NHS
The Shrewsbury and Telford Hospital
NHS Trust

Quality Account

The Shrewsbury and Telford Hospital NHS Trust

2021/22

Partnering
Ambitious
Caring
Trusted

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 2022-2023

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

Section 3: Other Information Relevant to the Quality of Care

National Patient Safety Alert Compliance
Serious Incidents
Never Events
Friends and Family Test
Ockenden Independent Review of Maternity Services
Pressure Ulcers
Infection Prevention and Control

Section 1: Introduction

1.0 Statement on Quality from the Chief Executive Officer

The Shrewsbury and Telford Hospital NHS Trust

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

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

The Trust also provides community and outreach services such as:

- Consultant-led outreach clinics (including the Wrekin Community Clinic at Euston House in Telford)
- Renal dialysis outreach 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. They are an important way for trusts to demonstrate how well they are performing, considering the views of service users, carers, staff and the public and to identify areas for improvements. Due to the ongoing impact of COVID-19 in 2021/2022, the routine external auditor assurance has been suspended again this year for the Quality Account.

Statement on Quality from the Chief Executive Officer

Welcome to the Quality Account Report for the Shrewsbury and Telford Hospital NHS Trust for 2021/2022.

The Shrewsbury and Telford Hospital NHS Trust is an organisation that strives to provide high quality, safe care for our patients in an environment in which our staff feel supported and are proud to work in. As a Trust we have committed to deliver year-on-year improvements to ensure our patients and our staff remain safe and supported at all times. In collating our Quality Account I have reflected on the last 12 months, which have been a challenging and productive year for the organisation. I am

pleased to share some of our improvement work and achievements through the Quality Account for the period 2021/2022.

Since March 2020, the NHS has endured an unprecedented challenge due to the pandemic. Throughout 2021/2022 we have continued to ensure we respond to all the demands resulting from the ongoing pandemic to deliver care and keep our patients safe, and at the same time have commenced work to restore all services fully whilst continuing to face the ongoing challenges presented by COVID-19. Despite the ongoing challenges caused by the pandemic we have continued our improvement journey. In March 2021, our Board of Directors approved our Quality Strategy (2021 to 2024). The Quality Strategy was developed around the pillar of quality: care that is safe, clinically effective and provides a positive patient experience, and includes key quality areas based on our known areas of risk, themes from regulatory compliance workstreams and the NHS Patient Safety Strategy. The Quality Strategy is the vehicle by which we have steered the direction of travel for quality and safety and is underpinned by 8 priorities, these priorities were approved as our quality priorities included in the Quality Account for 2021/2022 and remain the priorities in 2022/2023:

- Learning from Events
- Deteriorating Patients
- Falls
- Best Clinical Outcomes
- Right care, right place, right time
- Learning from Experience
- Vulnerable Patients
- End of Life Care

Key Achievements in 2021/2022 include:

- A new Quality Governance Framework was implemented in November 2021 to help support timely and high-quality investigations into incidents, complaints and learning from deaths embedding the learning to improve safety and the quality of care across the Trust.
- The Trust mortality data for the reporting period January 2021 to November 2021 demonstrates a Summary Hospital Level Mortality Indicator (SHMI) for the Trust which remains in the ‘as expected’ range. We know that our ongoing focus to drive improvements through our Learning from Deaths Programme and being aligned with the health care needs of our patients, will further contribute to this in 2022/2023.
- Whilst we did not see a reduction in the overall number of falls in 2021/22, 93% of patients have a falls risk assessment completed on admission and 86% had a falls prevention care plan in place. All inpatient falls have a review by the Quality team with immediate feedback in relation to good practice and actions required to embed real-time learning from falls. There remains significant progress to be made in relation to falls in 2022/23.
- We have seen an improvement in the number of complaints responded to within the agreed timescales in the latter part of 2021/22, actions to continue this improvement will continue in 2022/2023.
- We have seen consistent improvements in our application of MCA and DoLs; although we have not yet achieved our safeguarding training compliance, we have evidence of good application of the safeguarding principles in practice; this was acknowledged by the CQC

during their inspection and the subsequent lifting of all our Section 31 conditions in relation to safeguarding.

- We have implemented a 7-day specialist palliative care service across the Trust which has already demonstrated positive benefits to both our patients and staff. Alongside this we have seen improvements in our end-of-life care (EOLC) and syringe driver training and have implemented an EOLC care plan

The Trust was inspected by the CQC in July 2021, the report from this inspection was published in November 2021. Although the Trust remained “inadequate” overall there were improvements noted particular in both emergency care and medicine as well as an acknowledgement by the inspectors that they had found progress which laid the foundations to considerably improve patient care. The Trust had a number of Section 31 conditions in place in relation to its registration, and subsequent to the publication of the CQC report many of these were removed in February 2022 with 5 remaining in place across the two hospital sites.

Alongside managing two waves of COVID-19, we continued to manage infection prevention and control to manage other organisms effectively, the overarching safety of patients and staff was not compromised by the demands of the pandemic in relation to infection prevention and control. The Trust achieved all its national healthcare associated infection targets, with the exception of one MRSA bacteraemia in May 202.

In the 2020/2021 Quality Account we outlined that the first report of the independent review into maternity services at the Shrewsbury and Telford Hospital NHS Trust was published in December 2020. The report outlines Local Actions for Learning (LAFL’s) which are specifically for the Trust to implement and Immediate and Essential actions (IEA) for the Trust and wider system that were required to be implemented to improve safety in maternity services for both the Trust and across England. During 2021/2022 the Trust has completed 86% of these actions, those actions outstanding are in progress and have external dependencies. The final report of the Independent Maternity Review at the Trust was published on the 30th of March 2022. The report outlined 15 immediate and essential actions (IEAs) to improve maternity services across England as well as 66 local actions for learning (LAFLs) for Shrewsbury and Telford Hospital NHS Trust. Throughout 2022/2023 the Trust will continue its commitment to implement all actions to ensure these improvements are achieved.

The 2021/2022 Quality Account provides a clear picture of the importance of quality, safety, and patient experience to us at the Shrewsbury and Telford Hospitals NHS Trust and how we are striving to make the improvements so that all patients receive high quality, safe, cost-effective, and sustainable healthcare services that meet the high standards that our patients deserve all the time. It outlines the considerable progress made this year but also acknowledges significant the ongoing improvements which we need to deliver. I can confirm that the Board of Directors have reviewed the 2021/22 Quality Account and they agree that this is a true and fair reflection of our performance.

Thank you to everyone who has helped us compile and commented upon the Quality Account including Healthwatch and our Clinical Commissioning Group. Finally, I want to take this opportunity to thank all our staff who have continued to work tirelessly throughout 2021/2022 to care for our patients and carers.

Section 2: Priorities for Improvement and Statement of Assurance

This section outlines the detail behind each of the quality priorities for 2021/2022 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 2022/2023 are outlined, why we have chosen these and the actions we will take to achieve these throughout 2022/2023.

2.1 Review of the Priorities for Improvement 2021-2022.

As part of the Trust "Getting to Good" Programme which was implemented to support the Trust to progress its improvements and move towards achieving an improved rating with the CQC a workstream was set up to develop a Trust Quality Strategy. The priorities within the Quality Strategy were proposed based on known areas of risk, themes from the regulatory compliance work-stream and the Patient Safety Strategy. The Quality Strategy for 2021-2024 was agreed by the Trust Board in March 2021.

The eight priorities within the Quality Strategy were the priorities agreed for the Quality Account for 2021/2022 and the following year as the Strategy spans over 3 year and it was acknowledged that all the key elements of the eight priorities would not be achieved within the first year of implementation. These eight priorities and the progress made in relation to these is outlined.

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

Quality Priority 1: Learning from Events and Developing a Safety Culture

This priority aims to embed a patient safety culture across the organisation, which focused on systems learning and genuine quality improvement.

During 2021/202 we have based our patient safety culture work around the key principles outlined in the 2019 National Patient Strategy and have made that strategy reality in the day-to-day delivery of care in our hospitals. In 2021/22 embedding the learning from incidents including serious incidents and developing our safety culture has been a key priority, which will continue through 2022/23. The creation and implementation of the new Quality Governance Framework in November 2021 aims to reduce variation and increase standardisation across the Divisions and to further support the Trust to undertake timely and professional investigations into incidents/complaints and learning from deaths.

The new Quality Governance teams support with embedding the learning to improve the quality of care and safety for our patients. The Patient Safety Specialist Officer (PSSO) and the Clinical Patient Safety Lead are pivotal in the development of the new Patient Safety Incident Review Framework (PSIRF) which is due to be rolled out Nationally during 2022.

The Trust's Human Factors and Ergonomist Specialist who along with the PSSO and Patient Safety Clinical Lead work on thematic reviews of incidents and focused on a systematic approach to understanding the reasons why errors occur to support the clinical teams by developing work processes and procedures that reduce the risk of human error.

We have reported and investigated 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. We also 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 are developing 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.

What have we achieved?

- We have used 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, examples include thematic review of falls and pressure ulcers to develop overarching prevention plans and thematic reviews of urology services to support improvements in the service.
- We have seen an improved quality of investigations resulting in timely closure and feedback to families.
- The creation of the Quality Governance Teams is enabling close working with clinical areas and reviewing near miss and no harm incidents to identify themes and trends. An example of this is the work undertaken in relation to overarching prevention plans for falls and pressure ulcers, based on themes from near miss incidents.
- We have Increased the number of incidents reported as part of improving our open learning culture.
- We have seen improvements in the percentages of staff responding positively to the relevant safety culture elements included in the staff survey
- We have embedded 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 have developed new investigation tools and templates such as the new Serious Incident Investigation Report to support a system review of learning which has been modelled on the HSIB method of reporting.
- We have trained and supported our staff in human factors insights and tools and techniques and to better identify causes and contributory factors of incidents so we can focus improvement in the right areas, and we have developed a rolling programme of investigation training incorporating human factors into the Trust and also now have human factors training incorporated into leadership courses and masterclasses, along with bespoke training for specific specialities such as Maternity

- We have now adopted the Datix Action Module to monitor actions to reduce harm which has enabled the quality governance teams to have oversight and track completion of actions, both in response to serious incident investigations and following thematic analysis of incidents the serious incident review group receives updates on progress of improvement work
- The new quality governance teams are now linked to clusters of wards to support and share learning through huddles and safety boards
- We continue to monitor how Duty of Candour is delivered sharing best practice examples across teams, through the monthly checking, quarterly and annual audit
- We have implemented a new comprehensive Mortality Review process, including Learning Disability Mortality (death) Review (LEDER) in line with national guidance using structured judgement tool methodology

How do we know we have succeeded?

- We have seen a reduction in Never Events
- We have begun 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. The first of these was the deteriorating patient.
- We have good compliance with Duty of Candour which is checked via monthly checking, quarterly audit and an annual audit which show good compliance.

	Apology	N=51
The regulation states that the notification given to the relevant person includes an apology, which was evidenced in all cases.	Yes	51 (100%)
	No	0 (0%)

	Written record	N=51
The regulation states that the notification is to be recorded in a written record. Of the 51 serious incidents, all were documented in a written record.	Yes	51 (100%)
	No	0

	Notification given or sent	N=51
The regulation stipulates that after the patient or relevant other has been notified of the incident, it must be followed with a written notification, given, or sent to the relevant person.	Yes	50 (98%)
	No*	1 (2%)

- The proportion of reported patient safety incidents that cause no or low harm reported to NRLS remains consistently above 97% and is above national average
- We have increased patient safety incident reporting ratio per 1,000 bed days from 57% to 65%.
- The % of patient safety incidents that result in severe harm or death remains below the national average

