimto have the transitional nurse in post has been achieved. The Trust acknowledge that one of the three key elements to this priority is 'young patients need to be trained and empowered to allow them to be an effective partner in their own transition'. There is no indication of how patients are being engaged to achieve this or plans to seek their feedback on the outcome of the measuresbeing implemented.

CQC Improvement Plan

The Trust is to be commended on the progress it has made during the year in completing the individual actions outlined in the plan, 94% of the 403 individual actions having now been completed.

Participation in clinical audits and confidential enquiries

The Trust is also to be commended on increasing its' rate of participation in national clinical audits and the number of local audits undertaken during the pandemic.

Quality Indicators

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. Following the 2019-20 self-assessment submission the standards were again not met but it is unclear if there was an improvement on the previous year, more detail would be welcome.

Learning from Deaths

During 2020-21 there is an encouraging reduction in the percentage of deaths reviewed or investigated and 'judged to be more likely than not to have been due to problems in the care provided to the patient' compared with 2019-20.

Implementing the Priority Clinical Standards for 7 Days Services

The Trust reports that it has not met the national target of full implementation and will not until the Hospital Transformation Programme is complete however it would be useful to see how it is performing and how the measures they have implemented have improved performance.

Encouraging Staff to Speak Up

The continuing work of the Trust to encourage staff to speak up about concerns is fully supported. The number of concerns raised with Freedom to Speak UP guardians has again increased by over 100% on the previous year leading to a nearly 10 fold increase in 3 years. This could be, as the Trust asserts, due to increased visibility of the FTSU Guardians or increased staff confidence in reporting concerns or it could be due to an increase in events that cause concerns or a mixture of the three. It is noted that in the NHS staff survey for 2020 the Trust scores amongst the worst performing Trusts in the country against the statement 'my organisation encourages us to report errors, near misses or incidents'.

Guardian of Safe Working (GSW)

The focus on supporting Junior Doctors with respect to their safe working hours is welcomed not only for the support it provides to doctors and patient safety but also hopefully the effect it will have in encouraging applications to posts at the Trust.

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

The Trust readmission rate for adults sits near the national average for adults but is higher than the national average for under 16s and has been for the last 4 years although the slight fall compared to last year's figure is encouraging.

The Trust Responsiveness to the Inpatients' Personal Needs

We welcome the fact that the Trust has put in place actions to improve services but would welcome some detail of what they are. We look forward to the survey results in August and hope the year on year decline from the last 4 years will be turned round.

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

Although still below the national average this is the second year that this figure has risen and by a significant amount this year, hopefully an indication of staff confidence in how the measures set out in the Quality Accounts are taking effect and reassuring staff.

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

It is not possible to compare the rate of patient Safety Incidents per admission as the data is not available in this draft Quality Account. In the previous Quality Account (2019-20) the rate was shown to have risen continually for 3 years. However, the total of 5776 Safety Incidents in 6 months, on significantly lower patient activity due to the pandemic, compared to 7199 for the preceding 12 months would give an indication that there has either been a significant increase in incidents or a significant increase in staff reporting such incidents.

Performance against the Relevant Indicators and Performance Thresholds

Rate of Clostridium Difficile

Accepting that the rate shown has not been externally validated it is encouraging to see the reduction this year.

Mortality Indicators

As in 2019-20 the Trust performs 'as expected' in the Summary Hospital-Level Mortality Indicator, however 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.

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

The Trust's decision to continue to collect this data during the pandemic, even though national collection was paused, is to be commended and it is encouraging to see the improvement compared to the previous year.

Performance against the NHS Oversight Framework

The pandemic has impacted the performance in all of the other four performance areas in the NHS Oversight Framework. The Trust performs below average for all of these with the most impact in the 'Maximum time of 18 weeks from referral to treatment' performance. However we would like to commend the Trust in the improved performance in 'All cancers- maximum 62 day wait for 1st treatment from urgent GP referral'.

Other Quality Information

Falls Prevention

The increase in the falls rate and the correlation with the waves of Covid infections is noted. We welcome the development and introduction of the Falls Prevention Plan and the ongoing focus on falls prevention in the coming year. As part of this work we would like to see how the reintroduction of visiting impacts on the rate of falls once visitors are allowed again and they can resume the role they have in assisting patients mobilising safely.

Pressure Ulcers

It is useful to understand the impact of the pandemic on the incidence of category 3 ulcers and the reduction in total numbers of pressure ulcers is very welcome. It is unclear to what extent this reduction is due to the measures the Trust is putting in place or to the reduced number of inpatients during the year.

National Inpatient survey

The identification of two areas, ward food and discharge, where the Trust scored lower than the previous survey were concerning. The decline in satisfaction with ward food was mirrored in the Place based care feedback in the 2019-20 Quality Account. We look forward to an increase in satisfaction following the introduction of improvements in September 2020. The issues with discharge were highlighted in our report Hospital Discharges During the Covid-19 Pandemic | Healthwatch Shropshire. We look forward to seeing the improvements achieved by the Transfer andDischarge Group.

Priorities 2021 – 22

Healthwatch Shropshire supports the Trust in the choice of priorities for the coming year and are encouraged to see the continued focus on areas highlighted in this Quality Account where improvements are still sought. Having studied the SaTH Board meeting papers during the year we would have liked to see some reference to the quality improvements that would come from the planned greater integration of care and in particular the Information Technology challenges the Trust might face with the introduction of the Integrated Care Record.

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.

2. Shropshire, Telford & Wrekin Clinical Commissioning Group

Date: 22nd June 2021

NHS Shropshire, Telford & Wrekin CCG response to SaTH Quality Account 2020/21

Shropshire, Telford and Wrekin CCG act as the commissioner for Shrewsbury and Telford Hospital NHS Trust. We welcome the opportunity to review and provide a statement for the Trusts Quality Accounts for 2020/21. The CCG remains committed to ensuring, with partner organisations, that the services it commissions provide the highest of standards in respect to clinical quality and effectiveness, patient 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 a number of Trust Quality Assurance meetings, attended by commissioners, triangulated with information and further informed through Quality Assurance visits and feedback from exemplar visits to gain assurance around the standards of care being provided for our population.

Firstly the CCG would like to acknowledge the challenges during 2020/21 the Covid-19 pandemic has bought and acknowledge and commend the actions and contribution of the workforce duringthis difficult period of time.

In the Quality Account for 2019/20 the Trust set out nine Quality Priorities for 2020/2021. Of these nine priorities, one, in relation to the deteriorating patient was carried over from the previous year and eight were new priorities. The CCG acknowledge the nine priorities covered a number of clinical services as well as including cross cutting priorities across the Trust.

We recognise the work undertaken by the trust to improve the quality of patient care, clinical quality, patient safety and patient experience through 2020/21 and the trust have highlighted their improvements in the nine priority areas and identified further work that is required to be carried out however the trust has highlighted a number of issues that continue to be a challenge

- The delivery of sepsis management in the Emergency departments has shown a marked improvement during 2020 /2021 however there remain inconsistencies in relation to ensuring the “Sepsis 6” bundle for patients screened as high risk is implemented in a timely way and remains a focus for improvement works for 2021/2022.

- 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. A number of core services were rated inadequate.

- A focused CQC inspection of Children and Young People's (CYP) Services took place on the 24th February 2021 at the Princess Royal Hospital (PRH) related to the care of CYP with mental health needs and children's safeguarding resulted in services being downgraded to "inadequate". The Trust currently has conditions in place in relation to its registration following enforcement action taken against the Trust in 2018/19, 2019/20 and 2020/21.

- Detail around Children's assurance within the schedule could be strengthened to reflect the additional activity being undertaken to address concerns; however it is noted that the CQC Improvement Plan referenced in this section highlights that confirm and challenge sessions in relation to children, young people are in place and additionally safeguarding is one of the 6 themes to be monitored via appropriate Trust Governance Forums.

- There is limited detail confirming actions being undertaken to strengthen training and additionally oversight of child safeguarding, including those with mental ill health and LD. It would have been useful to see how the information gleaned from the Multi-agency Case File Audits which the Trust Safeguarding Team engage, influence changes in practice.

- The Children's hub is referenced and is an innovative way to seek children, young people views; often low in surveys and FFT.

- It was positive to note the following points in relation to safeguarding improvements:

    - Priority 8; a new PALS role has been created in Women and Children's to provide a more proactive service in 21/22.

    - Priority 9; a Transition Policy has been introduced which is essential to support transition of children and young people with varying complex needs including mental ill health, LD and where safeguarding issues are apparent.

    - Safeguarding is one of the 6 key measures for this year and with evidence based audit outcomes to support embedded safeguarding and MCA practice across the trust.

- 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 20202/2021. It is acknowledged that due to Covid-19 pandemic there have been challenges nationally to meet this target.

- All Cancers: 62 day wait for 1st treatment from urgent GP referral for suspected cancer performance against this target in 2020/2021 has remained below the national target and again it is acknowledged that due to Covid-19 pandemic there have been challenges nationally to meet this target.
- In 2020/2021 the 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 and we look forward to seeing the impact of these improvements.

The commissioners look forward to seeing further progress with continued improvements in 2022/23.

Whilst reviewing the Quality Account we were pleased to note many of the specific actions that the Trust has taken during 2020/21 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 tostrengthen learning from incidents, complaints and feedback; however, the CCG would like to commend the trust for the following key achievements achieved during 2020/21:

- Throughout 2020/2021 the matrons have been undertaking reviews of patients on the wards who have triggered NEWS score of 5 (this score indicates clinical deterioration). The audit results have consistently shown greater than 90% compliance with the criteria of patients being escalated for and receiving clinical review.
- The Trust has focused on reducing the number of overdue serious incidents and since June 2020 has seen a significant improvement in the turnaround time and quality of these reports; with no overdue serious incidents since August 2020.
- 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 vitally important. This has been particularly difficult for bereaved families and clinical staff alike through the Covid-19 Pandemic.

There are notable areas of success as well as areas that continue to require focus and improvement. 2021/22 will continue to bring challenges 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 ourpatients in the care they receive.

Feedback Form

We hope you have found the Quality Account useful.

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

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

Return to:

Corporate Nursing

Stretton House

The Royal Shrewsbury Hospital

Mytton Oak Road

Shrewsbury, SY3 8XQ