Priority 2: The Deteriorating Patient

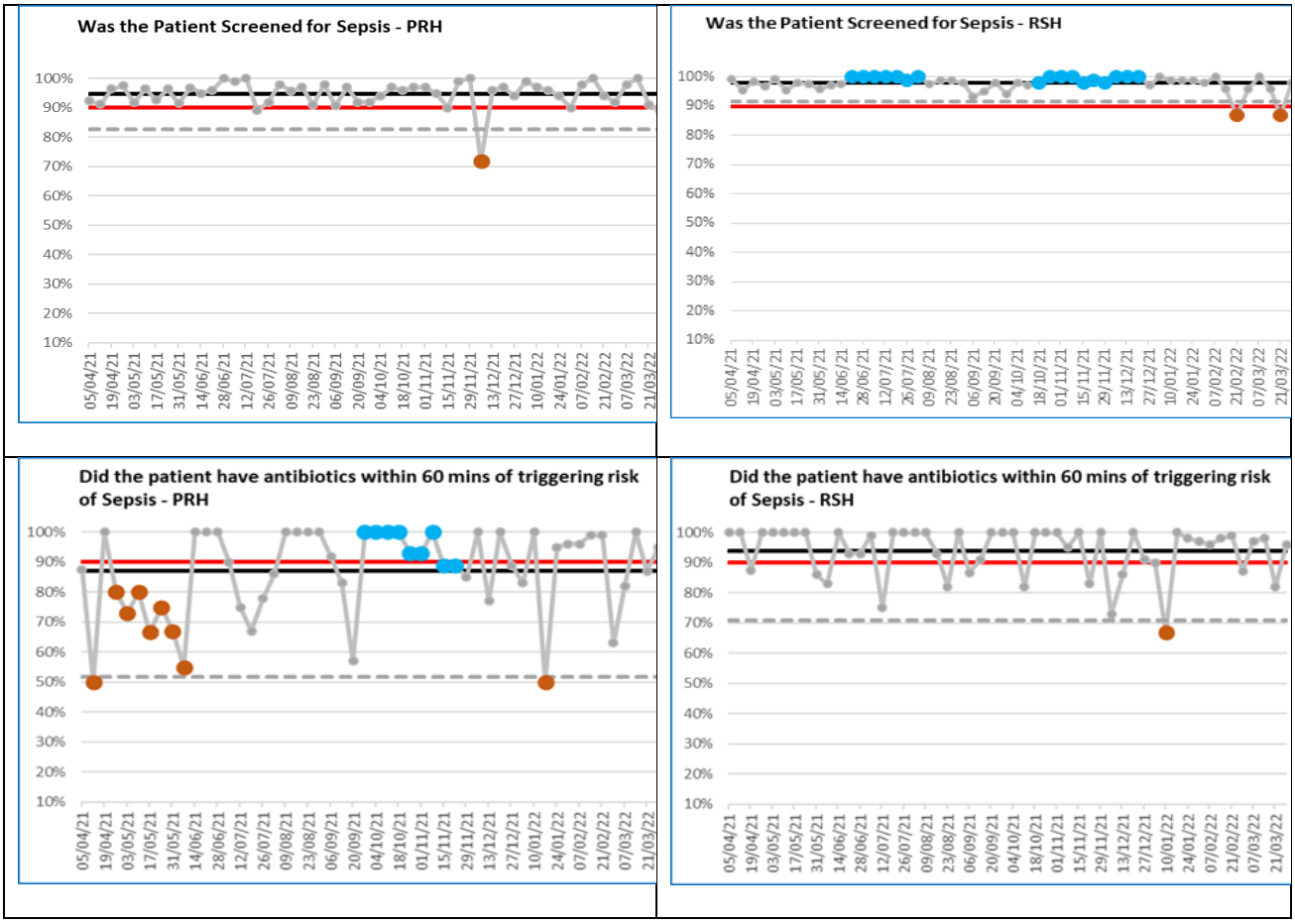
For this priority we aim to **r**ecognise deteriorating patients at the earliest opportunity and identify the most appropriate course of treatment for them to give them the best possible outcome we can. This includes identifying all aspects of deterioration and treating sepsis and Acute Kidney Injury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

What have we achieved in 2021/2022?

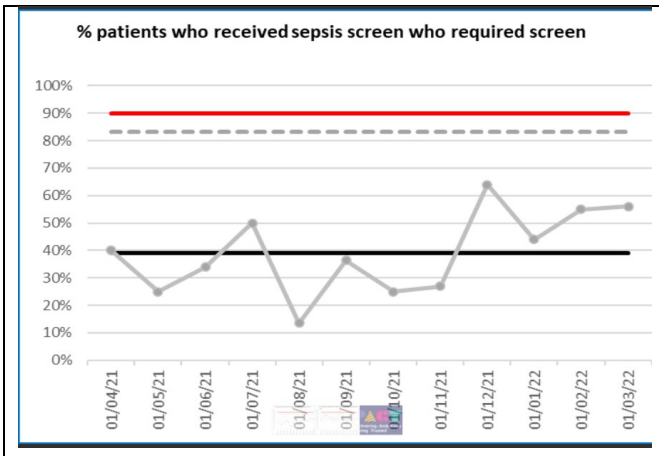
- **Further embed the use of sepsis screening tool and Sepsis Six bundle and pathway arrangements across the Trust**

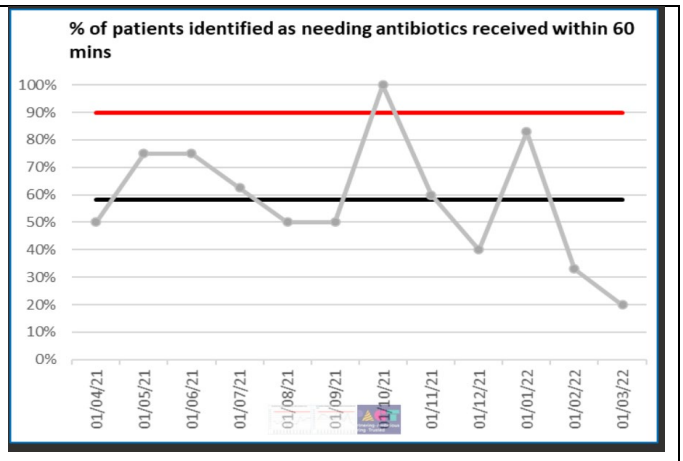
We continue to monitor sepsis screening compliance across our Emergency Departments and inpatient wards.

We continue to see good compliance with sepsis screening on admission to our Emergency Departments with average overall compliance in 2021/2022 of 96%. Antibiotics administered within 60 minutes shows more variation but an average of 89% for 2021/2022.



On the inpatient wards sepsis peer audits show that there has been an improvement since December 2021 in the percentage of patients screened for sepsis but an overall decline in the percentage of patients who received their antibiotics within an hour. Whilst the number of patients included in these audits are small there remains considerable improvements required to achieve compliance of 90%.





- **Review and monitor internal protocols regarding escalation that is shared across staff groups**

This year as part of the Vitals 4.2 rollout in December 2021 the Sepsis and Deteriorating Patient Team reviewed our processes for escalation throughout the Trust with Trust-wide communication and training delivered as part of this.

Alongside this the Deteriorating Patient Policy was developed and Standard Operating Procedures for the management of sepsis in Paediatrics. Work was completed to update the Maternity SOP for Sepsis and revised Adult Sepsis SOP.

- **Systematic Review using human factors principles and develop a longer-term improvement plan to reduce the risk of not responding to deterioration.**

A systematic review of the deteriorating patient using human factors was undertaken in 2021 and included:

- A review of key themes of published literature and national reports
- A review of two years of serious incident reports relating to the deteriorating patient
- Using a structured observation tool based on human factors principles a review was undertaken observing the 'work as done' relating to recognition, escalation, and response to the deteriorating patient across a number of clinical areas including medical and surgical wards, and assessment areas at both the PRH and RSH sites
- Using a human factors tool called FRAM there was a facilitated clinical focus group who looked at understanding the key factors to successful recognition, escalation, and response in our clinical areas.

All the information gathered during this systematic review has been themed using a framework called SEIPS (the system engineering initiative for patient safety) which themes insights into external, organisational, task, people and teams and tools and technology factors to give a rich in-depth view of where interventions could be targeted for systematic improvement of our response to the deteriorating patient.

How do we know we have succeeded?

- We have maintained good performance in relation to sepsis screening and the administration of antibiotics within an hour in both our Emergency Departments for a 2nd year
- We have completed the systematic review in relation to the deteriorating patient

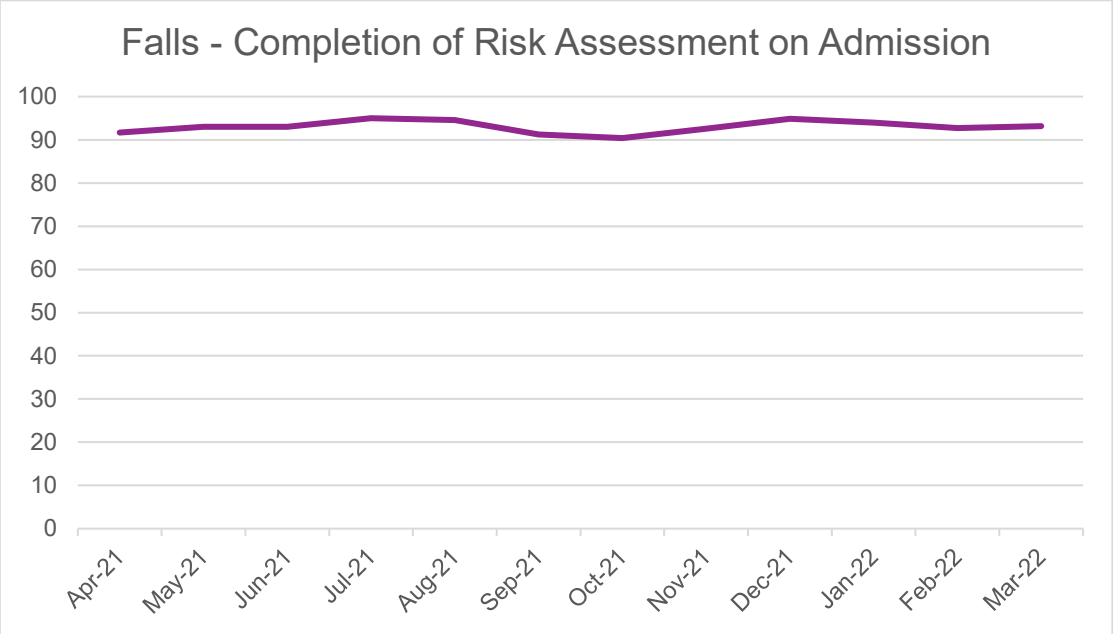
Priority 3: Inpatient Falls

This priority aimed to keep patients safe from harm by reducing the risk of a fall, reducing both the number of patient falls and the level of harm associated with a fall for patients in our care. Falls amongst inpatients are the most frequently reported safety incident in NHS hospitals with 50% of patients over 80 estimated to fall at least once a year and 30% of over 65's. Approximately 30-50% of falls result in some form of injury and fractures occur in 1 to 3% of incidents. Since the start of the COVID 19 pandemic it is now projected that 110,000 more older people will fall in the next year (an increase of 3.9%) Exercise reduces the rate of falls by 23% and with an extended lockdown period it is also predicted that the COVID 19 pandemic will be followed by a deconditioning pandemic. Reducing the number of patients who fall in our care and reducing the risk of harm associated with a fall is a key quality and safety issue and priority for improvement for the Trust.

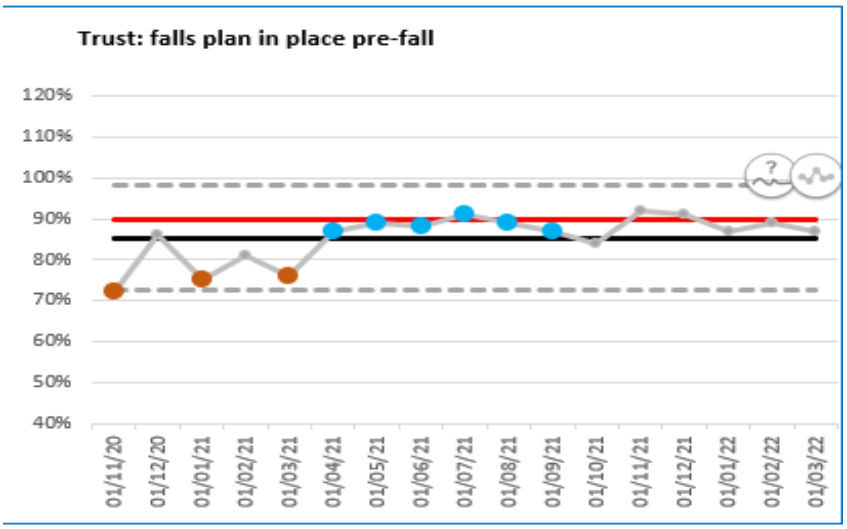
What have we achieved?

- To 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 our staff have completed falls training with 84% of nurses and healthcare assistants in the inpatient areas have completed falls training. Alongside this bespoke training has been provided by our Falls practitioner to areas with high incidents of falls.
- A part of our Falls "Always" plan is to ensure that every patient has a multifactorial falls risk assessment completed on admission, and that patients who are assessed as at risk of a fall have a Falls Prevention Care Plan in place

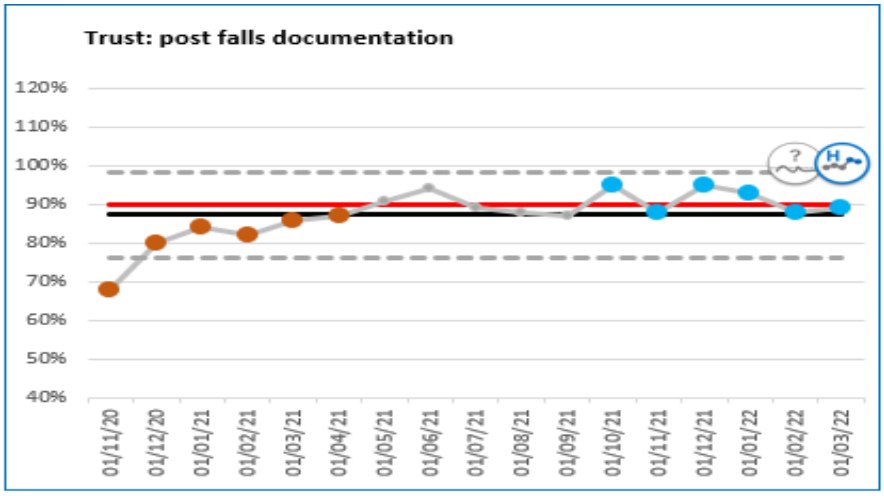
  In 2021/22 93% of patients admitted to the Trust had a falls risk assessment completed on admission.



For the period April 2021 to March 2022 86% of falls reviewed had a falls plan in place.



We aim to reduce the number of patients who fall in our care but when a patient does have a fall, we want to ensure that 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. In 2021/2022 the number of patients who had a post falls care bundle in place has increased from 67% to consistently above 85%.



- We have educated our patients on their risk of falls and the risk of sustaining a severe harm if they do fall whilst in hospital with 74% of patients having been given a "Preventing Falls in Hospital" Leaflet.
- To ensure we have robust governance processes are in place for the reporting and investigation of falls incidence and embed a culture of learning from falls incidents all falls resulting in serious harm (head injury or fractured neck of femur) are reported as a serious incident and have a full investigation completed. All Falls Serious Incident investigations are presented at the Nursing Incident Quality Assurance Meeting to ensure that learning is cascaded across the clinical areas. These are also included in the monthly Falls Steering Group and as a summary to the Trust Review, Action, and Learning from Incident Group (RALIG).

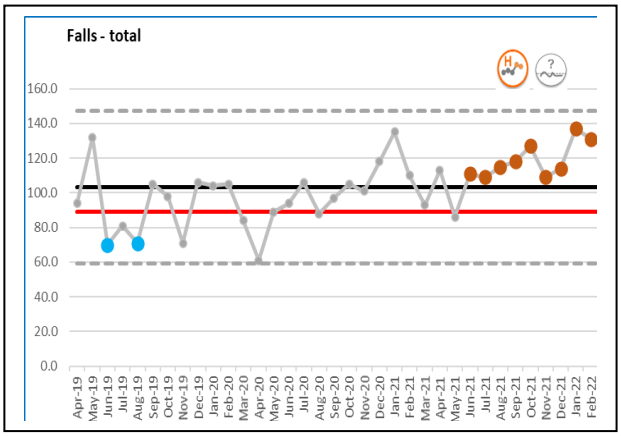
- The falls prevention plan has been further extended to include a number of workstreams aimed to prevent falls and ensure that all staff within the trust 'think falls'
- The quality team continue to review any patient that has fallen in the Trust, a feedback letter is provided to the individual staff member highlighting areas of good practice and areas for improvement and a weekly meeting takes place to discuss these findings and inform the quality teams educational agenda for the forthcoming weeks. Results from these reviews show that performance pre fall and post fall has significantly improved

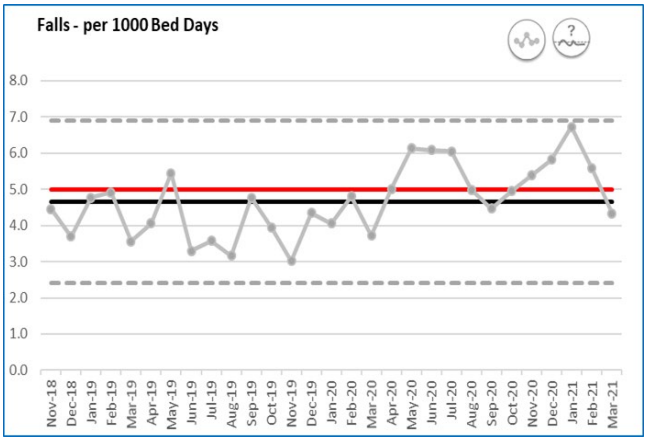
How will we know if we have succeeded?

Although we have made improvements we have not seen a reduction in falls, falls per 1000 bed days or in the number of falls which result in significant harm for our patients.

Reducing the ratio of falls per 1000 bed days to below the national average and reducing the number of falls with harm

A summary of falls for 2021-22 and a comparison with previous years is shown below





Falls	2018/19	2019/20	2020/21	2021/22
Total Number of falls	1185	1117	1194	1396
Falls per 1000 bed days	4.62	4.02	5.42	5.33
Falls with moderate harm or above per 1000 bed days	0.09	0.11	0.123	0.12

- There has been an increase in falls each quarter for 2021/22 but a small reduction in falls per 1000 bed days for this year.
- Overall the Trust saw an increase in the number of falls which resulted in a patients sustaining a fractured neck of femur with 16 reported in 2021/22 compared to 2020/21
- Falls resulting in moderate harm or above has increased from 27 in 2020/2021 to 31 in 2021/2022 with more falls reported as serious incidents. The ratio of falls with harm per 1000 bed days has remained the same at 0.12
- Comparisons with other acute trusts within the region shows a similar pattern in both measures above.
- We have seen improvements in our falls training compliance
- We have seen improvements in our pre and post falls documentation

Priority 4: Best Clinical Outcomes

Within this priority we 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, using innovation and ensuring our teams base their practice on the best available evidence including clinical outcome monitoring, audit, NICE compliance and GIRFT recommendations.

The 4 key themes of effectiveness for the Trust included:

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

To achieve this in 2021/2022 we aimed to:

- Implement a programme to develop a clear set of clinically owned standards for each of our clinical specialties.
- Review and further develop specialty and Divisional governance framework to implement and monitor standards (See Priority 1 which outlines the implementation of new Divisional Quality Governance Teams)
- 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
- Use outcome measures from national and local audits to inform us, our patients, and commissioners in relation to our performance (See Clinical Audit Section in this Report)

What have we achieved in 2021/2022?

Best Clinical Outcomes: A Clinical Standards Framework

The development of the Clinical Standards Framework has been led by one of our senior Consultants in the Trust, The Clinical Standards Framework aims to provide a significant contribution to the quality assurance of all clinical services within the Trust. All clinical specialities will have set standards for clinical services that offer a common language to describe high quality, safe and reliable healthcare. Such standards must be considered in day-to-day practice to encourage a consistent level of quality and safety and remove unwanted variation in healthcare that impacts upon patient outcomes and equity of care.

The framework Is supported by best practice contained within national clinical standards such as the National Institute for Health and Clinical Excellence (NICE) guidance. Clinical audit will be employed to allow performance to be assessed against such standards and, where required Quality Improvement Programmes (QIP) will be implemented. Specific specialities already engage with national clinical audits but there is a need to ensure that the results are publicised across applicable

specialities and all recommendations implemented to alter local healthcare practices and improve quality (e.g., Myocardial Ischaemia National Audit Project (MINAP), National Heart Failure Audit (NHFA), National Diabetes Inpatient Audit (NaDIA) and the Sentinel Stroke National Audit Programme (SSNAP). A patient experience standard will also be included in these speciality performance measures.

Work undertaken in the specialities to date includes:

Emergency Medicine (EM)

The Emergency Medicine governance team have produced a document which defines five key clinical standards (Clinical Care, Infection Prevention & Control, Patient Flow, Workforce and Leadership & Culture) that are underpinned by several quality measures. These standards recognise the recent publication of the 'Transformation of Urgent and Emergency Care: Models of Care and Measurement' (NHSE and NHSEI).

As Emergency Medicine is a multi-faceted speciality that interfaces with many clinical specialities, it is important that co-dependencies are recognised to ensure designated standards are upheld e.g., management of sepsis, stroke, acute coronary syndrome, and trauma.

Acute Medicine

Following collaboration with colleagues within Acute and General Medicine, several quality metrics have been proposed. Discussions with the Performance team have taken place to ensure these metrics can be included in *Inphase* to develop the dashboard. A programme of audits will be developed and undertaken against these standards.

Quality Indicators: Acute Medical Unit, Same Day Emergency Care and Short Stay Medical Ward

ACUTE MEDICAL UNIT

1. VTE Compliance
2. Screening for delirium and dementia in those aged ≥ 65 years (using 4AT and cognitive assessment tools).
3. Antibiotic prescribing within trust prescription chart: Documentation of indication, antimicrobial prescribed according to trust guidance and duration of antimicrobial use.
4. Engage with the Pathology Quality Management System for: blood culture contamination rates, haemolysed blood specimen contamination rates and wrong blood in tube (WBIT) error rates.
5. CIWA score for patients with confirmed or suspected Alcohol Withdrawal Syndrome; on first assessment and if appropriate ongoing monitoring.
6. Documentation of the Estimated Date of Discharge (EDD) and/or Clinical Criteria for Discharge (CDD) within the post take ward section of the medical assessment booklet.
7. Emergency readmissions within 30 days of discharge.
8. Discharges before 11am and 5pm (general medical wards).

SAME DAY EMERGENCY CARE (S-DEC)

1. Number of non-elective presentations treated and reviewed by a consultant acute physician
2. % conversion rate to admission
3. Number of unplanned re-presentations within 5 days.
4. CT pulmonary angiogram 'positive' rate for pulmonary embolus.
5. % of the following conditions treated on an ambulatory basis:
   - Pulmonary Embolus
   - Atrial Fibrillation

SHORT STAY WARD (SSW)

1. All patients on the SSW have an EDD of ≤ 72 hours which is documented at the time of first medical consultant review.
2. % of all patients on the SSW who have a LoS ≤ 72 hours
3. % of all patients transferred to another medical ward (including those who LoS exceeded 72 hours)
4. Mean, median and range LoS (hours)
5. % discharge drugs ordered and prepared the day before discharge

Neurology

A draft set of clinical standards for Neurology was presented in March 2022 for consideration at the Royal Wolverhampton Trust's clinical governance meeting. These standards were split into four domains; neurology liaison service (NLS), condition specific (to link in with pathway development), procedures (to link in with LocSSIPS) and clinical coding.

There was particular interest in the consultant-led liaison neurology services (LNS) within both hospitals for despite being an important part of neurological services offered, such services are not measured in any regularly collected metrics. Examples of specific metrics proffered within the draft set included:

NEUROLOGY LIAISON SERVICE

1. No. of patients seen by the LNS per month/per consultant.
2. Ward referrals as a % of the number of non-elective admissions
3. % of referral to NLS managed with verbal advice alone
4. % of referrals reviewed by a consultant neurologist within one working day
5. Reduction of non-elective LoS for patients admitted primarily with a neurological condition
6. Readmission rates for headache.

The Consultant leading on the Clinical Standards Framework and a consultant neurologist are drafting a bespoke electronic referral system which if implemented has the potential to provide a legible, trackable, and auditable train of information such that it will allow for a real time appreciation of designated quality metrics underpinning quality standards for the NLS.

Assess our performance against NICE guidance within 28 days of issue of the guidance and meet or exceed the requirements of NICE quality standards

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 2021/2022 the Trust aimed to:

- Continue to review and comply with relevant NICE guidance to ensure relevant clinical practice and effectiveness is in place throughout the Trust.
- Continue to improve the number of timely NICE compliance reviews, aiming for 90% of these to be completed within specified timescales during 2021-22.

This target was exceeded, with 98% of NICE compliance being reviewed during target timescales, supporting delivery of appropriate clinical care by adherence to this evidence-based guidance.

During 2021/2022 the Clinical Audit Team provided one-to-one support to Clinicians to help with completion of NICE benchmark assessment templates. During the year links have also been developed with Specialist Nurses to further strengthen this process, and this work will continue during 2022-23.

Percentage of guidance published during the year completed within target timescale

	Percentage of guidance published during the year completed within target timescale 2020/2021	Percentage of guidance published during the year completed within target timescale 2021/2022
Clinical guidelines (NG)	93% (28/30)	92% (11/12)
Quality Standards (QS)	62.5% (5/8)	100% (3/3)
Interventional Procedural Guidelines (IPG)	67% (12/18)	100% (26/26)
Total	**80% (45/56)**	**98% (40/41)**

The focussed work in this area has also resulted in an increase in the overall percentage of all published guidance completed during 2021-22, from 99% in 2020-21 to 99.9% in 2021-22. This target has been set at 100% for 2022/23.

Overall percentage of all published NICE guidance completed

	Percentage of all published guidance completed 2020-21	Percentage of all published guidance completed 2021-22
Clinical guidelines (NG)	97% (283/291)	99.6% (289/290)
Quality Standards (QS)	99% (195/197)	100% (97/97)
Interventional Procedural Guidelines (IPG)	99% (543/544)	100% (552/552)
Total	**99% (1021/1032)**	**99.9% (938/939)**

How do we know we have succeeded?

- We have achieved year on year improvement in compliance against NICE guidance compliance within 28 days of issue, increasing from 65% in 2019/20, to 80% in 2020/21, and 98% in 2021/22
- A set of Clinical Standards has now been embedded for some specialities
- During that period, the Trust participated in **98%** (41/42) of the national clinical audits and 100**%** *(2/2)* of the national confidential enquiries which it was eligible to participate in and developed/implemented actions following these (See Clinical Audit Section).

Priority 5: Right Care, Right Place, Right Time

The aim of this priority is to ensure that all of our patients are located and cared for 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 and 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**

During 2021/22 Covid-19 had a significant impact on the right available capacity and therefore to manage this safely a clinically led patient cohorting plan was established. This was to ensure patients received the right care in the correct environment.

- **Ensure patients have accurate estimated date of discharge**

All patients who are admitted to a hospital bed must have an Estimated Discharge Date (EDD) for the Multidisciplinary Teams (MDT) to work towards this discharge date. Further work is being undertaken with the clinical teams to improve the accuracy of this information, to ensure robust discharge planning.

- **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**

Board rounds take place on each ward using SAFER principles, and planning meetings take place twice a day to identify early 'next day' discharges to aid patient flow. Fortnightly report out sessions in place with the clinical teams, to monitor performance against discharge times and support teams to improve this patient metric.

The introduction of the Flow coordinator role in January 2022, is supporting wards to manage discharge safely and in a timely way. Further work is being undertaken with the clinical teams and feedback from system partners to enhance this process.

- **Executive Medical Director to lead review of all patients in hospital over 21 days**

Weekly MDT meetings with system partners are now in place to review discharge plans for patients who remain in hospital after 14days, this is led by the Deputy Medical Director. This will enable planning for discharge to take place at the earliest opportunity. The Integrated Discharge Team (IDT) are working to reduce delays in transferring patients to their next care setting.

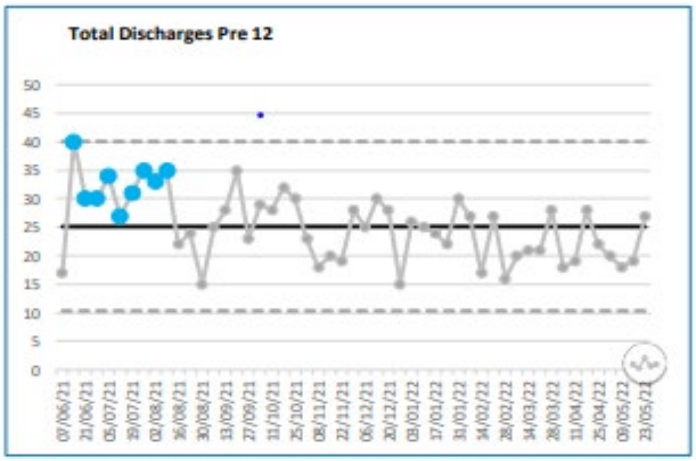
- **Improve communication for handover and transfers of care throughout the Trust**

A new Trust Transfer Policy has been developed which aims to standardise intra/inter-hospital transfers and the types of escorts required to perform this task for Shrewsbury and Telford Hospitals Trust ensuring

that patients are assessed as to the level of escort provision that is necessary for the effective risk management and care of the patient during transfer.

- **30% of patients who are being discharged to have left their bedded area by 12 noon, 80% by 5pm**

There has been ongoing improvement work in 2021/22 supported by the Trust Improvement team which has included a focus on home before midday. Despite this there is further work to do to ensure that patients are discharged earlier in the day. Capacity in relation to the discharge lounges, particularly at the Princess Royal Hospital site has been identified as requiring improvement.



How will we know if we have succeeded?

With regards to success in relation to this priority, the pandemic and the associated impact on both the Trust, community and social care has had an impact in relation to achieving the agreed actions for this priority. This remains a key focus for the Trust in 2022/2023 actions.

Priority 6: Learning from Experience

This priority aims 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.

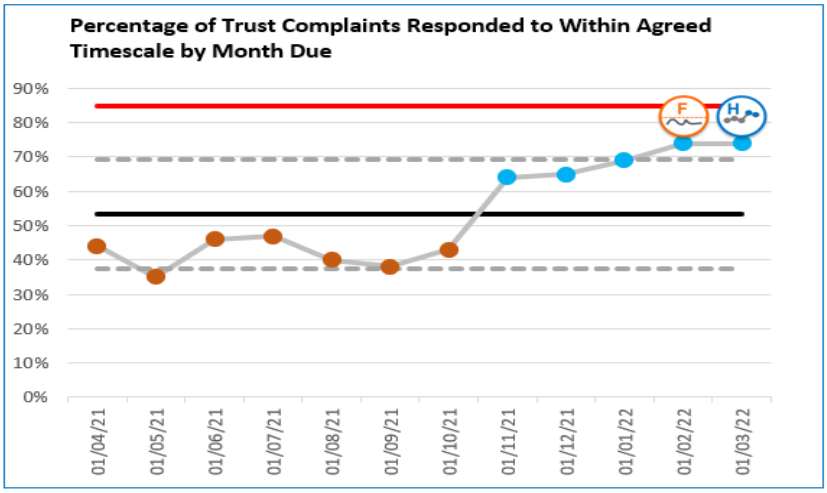
What have we achieved in 2021/2022?

In 2021/2022 a key focus for the learning from experience priority was to address our complaints processes across the Trust

- **Improve the timeliness of our responses to patient complaints**

Improving the timeliness of our responses to patient complaints, ensuring that patients receive a response to their concerns within the agreed timescales, with at least 85% of complaints responses

completed within the agreed timescale was identified as a priority for 2021/22.



There has been a significant focus on improving both the timeliness and quality of responses to complaints. This has been impacted by high levels of demand and clinical pressures, as well as staffing challenges, however the responses rates have improved to 74% in comparison to 2020/2021 (60%). Whilst the target of 85% has not been achieved, the Trust is demonstrating a high special cause improving variation, and this remains an area of focus.

As a Trust we have recognised that we needed to take action to improve our process in relation to how we work with complainants and keep them updated throughout the complaints process. In 2021 we have implemented a personalised approach in relation to engaging with our complainants and how we ensure regular contact and updates are provided.

- **Reduce the Number of Formal Complaints**

Between April 2021 and March 2022, the Shrewsbury and Telford Hospitals NHS Trust received 688 complaints as shown in the table and graph below. This reflects a 17% increase in the number of complaints received in 2021/2022 compared to the previous year. However, it should be noted that activity was significantly reduced during 2020/2021 with cessation of elective activity during the COVID-19 pandemic.

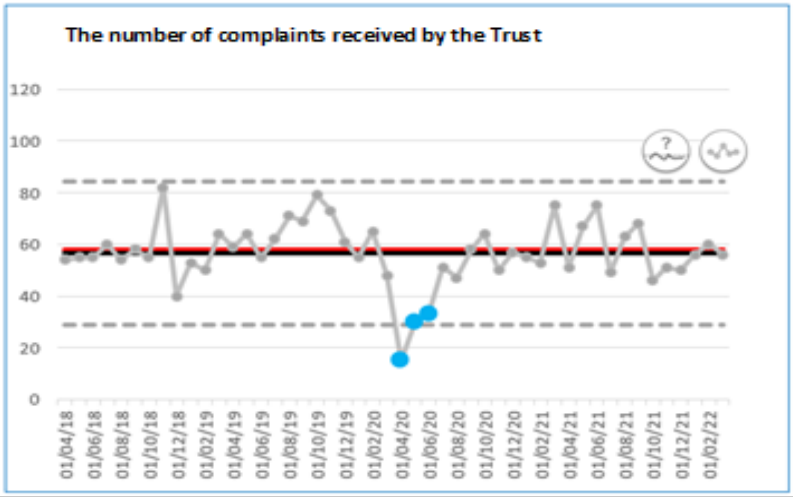


Table 1: Number of Complaints

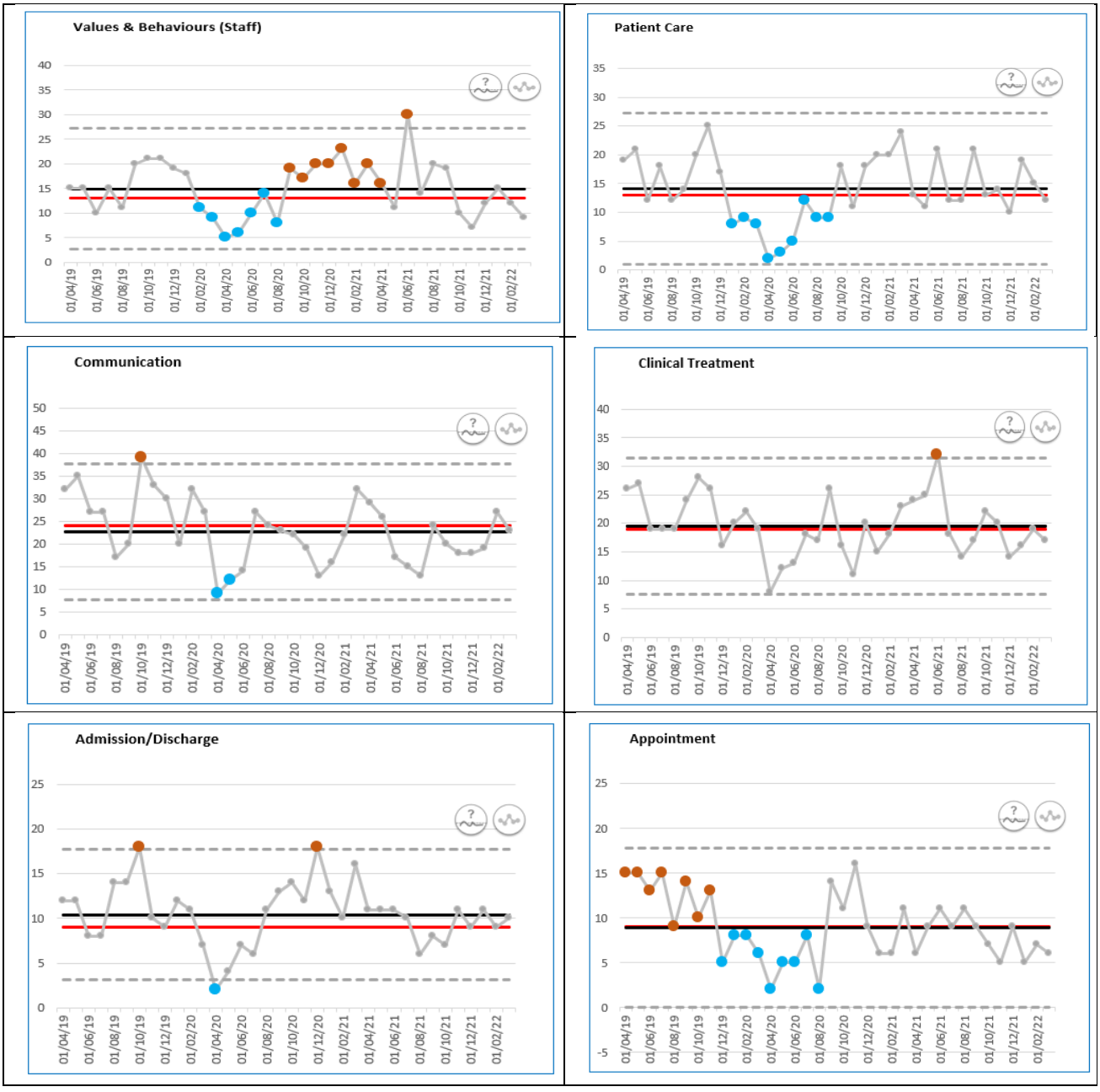
Year	Number of Complaints
2017/2018	600
2018/2019	680
2019/2020	760
2020/2021	587
2021/2022	688

- **Decrease the number of complaints not answered first time**

The number of complaints that are re-opened remains low, with 28 cases re-opened in 2021/22.

- **Reduction in formal complaints that identify specific themes**

During 2021/22, we have continued to see a theme in complaints about problems with communication, linked to restrictions on visiting. Families are reporting difficulties in getting through to wards, and in getting updates about their loved ones. Work to improve this is ongoing, with a number of measures in place to support better communication, including using volunteers to support, use of communication books, and developing virtual visiting. In addition, high absence levels in clinical areas and cancellations of elective procedures, again linked with the pandemic, have led to complaints about the standard of care and waiting times for appointments and surgery.



- **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 Committees and Specialty Governance meetings, to ensure that learning is cascaded and discussed at a variety of levels.

Further improvements the timeliness of responses is planned for 2022/23, with close working with divisions to support timely investigations. In addition, there are plans to develop the reporting and analysis of complaints data and improving how we follow-up and monitor actions and learning that are implemented as a result of complaints, bringing processes in line with those used for serious incidents.

- **Analyse, report and learn from patient surveys, complaints, concerns and compliments**

Using learning from Complaints to Improve Patient Care

As part of the learning from experience the Trust aims to ensure that actions and learning from complaints is embedded into the improvements we make in patient care.

Details of learning from both complaints and PALS contacts are discussed at the Divisional Committees and Specialty Governance meetings, to ensure that learning is cascaded and discussed at a variety of levels within the Trust.

The following information provides examples of learning from complaints:

Staff awareness choosing the optimum continence products for individual patients:

A Ward developed a training programme with a continence product supplier, to improve staff awareness of choosing the optimum continence products for individual patients dependent upon their requirements.

The Ward has since been identified as a pilot area for continence products and staff learning.

Confusion over delays in surgery and poor communication between specialties:

Feedback given through the departmental governance meetings to ensure that staff are aware of the importance of liaising with other specialty teams when patients are under more than one specialty.

The secretarial team have been reminded of the importance of checking the patient's history thoroughly to ensure that they are reporting on the correct pathway, as patients may be under more than one specialty.

In response to feedback from complainants that has been shared with the Trust a number of actions have been taken as outlined below:

Examples of feedback from complainants and actions taken:

- A digital patient story has been captured to share with staff involved in the patients care to raise awareness, support reflection and learning.
- The digital story will additionally be shared at Gynaecology Clinical Governance.
- A patient information leaflet for women experiencing a miscarriage has been developed to provide information and highlight support available to them. Tommy's information has now additionally been made available.
- A new process is being introduced, enabling people to self-refer to the Early Pregnancy Assessment Service, avoiding delays in awaiting referral via a GP or Emergency Department.
- A business case has been developed, seeking funding for an early pregnancy bereavement nurse position.
- The Chaplaincy Team are now visiting the Gynaecology Ward daily to provide pastoral support for people who have experienced a loss.

How do we know we have succeeded?

- We have seen a decrease in the time taken to respond to formal complaints, with 74% responded to within the timescales.
- Adopting personalised approach with earlier intervention from Divisional Directors of Nursing making contact with complainants
- There has been a decrease in the number of re-opened complaints with 28 in 2021/22 compared to 36 in 2020/2021.

Priority 7: Vulnerable Patients

We will 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 safeguarding needs, Learning Disabilities (LD) and Dementia. We also aim to have arrangements 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.

What have we achieved in 2021/2022?

- **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**

The appointment of a dedicated Safeguarding Trainer in 2021 has expanded the provision of safeguarding training across the Trust. Training packages have been developed which include face to face training and e-learning, these are ongoingly reviewed. Additional training resources such as Trust specific e-learning module for Level 3 safeguarding (released in February 2022) , MS teams training and face to face training provision have also been implemented. A Medical staff training package has also now been introduced.

Training compliance across Adult Safeguarding, MCA & DoLS remains below the Trust 90% compliance target, affected by the availability of staff to access training as an impact of Covid-19.

Category of safeguarding training	% as of end of Q1	% as of end of Q2	% as of end of Q3	% as of end of Q4
Safeguarding Level 1 Adults & Children	98%	98%	98%	94%
Safeguarding Level 2 Adults	90%	89%	81%	84%
Safeguarding Level 2 Children	88%	81%	89%	84%
Safeguarding Level 3 Children	97%	83%	85%	76%
Safeguarding Level 3 Adults	48%	54%	62%	60%
MCA & DoLS	74%	76%	77%	79%
Prevent – BPAT	84%	84%	84%	82%
Prevent – WRAP	83%	82%	81%	79%

From Quarter 4 of 2021/2022, medical staff on the designated adult wards caring for 16 to 18 year olds were also included. We have also delivered Mental Health Act training to over 70 senior nursing staff and provided a one day de-escalation training course monthly which over 50 staff across the Trust have attended.

To ensure that training is consolidated and can be applied in practice the ‘ASK 5’ Safeguarding audits commenced in 2021/2022, 5 members of staff on each ward across the Trust are asked questions around safeguarding to ensure compliance and triangulation of assurance to the safeguarding policies

Month	Staff knew where to find an Adult Safeguarding Concern form	Staff able to name at least 5 out of the 10 types of safeguarding	Staff knew at what age does the Mental Capacity Act come into effect	Staff able to name at least 2 out of the 5 principals	Staff knew how to contact the Trust Adult safeguarding team in hours	Staff knew who to contact out of hours
Jul-21	94.9	81.8	79.6	64.2	90.5	80.3
Aug-21	94.9	94.9	69.4	76.5	94.9	93.9
Oct-21	97.6	90.2	80.5	87.8	97.6	84.1
Feb-21	100	100	89.1	87	100	93.5

Overall these audits show good compliance. When a staff member cannot answer the questions education is provided at the time of the audit being completed and the staff member is then followed up to ensure they are confident with safeguarding principles.

Month	Age which describes a child/young person	Able to provide examples of a child or young person safeguarding concern?	Correct process for a child/young person who may have self-harmed?	Trust process for raising a children's safeguarding concern?	Able to contact the Trust Children's safeguarding team in office hours?	Asking for advice at Bank Holidays, weekends and at night?	Do you know where to access information on how to raise a concern?
Mar-21	50	100	85.7	89.3	96.4	96.4	100
Apr-21	75.4	96.7	95.1	83.6	91.8	85.2	95.1
May-21	93.6	98.1	98.1	96.2	96.8	92.4	97.5
Jun-21	100	100	100	100	100	94.1	100
Jul-21	78	95.1	97.6	97.6	97.6	85.4	97.6
Oct-21	95.9	98	93.9	100	93.9	85.7	98
Jan-22	76	100	100	100	96	96	96
Apr-22	100	96.9	100	96.9	93.8	78.1	93.8

A successful Safeguarding conference was organised by the safeguarding teams and held in November with a focus on Domestic Abuse from several differing perspectives: Older People including LGBTQ+, Honour Based Violence and Forced Marriage, Domestic Homicide (a survivor's story) and West Mercia Women's Aid and Shropshire Domestic Abuse Service

- **Develop the Safeguarding team to support staff through safeguarding supervision and enable prompt recognition of emerging themes and trends**

The safeguarding team has been strengthened in 2021 with the appointment of a substantive Head of Adult Safeguarding. Safeguarding supervision is offered to staff across the Trust. A new safeguarding supervision session was set up in 2021/2022 for staff on the designated adult wards where 16 to 18 year old patients are cared for.

- **Champion improvements in dementia care at all levels within the organisation which includes dementia screening, personalised support plan (Patient Passport), and staff training**

We continue to take actions to ensure that anyone over 75 years of age admitted an emergency is screened for confusion and memory problems. Our aim is to ensure that over 90& of appropriate patients are screened on admission, our current compliance is 72%.

We aim to support our patients with dementia to ensure that a personalised support plan is implemented to meet their needs (Patient Passport) is completed for each person within 48hours of admission to hospital. In 2021/2022 we achieved:

- 81% completed within 24 hours
- 15% within 48 hours
- 4% within 72 hours

The Dementia team has continued to work to improve the knowledge and skills through face to face bespoke ward training and teams training. Compliance with Tier 1 training in 2021 was 80%. Tier 2 dementia training commenced and compliance is at 48%.

- **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 psychologist's input**.

We have continued to develop a core 24 service at the Royal Shrewsbury Hospital, we have implemented side by side working in the Emergency department for people with self-harm related attendances. The aim is to extend this to the Princess Royal Hospital in 2022/23.There are also third sector mental health "outreach" and "inclusion" workers available at both hospital sites to support those people with mental health needs in the Emergency Departments to assist in facilitating discharge and alternatives to attending ED.

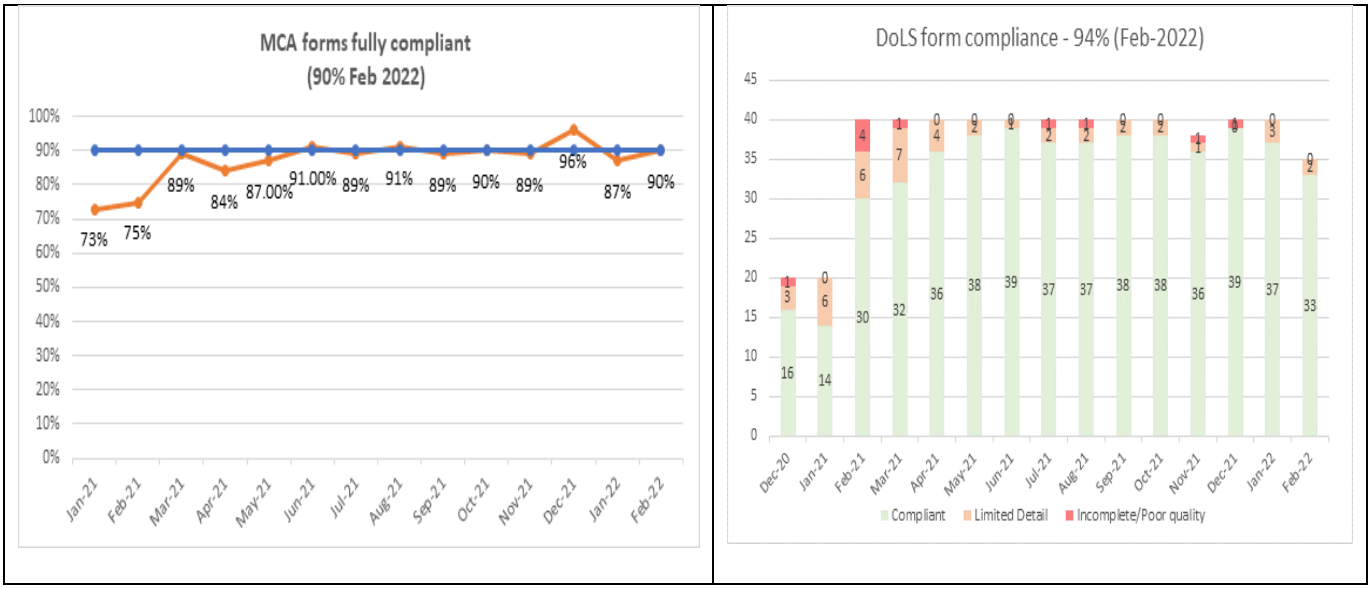
During 2021/2022 the Trust has made appointments to help further support its staff caring for patients with mental health issues. A mental health nurse has been appointed in the Paediatric Unit to support the provision of care to children and young people on the ward and in the ED and a substantive Lead Nurse for Mental Health and Learning Disabilities has been appointed. These posts with further support the work to improve the quality of assessment, care planning, treatment and discharge.

- **Actively participate in audits to maintain and improve standards for vulnerable patients**

Evidence based audit outcomes to support embedded safeguarding and MCA practice across the Trust. Throughout 2021/2022 the Trust has continued to audit the care in relation to safeguarding including Deprivation of Liberty Safeguards (DoLS), Mental Capacity Act (MCA) compliance, mental health risk assessments, restrictive intervention and complex eating disorder care plans.

How do we know we have succeeded?

- Dementia screening compliance has improved but remains below our target of 90%
- We have seen consistent improvements in the quality of our MCA and DoLS forms



- Although we have not achieved 90% target for safeguarding training we have seen improved compliance for nurses on our inpatient wards and good application of the principles in practice (as evidenced by ASK 5 audits)

Priority 8: End of Life Care

This priority aims 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.

In 2021 the Palliative and End of Life Care (PEoLC) Team developed an overarching improvement plan to address all aspects of service improvements. This plan identified all aspects of the service the team wanted to improve alongside addressing issues and concerns raised through from our regulators in previous and recent inspections. This plan has been reviewed monthly throughout the year at the PEoLC Steering Group.

In Quarter 4 of 2022 the Trust facilitated a visit by NHSE/I Midlands Strategic Clinical Network PEoLC, this was a supportive visit to aid and inform our improvement program. Recommendations from this visit have been included in the PEoLC overarching improvement plan. A follow up meeting with the regional team recognised the significant amount of improvement work being undertaken by the team at the Trust.

What have we achieved in 2021/2022?

- **Deliver the Trust's End of Life Care Strategy**

The team has continued to deliver the PEoLC Strategy (2019/2022) aims to ensure that:

1. Each person is seen as an individual
2. Each person gets far access to care
3. Maximising comfort and wellbeing

4. Care is co-ordinated
5. All staff are prepared to care
6. Each community is prepared to help

This Strategy will be reviewed and refreshed in 2022/2023.

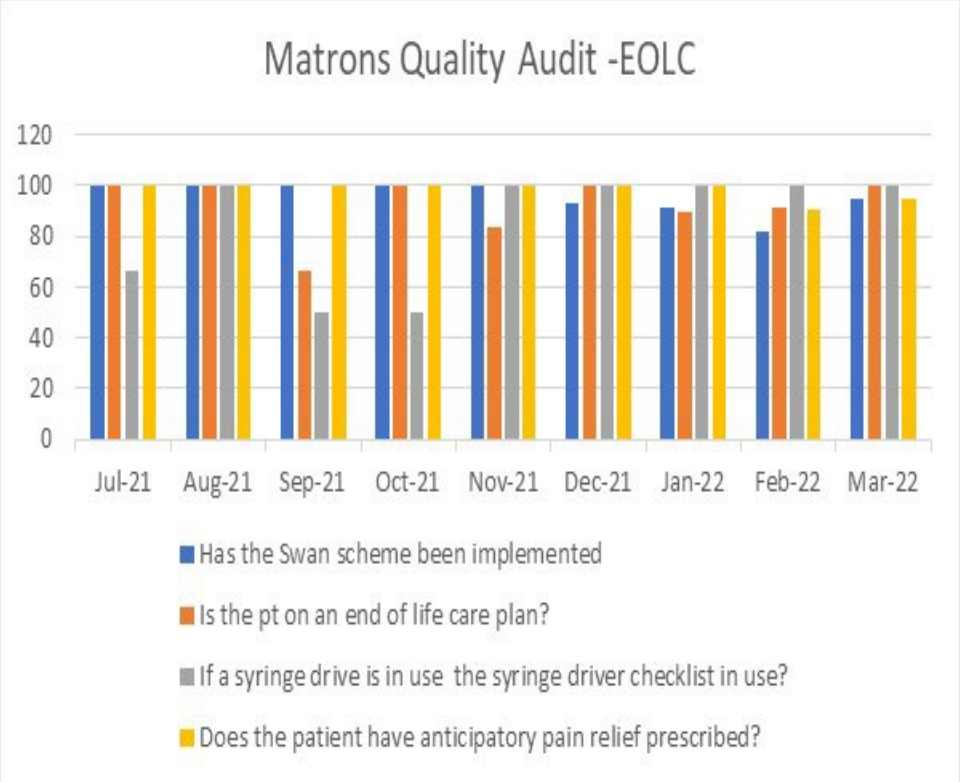
- **Ensure clear and timely identification of patients**

In order to ensure that PEoLC patients are identified across the Trust an alert system on SemaHelix has been set up. This flags PEoLC patients, with the alert being manually added to the SemaHelix system by the team.

Other ways to identify these patients in a timely way include the PEoLC team in-reaching to wards. The PEoLC team also attend the daily "Plan of the Day" meetings attended by all the ward managers at each hospital site. Ward managers bring the details of any PEoLC patients to this meeting

- **Using the EoLC plan to deliver individualised (personalised) care and ensure that all patients approaching the end of life have anticipatory medications prescribed**

As part of the Matrons monthly Quality Metrics Audits, the EoLC for patients is also audited to ensure that key aspects of care are in place, although the numbers included in this audit are small the results show good compliance with key aspects of end-of-life care.



A new EOL care plan for the last hours and days of life was launched in February 2022. Initial feedback from clinicians using the care plan has been positive. Communication and education is ongoing as a part of the embedding of the new care plan. This will be audits in 2022/2023.

- **Implement a 7-day nursing specialist palliative care service across the Trust and the provision of 24 hour advice for palliative care.**

A 7 days PEoLC nursing service was implemented in September 2021. This has been well received by nursing and medical teams across the Trust as well as demonstrating positive benefits for patients and their loved ones including facilitating EoLC patient discharges to home and hospice at the weekend and timely access to symptom control. Some examples of feedback received includes:

"It's great to have the specialist palliative care nurses here on weekends as I know I can ring them now for advice about how to manage my patients".
(Band 5 Registered Nurse, Ward 27)

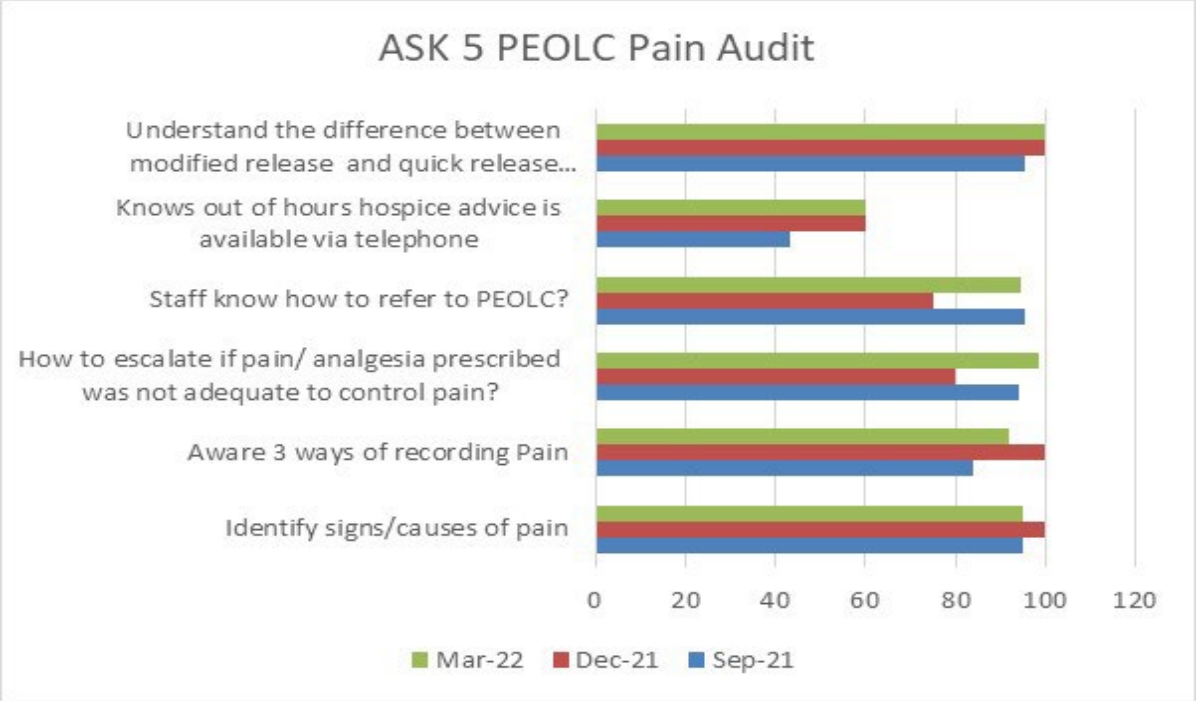
"It was lovely to have contact with Diane from the Palliative Care team on Saturday and Sunday. It felt like I had continuity as Di and her team had been seeing me all of the previous week. Over the weekend they were able to help the ward team to get me on the right dose of drugs to get my pain controlled properly. Before Di saw me on the Saturday morning, I had been in pain overnight and although the ward nurses were trying to help nothing they gave me was working. Di also checked up on me on the Sunday and again adjusted what I was on to make the pain even better controlled.'
(Patient Ward 23)

- **Ensure there is clear staff training to deliver PEoLC on the wards**

Throughout 2021/2022 there has been a focus on PEoLC training in our inpatient areas. Compliance has improved and at the end of the year there was good compliance across these areas.

	Inpatient Wards, Emergency Department and Critical Care	Trust-wide
EOLC Training	84%	71%
T34 Syringe Driver Training	88%	NA

Alongside staff undertaking PEoLC training regular "ASK 5" audits are undertaken in all inpatient areas to ensure that staff can apply their training in their clinical practice. The "ASK 5" audit is undertaken in all inpatient areas and 5 staff on each ward/clinical area are asked the questions. In 2022/2023 the audit will be varied to include the management of a variety of symptoms.



How do we know we have succeeded?

In 2021/2022 we have seen improvements in relation to

- Compliance with PEoLC training including T34 syringe driver training
- We have implemented a 7-day nursing service with positive feedback
- We have developed a PEoLC dashboard in March 2022 which will enable the tracking of key indicators

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 2021/2022 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 2021/2022 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 2021/2022 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:

- 49,604 elective/day cases
- 60,690 non-elective cases
- 150,146 emergency attendances
- 404,487 outpatient attendances

The Trust has reviewed all the data available to us on the quality of care in these categories.
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 July to August 2021.

The core services inspected included:

- Maternity (at the Princess Royal Hospital)
- End of Life Care
- Medical Care
- Urgent & Emergency Care

The Report from the CQC inspection carried out in July 2021 was published in November 2021. The consolidating ratings from previous inspections and the most recent inspection from July 2021 are shown:

Royal Shrewsbury Hospital – CQC Consolidated Ratings Previous Inspections

Royal Shrewsbury Hospital	Safe	Effective	Caring	Responsive	Well Led
Medical Care (inc. Older peoples care)	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate
Children & Young People	Good	Good	Good	Good	Good
Critical Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
End of Life Care	Inadequate	Inadequate	Good	Requires Improvement	Inadequate
Surgery	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Urgent and Emergency Services	Inadequate	Inadequate	Inadequate	Inadequate	Inadequate
Maternity	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Not Rated	Good	Requires Improvement	Good

Royal Shrewsbury Hospital – CQC Consolidated Ratings July 2021 Inspection

Service	Safe	Effective	Caring	Responsive	Well Led
Medical Care (inc. Older peoples care)	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Children & Young People	Good	Good	Good	Good	Good
Critical Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
End of Life Care	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate
Surgery	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement	Requires Improvement
Urgent and Emergency Services	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Requires Improvement
Maternity	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement
Outpatients	Requires Improvement	Not Rated	Good	Requires Improvement	Good

Princess Royal Hospital – CQC Consolidated Ratings Previous Inspections

Princess Royal Hospital	Safe	Effective	Caring	Responsive	Well Led
Medical Care (inc. Older peoples care)	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate
Children & Young People	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate
Critical Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
End of Life Care	Inadequate	Inadequate	Requires Improvement	Requires Improvement	Inadequate
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Urgent and Emergency Services	Inadequate	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Maternity	Requires Improvement	Good	Good	Good	Requires Improvement
Outpatients	Good	Not Rated	Good	Good	Good
Maternity (inpatient services)	Requires Improvement	Good	Good	Good	Requires Improvement

Princess Royal Hospital – CQC Consolidated Rating July 2021 Inspection.

Service	Safe	Effective	Caring	Responsive	Well Led
Medical Care (inc. Older peoples care)	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Children & Young People	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate
Critical Care	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
End of Life Care	Inadequate	Inadequate	Requires Improvement	Inadequate	Inadequate
Surgery	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement
Urgent and Emergency Services	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Maternity	Requires Improvement	Good	Good	Good	Requires Improvement
Outpatients	Good	Not Rated	Good	Good	Good
Maternity (inpatient services)	Requires Improvement	Good	Good	Good	Requires Improvement

Although the overall ratings of the Trust did not change with the Trust remaining rated as “inadequate” following the most recent inspection, however, there were improvements seen across both Medicine and Urgent & Emergency Care at both hospitals but particularly at the Princess Royal Hospital site where each domain improved by one rating.

The Trust had a number of Section 31 conditions in place in relation to its registration following enforcement action taken against the Trust in previous inspections. No enforcement action was taken following the July 2021 inspection.

A review of all the conditions in place against the Trust was undertaken by the CQC in February 2022, of the 60 conditions imposed against the Trust, a majority of these were removed or varied including those relating to sepsis and deteriorating patient, restraint, safeguarding (including conditions relating to adult and children’s safeguarding), mental health including children and young people and mental health risk assessments in the Emergency Department. A list of our previous conditions and the conclusion of the review undertaken by the CQC following the publication of our most recent Inspection report are outlined.

Regulated Activity : "Assessment or medical treatment for persons detained under the Mental Health Act" (1983)				
Conditions Imposed by Hospital Site	**Royal Shrewsbury Hospital**	**Theme**	**Princess Royal Hospital**	**Theme**
Condition 1	**REMOVED**	Immediate Review of Patients under 18 years of age included in CQC Inspection and feedback by 1sy March 2021	**REMOVED**	Immediate Review of Patients under 18 years of age included in CQC Inspection and feedback by 1sy March 2021
Condition 2	**REMAINS**	Must not admit patients: •Patients<18 years of age who present with isolated acute mental health needs •Do not have physical health needs that require inpatient assessment and treatment	**REMAINS**	Must not admit patients: •Patients<18 years of age who present with isolated acute mental health needs •Do not have physical health needs that require inpatient assessment and treatment
Condition 3	**REMOVED**	Must deliver appropriate training to ensure all staff working with patients under the age of 18 are competent in providing care and treatment to patients with mental health and learning disability needs	**REMOVED**	Must deliver appropriate training to ensure all staff working with patients under the age of 18 are competent in providing care and treatment to patients with mental health and learning disability needs
Condition 4	**REMOVED**	Adopt effective system to identify where all under 18 patients are in the hospital. Appropriate oversight by suitably competent staff including by mental health and psychiatrist	**REMOVED**	Adopt effective system to identify where all under 18 patients are in the hospital. Appropriate oversight by suitably competent staff including by mental health and psychiatrist
Condition 5	**REMOVED**	Must implement effective safeguarding systems, including appropriate training and timely safeguarding referrals	**REMOVED**	Must implement effective safeguarding systems, including appropriate training and timely safeguarding referrals
Condition 6	**REMOVED**	Weekly Reporting of Safeguarding Children	**REMOVED**	Weekly Reporting of Safeguarding Children
Regulated Activity : "Treatment of disease, disorder and injury"				
Condition 1	**REMOVED**	Immediate Review of Patients under 18 years of age included in CQC Inspection and feedback by 1sy March 2021	**REMOVED**	Immediate Review of Patients under 18 years of age included in CQC Inspection and feedback by 1sy March 2021
Condition 2	**REMAINS**	Must not admit patients: •Patients<18 years of age who present with isolated acute mental health needs •Do not have physical health needs that require inpatient assessment and treatment	**REMAINS**	Must not admit patients: •Patients<18 years of age who present with isolated acute mental health needs •Do not have physical health needs that require inpatient assessment and treatment
Condition 3	**REMOVED**	Must deliver appropriate training to ensure all staff working with patients under the age of 18 are competent in providing care and treatment to patients with mental health and learning disability needs	**REMOVED**	Must deliver appropriate training to ensure all staff working with patients under the age of 18 are competent in providing care and treatment to patients with mental health and learning disability needs
Condition 4	**REMOVED**	Adopt effective system to identify where all under 18 patients are in the hospital. Appropriate oversight by suitably competent staff including by mental health and psychiatrist	**REMOVED**	Adopt effective system to identify where all under 18 patients are in the hospital. Appropriate oversight by suitably competent staff including by mental health and psychiatrist
Condition 5	**REMOVED**	Must implement effective safeguarding systems, including appropriate training and timely safeguarding referrals	**REMOVED**	Must implement effective safeguarding systems, including appropriate training and timely safeguarding referrals
Condition 6	**REMOVED**	Weekly Reporting of Safeguarding Children	**REMOVED**	Weekly Reporting of Safeguarding Children
Condition 7	**REMOVED**	Accurate risk assessment and care planning, in particular ensure the patients' needs are individualised, recorded and acted upon. Including but not limited to nutritional needs, pressure ulcers, risk assessment/falls and medical equipment from home	**REMOVED**	Accurate risk assessment and care planning, in particular ensure the patients' needs are individualised, recorded and acted upon. Including but not limited to nutritional needs, pressure ulcers, risk assessment/falls and medical equipment from home
Condition 8	**VARIED**	Devise, review and assess effectiveness of the system, process for care planning records and provide report setting out actions taken or to be undertaken monthly	**VARIED**	Devise, review and assess effectiveness of the system, process for care planning records and provide report setting out actions taken or to be undertaken monthly
Condition 9	**REMOVED**	MCA/DoLS Sufficient numbers of suitably trained and experienced staff Undertake DoLS in line with provider's policy and protocol Clear documentation and care planning of DoLS Monitoring conducted to ensure this is measured	**REMOVED**	MCA/DoLS Sufficient numbers of suitably trained and experienced staff Undertake DoLS in line with provider's policy and protocol Clear documentation and care planning of DoLS Monitoring conducted to ensure this is measured
Condition 10	**REMOVED**	Learning from incidents and the systems in place for the effective management of incidents	**REMOVED**	Learning from incidents and the systems in place for the effective management of incidents
Condition 11	**REMOVED**	Reporting against conditions 7-10	**REMOVED**	Reporting against conditions 7-10
Condition 12	**REMOVED**	Effective management of the deteriorating patient and sepsis	**REMOVED**	Effective management of the deteriorating patient and sepsis
Condition 13		Reported under Emergency Care		Reported under Emergency Care
Condition 14	**REMOVED**	Systems in place to ensure de-escalation management and intervention holds are completed in line with relevant national guidance	**REMOVED**	Systems in place to ensure de-escalation management and intervention holds are completed in line with relevant national guidance
Condition 15	**REMOVED**	Report monthly the de-escalation management and intervention holds including: Type and length of hold and post hold actions Results of monitoring data and audits undertaken for physical intervention	**REMOVED**	Report monthly the de-escalation management and intervention holds including: Type and length of hold and post hold actions Results of monitoring data and audits undertaken for physical intervention
Emergency Department - Regulated Activity - Treatment of disease, disorder and injury"				
Condition 13 (Nov 2019)	**VARIED**	Effective Management of patients under the age of 18 through the ED including: I Number <18 yrs not triaged within 15 minutes I Monitoring/audits to provide assurance: Details of Children who left without being seen, follow up and details of any harms	**VARIED**	Effective Management of patients under the age of 18 through the ED including: I Number <18 yrs not triaged within 15 minutes I Monitoring/audits to provide assurance: Details of Children who left without being seen, follow up and details of any harms
Condition 16	**REMOVED**	Effective system to ensure Mental Health Risk Assessments are completed	**REMOVED**	Effective system to ensure Mental Health Risk Assessments are completed
Condition 17	**REMOVED**	Effective identification, escalation and management of patients who present with possible sepsis or a deteriorating conditions	**REMOVED**	Effective identification, escalation and management of patients who present with possible sepsis or a deteriorating conditions
Condition 18 (April 2019)	**REMOVED**	Effective management of children through the ED including effective systems, audited and monitored, results of monitoring data/audits that provide assurance, redacted information of children who left without being seen, follow-up any harm.	**VARIED**	Ensure that all children who present to ED are assessed within 15 minutes of arrival
Condition 19	**VARIED**	Effective system to ensure adults who present to ED are assessed within 15 minutes	**REMOVED**	Staff are suitably qualified and competent to undertake and carry out triage
Condition 20	**REMOVED**	Must ensure system in place in ED to monitor patient acuity and location at all times	**REMOVED**	Effective monitoring of patients pathway through the ED from arrival
Condition 21	**REMOVED**	Ensure that all children who present to ED are assessed within 15 minutes of arrival	**REMOVED**	Ensure that all children who leave the ED without being seen are followed up in a timely way by a competent healthcare professional
Condition 22	**REMOVED**	Staff are suitably qualified and competent to undertake and carry out triage	**REMOVED**	Effective management of children through the ED including effective systems, audited and monitored, results of monitoring data/audits that provide assurance, redacted information of children who left without being seen, follow-up any harm.
Condition 23	**REMOVED**	Effective monitoring of patients pathway through the ED from arrival	**REMOVED**	Must ensure system in place in ED to monitor patient acuity and location at all times
Condition 24	**REMOVED**	Ensure that all children who leave the ED without being seen are followed up in a timely way by a competent healthcare professional	**REMOVED included in varied condition 18 RSH**	Effective system to ensure adults who present to ED are assessed within 15 minutes

Five conditions remain in place in relation to the Trust which are applied against both the Princess Royal Hospital and the Royal Shrewsbury Hospital.

Conditions relating to Regulated Activity : "***Assessment or medical treatment for persons detained under the Mental Health Act" (1983)***		
Trust Wide CYP Mental Health	Condition 1	Must not admit patients: • Patients<18 years of age who present with isolated acute mental health needs • Do not have physical health needs that require inpatient assessment and treatment
Conditions relating to Regulated Activity : ***"Treatment of disease, disorder and injury"***		
Trust-Wide (RSH and PRH)	Condition 1	Must devise, review and assess the effectiveness of the system and process for care planning records across all services to ensure accurate risk assessments and care planning ensure that patients' needs are met and provide report monthly to CQC setting out actions taken or to be taken in relation to the findings of the review
Emergency Departments (PRH and RSH)	Condition 2	Submit a monthly report to the CQC describing the systems in place for effective management of service users under the age of 18 through the emergency care pathway a) The number of service users under the age of 18 not triaged within 15 minutes or seen by the paediatric medical team within the hour of arrival to the emergency department and details of any avoidable harm arising as a result of the delay. b) Results of monitoring data and audits undertaken that provide effective assurance that a process is in place for the management of children requiring emergency care and treatment. c) Details of all children who left the department without being seen by a clinical practitioner and details of harm or follow-up arising from a child leaving the emergency department without being seen
Emergency Departments (PRH and RSH)	Condition 3	The registered provider must ensure it implements an effective system with the aim of ensuring that all patients who present to the emergency department are assessed within 15 minutes of arrival in accordance with the relevant national clinical guidelines accounting for patient acuity and the location of patients at all times
CYP Mental Health (applies to RSH and PRH)	Condition 4	Must not admit patients: • Patients<18 years of age who present with isolated acute mental health needs • Do not have physical health needs that require inpatient assessment and treatment

CQC "Must" and "Should" Do Actions Summary from the July 2021 Inspection

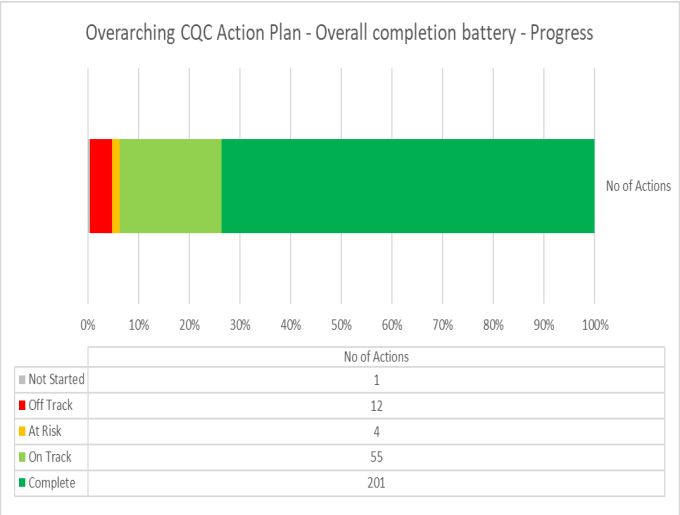
The CQC Inspection from July 2021 was published in November 2021. The "Must" and "Should" actions in relation to the latest CQC inspection are shown:

		SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL-LED
Trustwide	Must Do	3	2			
Maternity	Must Do	3				
	Should Do	7	3			6
EOLC	Must Do	12	6	1	2	3
	Should Do	2	4	1	1	8
UEC	Must Do	16	0	0	0	1
	Should Do	4	3	3	1	2
Medical Care	Must Do	19	1	0	0	2
	Should Do	18	3	2	3	0

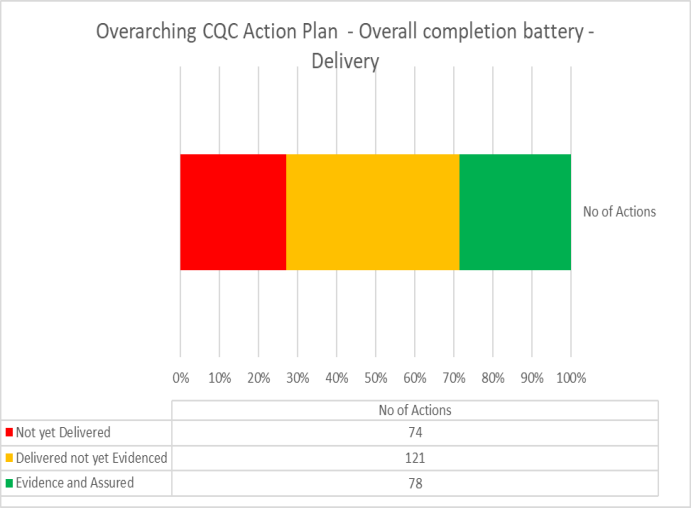
Medical Care has a total of 22 "Must Do" and 26 "Should Do" actions. Urgent and Emergency Care has 17 "Must Do" and 13 "Should Do" actions. There are 24 "Must Do" and 16 "Should Do" actions in relation to EoLC. Maternity had 3 "Must Do" and 16 "Should Do" actions as a result of the most recent CQC inspection. There are also 5 Trust-wide "Must Do" actions.

Following receipt of the CQC inspection report in November 2021 a full action plan to address all the "Must" and "Should" do actions was developed and agreed by the Executive Team. The action plan has been cross referenced with the previous Section 31, Section 29A and previous action plans. The RAG rating of actions has been reviewed to be in line with the RAG rating system used in Maternity.

Overall CQC Improvement Plan Progress



	No of Actions
Not Started	1
Off Track	12
At Risk	4
On Track	55
Complete	201



	No of Actions
Not yet Delivered	74
Delivered not yet Evidenced	121
Evidence and Assured	78

Review meetings with the Core Services and Divisions commenced in February 2022. Progress against the action plans via the Steering Groups such as the Deteriorating Patient Group, Safeguarding Operational Groups, and Palliative and End of Life Steering Group continue as well as reporting progress through Quality Operational Committee and Quality and Safety Assurance Committee.

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 2021/22 72 national clinical audits and 5 national confidential enquiries were prioritised by the HQIP (Healthcare Quality Improvement Partnership) commissioned National Clinical Audit and Patient Outcomes Programme (NCAPOP) for Trusts to participate in (where applicable). During that period, the Shrewsbury and Telford Hospitals NHS Trust participated in **98%** (41/42) of the national clinical audits and 100**%** *(2/2)* 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.

Table 1: National Clinical Audits 2021/2022.

Table 1 – National clinical audits 2021-22 (88)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
*Case Mix Programme (CMP) - ICNARC		✓	✓	PRH - 274 patients (Apr 21 – Mar 22) RSH – 586 patients (Jan 21 – Dec 21
*Chronic Kidney Disease Registry		✓	✓	All applicable
*Cleft Registry and Audit NEtwork (CRANE)		×	×	Referred to specialist centre
[1]DAX health companion		✓	✓	Currently in progress
[1]DEFINITE: Diabetic foot debridement in theatre		✓	✓	Currently in progress
*Elective surgery (National Proms Programme)		✓	✓	238 questionnaires returned
*Emergency Medicine QIPS (RCEM)	**Assessing Cognitive Impairment in Older People	✓	✓	100% of eligible cases
	*Consultant Sign-Off PRH 2021	✓	✓	Currently in progress
	**Care of Children	✓	✓	100% of eligible cases
	**Mental Health	✓	✓	100% of eligible cases
	*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	×	×	Not applicable
	*Inpatient Falls	✓	✓	100% of eligible cases
	*National Hip Fracture Database (NHFD)	✓	✓	All applicable
*Inflammatory bowel disease (IBD) Registry, Biological Therapies Audit		✓	✓	All applicable
*LeDeR - Learning Disabilities Mortality Review		✓	✓	100%

Table 1 – National clinical audits 2021-22 (88)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
[1]Management of children in the West Midlands with suspected & confirmed COVID-19		✓	✓	621 patients
Management of supracondylar fractures		✓	✓	Currently in progress
*Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	[1]Learning from SARS-CoV-2 related and associated maternal deaths in the UK, 2020/21	✓	✓	All applicable
	*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 care	×	×	Not applicable
	Suicide & Homicide	×	×	Not applicable
[1]Morbidity and Mortality AROMA Study - Emergency Surgery for Abdominal Hernia - A TUGS Multinational Audit – 30day		✓	✓	Currently in progress
[1]Morbidity and Mortality of Surgery for Perforated Peptic Ulcer – 30day		✓	✓	Currently in progress
[1]Morbidity and mortality of Surgery for Peptic ulcer bleeding – the ASPIRE study – 30day		✓	✓	Currently in progress
National Asthma & COPD Audit Programme (NACAP)	*Adult Asthma Secondary Care	✓	✓	Currently in progress
	*Paediatric - Children and young people asthma secondary care	✓	✓	All applicable

Table 1 – National clinical audits 2021-22 (88)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
	*Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	✓	✓	All applicable
	*Pulmonary rehabilitation	×	×	Not applicable
*National Audit of Breast Cancer in Older People (NABCOP)		✓	✓	All applicable
*National Audit of Cardiac Rehabilitation		×	×	Not applicable
*National Audit of Cardiovascular disease		×	×	Primary care
*National Audit of Care at the End of Life (NACEL)		✓	✓	All applicable
*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
*National Cardiac Arrest Audit (NCAA)		✓	✓	All applicable
National Cardiac Audit Programme (NCAP) - NICOR	*National Audit of Cardiac Rhythm Management (CRM)	✓	✓	544 PRH
	*Congenital Heart Disease (CHD)	×	×	Not applicable
	*Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	2019-2020: PRH - 255 RSH - 301
	*Heart Failure Audit	✓	✓	19/20 data (2021 report) PRH - 462 RSH - 340
	*National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	×	×	Not applicable
	*National Adult Cardiac Surgery Audit	×	×	Not applicable
*National child mortality database		✓	✓	All applicable

Table 1 – National clinical audits 2021-22 (88)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
*National Clinical Audit of Psychosis (NCAP)	EIP audit 2021/2022	×	×	Not applicable
National Comparative Audit of Blood Transfusion programme	*2021 Audit of Blood Transfusion against NICE Guidelines	✓	✓	All applicable
	*2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	✓	N/A	Start date delayed
National Diabetes Audit - Adult	*Inpatient Audit Harms (NaDIA-Harms)	✓	×	Registration issues
	*National Diabetes in Pregnancy Audit (NPID)	✓	✓	All applicable
	*Core Diabetes Audit	×	×	Primary care audit
	*Foot Care Audit	✓	✓	132 submissions for 2021 to date
*National Early Inflammatory Arthritis Audit (NEIAA)		×	×	Not applicable
*National Emergency Laparotomy audit (NELA)		✓	✓	147 cases submitted to date for 2021
National GastroIntestinal Cancer Programme	*Oesophago-gastric Cancer (NAOGC)	✓	✓	104 patients
	*National Bowel Cancer (NBOCA	✓	✓	All applicable
*National Joint Registry (NJR)		✓	✓	37 included
*National Lung Cancer Audit (NLCA)		✓	✓	All applicable
*National Maternity and Perinatal Audit (NMPA)		✓	✓	All applicable
*National Paediatric Diabetes Audit (NPDA)		✓	✓	279 patients for 2019/20
*National Perinatal Mortality Review Tool (MBRRACE)		✓	✓	All applicable
*National Vascular Registry		✓	✓	100%
*Neonatal intensive and special care (NNAP)		✓	✓	100%
*Neurosurgical National Audit Programme		×	×	Not applicable
*Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry		×	×	Primary care
*Paediatric intensive care (PICaNet)		×	×	Not applicable
[1]PPF Study: A national retrospective review of femoral periprosthetic fracture management. Is there variation in practice?		✓	✓	19 patients submitted

Table 1 – National clinical audits 2021-22 (88)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
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
*Prostate Cancer Audit		✓	✓	628 cases identified
Respiratory Audits (BTS)	*National Outpatient Management of Pulmonary Embolism	✓	✓	27 cases submitted
	[1]Pleural services	✓	✓	Organisational data submitted
	[1]Smoking Cessation	✓	✓	281 cases submitted
*Society for Acute Medicine's Benchmarking Audit (SAMBA)		✓	✓	All applicable
*Sentinel Stroke National Audit Programme (SSNAP)		✓	✓	90%+
*Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme		✓	✓	All applicable
[1]Tackling Serious Violent Crime		✓	✓	All applicable
[1]TRANSFER (ThReatened preterm birth, Assessment of the Need for in utero tranSFER between 22+0-23+6 weeks' gestation)		✓	✓	All applicable
*Trauma Audit & Research Network		✓	✓	All applicable
*UK Cystic Fibrosis Registry		×	×	Not applicable
[1]UK Registry of Endocrine and Thyroid surgery		✓	✓	All applicable
Urology Audits (BAUS)	*Management of the Lower Ureter in Nephroureterectomy Audit	✓	✓	16 cases submitted
	*Cytoreductive Radical Nephrectomy Audit	✓	✓	3 cases submitted
	[1]Renal Colic Audit	✓	✓	9 cases submitted

Based on information available at the time of publication.
***Audits on HQIP commissioned NCAPOP List 2021/2022**
**** from HQIP commissioned NCAPOP list 2020/2021 – action plan received 21/22**
[1]Registered locally.

Table 2: National Confidential Enquiries 2021/2022.

Table 2 – National Confidential Enquiries 2021-22 (5)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
*Child Health Clinical Outcome Review Programme (NCEPOD)	*Transition from child to adult health services	✓	✓	Currently in progress
*Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	*Community acquired Pneumonia	✓	N/A	Start date delayed
	*Physical Health in Mental Health Hospitals	×	×	Not applicable
	*Crohns disease	✓	N/A	Start date delayed
	*Epilepsy study	✓	✓	30%

Based on information available at the time of publication.
***Audits on HQIP commissioned NCAPOP List 2021/2022**

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

Table 3: Examples of Actions taken following National Audits.

Table 3 - Examples of actions taken following National Audits	
Title	**Action / Outcome**
BAETS (British Association of Endocrine & Thyroid Surgeons) National Audit 2018	• Numbers of operations during the audit period less than the recommended annual workload. • Very high day case rate - when GIRFT teams visited recently we had the highest day case rate in the country.
BTS Smoking Cessation Audit 2021 PRH	• Good compliance with majority of the audit standards. • An email has been sent to juniors to raise awareness of pharmacotherapy prescribing for smoking cessation.
ENT UK COVID guidance for sore throat and epistaxis management	• Management of acute epistaxis was notably affected during the initial peak of the pandemic, with a shift towards reduced admissions. • This national audit highlights that many patients who may previously have been admitted to hospital may be safely discharged from the ED following acute epistaxis
Epilepsy 12 audit round 3 19-20 (cohort 2)	• The audit highlighted a number of significant strengths in the care provided to children and young people in cohort Evidence suggests a high degree of appropriate diagnosis- with most children and young people having a consistent epilepsy diagnosis. • To improve practice, ECG requests are now made in all patients with generalised seizures
Fragility fracture post-operative mobilisation	• No recommendations needed as trust is performing very well compared to the national average and is

Table 3 - Examples of actions taken following National Audits	
Title	**Action / Outcome**
	meeting all the British orthopaedic Association standards
GIRFT (Getting It Right First Time) Surgical Site Infection - Max Fax	• Good surgical outcomes and low complication and litigation rates highlighted
National Diabetes Inpatient audit 2019 SaTH (NaDIA)	• On-line training for every healthcare professional who dispenses, prescribes and/or administers insulin, appropriate to their level of responsibility, including an assessment of competency is in place and is now included as part of the induction of Trust junior doctors
National Maternity and Perinatal Audit (NMPA) 2021 (births Apr-17 to Mar-18)	• Induction of labour rate appears high but is being monitored on the dashboard and audited. Previous in-depth review (2020) did not reveal any concerns and rates have not changed significantly since then. • One finding previously was that inconsistent data entry was inaccurately elevating the induction of labour rate. This will be addressed this year with the introduction of the new Maternity Information System
National Neonatal Audit Programme (NNAP) - Neonatal Care 2020 (2019 data)	• 16 parameters are audited in the national report. The Trust has performed well overall, with most of our rates being comparable or exceeding national rates for those parameters. • Reducing Central line associated blood stream infections (CLABSI) rates by – Local neonatal guidelines already available on the intranet with regards to asepsis on the neonatal unit. – Local Safety Standards for invasive procedures (LocSSIPs) forms are now used for central line insertion. – Rolling LocSSIPs audit in place. – Staff education through sessions on Infection Control and LocSSIPs during Induction and Nursing Study Days • A Neonatal Breastfeeding Link Nurse has been appointed to work on a strategy to achieve UNICEF Baby Friendly status
National Paediatric Diabetes Audit 2019/20	• To improve patient engagement with dietetics and uptake of appointments, the Trust plans to: – Utilise existing dietetic time more efficiently and improve pre clinic planning & clinic contacts – Organise structured education sessions – Develop Business case further. • To improve percentage of patients accessing psychological support the development of a pathway with Shropshire Community Health Trust is underway
National Prostate Cancer Audit (NPCA) April 2018 to March 2019)	• All parameters are within expected range
National Renal Colic Audit 2021	• To ensure more patients are offered Extracorporeal shock wave lithotripsy (ESWL), additional sessions have been put in place.

Table 3 - Examples of actions taken following National Audits	
Title	**Action / Outcome**
	• Serum stone screen should be done to all patients who were admitted with stones. Screening at discharge will be carried out.

Based on information available at the time of publication.

The Trust also undertook 196 local audits, shown in table 4 below.

Table 4:Trust Local Audits

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
CLINICAL SUPPORT – PATHOLOGY & RADIOLOGY AND THERAPIES		
1	Accuracy of Image Guided Needle Localisation of Breast Lesions - re-audit (4914)	• Audit showed good compliance, no concerns identified.
2	CTVC for BCSP (Jan-Dec 2020) (4743)	• Small group but our results are above aspirational standard. • A re-audit is planned
3	Does the frailty team therapy assessment meet current guidelines? (4659)	• Additional prompts to the Frailty Therapy Assessment' pro-forma are required to improve compliance • A re-audit is planned
4	Hip fracture physiotherapy rehabilitation (4836)	• Team training sessions are planned for summer 2022 to ensure the portal is completed • Introduce the prioritisation system used at RSH to PRH • A re-audit is planned
5	Image quality of Chest X-Ray general images (4785)	• A high proportion of chest x-rays within this audit were suboptimal • Findings have been disseminated to staff to raise awareness
6	Plain abdominal Xray re-audit (4999)	• The audit showed good compliance, no recommendations necessary.
7	Shropshire Breast Screening Programme Client Satisfaction Survey 2020 (4629)	• The audit showed that we received very positive comments from the women even when working within the constraints of Covid restrictions
8	Social Functional History Audit (4952)	• Areas of good practice highlight that on the majority of social functional histories audited the signing and dating of therapy notes was completed. • Refresher training to be offered to existing staff • A re-audit is planned
9	Therapies Documentation Audit 2021 (5062)	• Good level of compliance achieved
10	Thyroid u-scoring and subsequent fine needle aspiration cytology - re-audit (5016)	• As per British Thyroid Association guidelines approved by Royal College of Radiologists (RCR), every thyroid nodule has been scored with a scoring system
11	Triage to first appointment audit: a pilot (4963)	• A large proportion of patients are not being seen within the recommended timeframe.

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
		• A new Occupational Therapy (OT) lead clinic based within fracture clinic is now running alongside consultant clinic to improve patients being seen within the timeframe.
CORPORATE – TRUST WIDE		
12	Care after Death - May 2020 (4520)	• More band 6/7 registered nurses will receive verification of death training to reduce the delays in the verification/ certification of the patient's death • All ward based clinical staff in adult areas have now completed the End of Life Care eLearning training
13	Care after Death - October 2020 (4753)	• The COVID19 pandemic has resulted in some delays in the transfer of the deceased person to the Swan Bereavement Suite (SBS). The wards have been allowing people important to the deceased person to visit on the ward and when they have been traveling considerable distances it has resulted in a delay of the deceased person being transferred to the SBS. • Handover document has been amended to leave sufficient space for the registered nurse to write the reason why the eyes/mouth may not be closed.
14	Care after Death - April 2021 (4839)	• There was an improvement in the number of patients transferred to the Swan bereavement suite in RSH. • There continues to be a delay transferring the deceased person to the Swan Bereavement Suite (SBS) due to the ongoing Covid 19 pandemic
15	Compliance with the use of the End of Life Care plan in Clinical Practice, February 2021 (4779)	• Compliance with the use of the End of Life Care plan remains high and ReSPECT conversations are happening before decisions about EOLC • The End of Life Care Plan has been redesigned. Trial for the new document (The SWAN Care Plan for the Last Hours and Days of Life) has taken place
16	Grab and Go T34 Syringe Pump Boxes March-21 (4720)	• Poster created and delivered to all ward areas to explain the Grab and Go box for T34 Syringe pump • The Grab and Go T34 Syringe Pump box has been recognised as being helpful by ward staff • A re-audit has taken place
17	Grab and Go T34 Syringe Pump Boxes September-21 (4889)	• Overall, a significant improvement was identified at PRH, and RSH needs more support to really embed this new resource • A re-audit is planned
18	Mouth care audit 2020 (4617)	• The audit outcome showed that there is a lack of awareness of the Mouth Care Policy across the Trust and therefore the policy needs to be relaunched and promoted by the ward/ department leads supported by the End of Life Care team and the Dental Hygienist. The SWAN EOLC team are providing support and education regarding mouth care during their ward visits. • A re-audit has taken place.
19	Mouth care audit sept-21 (5030)	• The Swan End of Life Care nurses have planned dates to deliver mouth care at End of life as part of their annual training programme. These will be face to face

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
		sessions, which will be presented to small groups of staff on the ward. If staffing levels do not allow more than one staff member to attend, then the training will be delivered on a 1:1 basis. • The Swan Care plan has been implemented in to practice across the Trust on 21/02/22
20	Policy for the use of the Recommended summary care plan for emergency care and Treatment (ReSPECT) form - Jul-20 (4602)	• A large proportion of patients were found to have a ReSPECT form over both sites with most of the ReSPECT forms having been completed in the hospital. • Mental capacity assessment was not completed on almost half on the patient that were identified as lacking capacity to complete the ReSPECT form. Will continue to be part of teaching for all medical and nursing ReSPECT updates during CPR stat training and induction.
21	Policy for the use of the ReSPECT form - Oct-20 (4603)	• Section 9 had only been filled in on one of all ReSPECT forms audited. This may show lack of review of the form when a change of clinical setting or condition has taken place. Resuscitation team is trailing focused ward teaching to try and improve the documentation of ReSPECT. Continues to be taught on Nurses and Doctors stat updates.
22	Policy for the use of the ReSPECT form - May-21 (4772)	• The ReSPECT policy to be reviewed and updated with latest guidance • Teaching about the ReSPECT conversation and the completion of the ReSPECT form is given during statutory updates and online teaching is available via eLearning for health and RCUK. Recommend that it is mandated for all medical staff and recommended for all nursing staff and AHP website on the ReSPECT app
23	Safeguarding Self-Assessment Audit (4421)	• The majority of areas that see children on a daily basis had good understanding of policies, procedures and processes, knew who to contact and had enveloped safeguarding in their daily practice
24	Swan Care Plan - last hours/days of life (4784)	• Following the successful trial of the Swan Care Plan, this has now been implemented across the Trust.
25	The Deteriorating Patient (Jul-Dec 2016) (3648)	• Deteriorating patient policy agreed • To ensure a more robust monitoring of late observations, weekly matron audits are taking place.
SURGERY - ANAESTHETICS, THEATRES & CRITICAL CARE		
26	Anaesthetic casenote RSH 2021 (4866)	• The audit showed good compliance, however there are some areas that required improvement. These have been highlighted to the anaesthetists. • A re-audit is planned
27	Data collection for previous anaesthetic chart availability (4604)	• No meaningful recommendations have been made. • A re-audit is planned.
28	Epidural Cases 2020 (5000)	• Our complication rate is low, and our patient satisfaction is high – testament to excellent and experienced anaesthetists

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
29	Obstetric theatre cases re-audit 2019 (4885)	• Actual follow-ups only 47%. Paper project to improve this was attempted but failed to progress.
30	Obstetric theatre cases re-audit 2020 (4886)	• There has been a slight improvement in actual follow ups – now 53%. • Moved to Badgernet system, hopefully this will improve follow up rates.
31	Rectus sheath catheter for postoperative anaesthesia (4591)	• Departmental teaching session on insertion technique have taken place
32	Review of apparent 'early deaths' from ICNARC data for ITU (4364)	• Case reviews revealed no major concerns with care
33	Theatre Patient Satisfaction survey (4467)	• A really positive first patient satisfaction survey for RSH • Very positive comments on the whole from patients who were satisfied with their care
SURGERY - HEAD, NECK AND OPHTHALMOLOGY		
34	Calibration errors in Goldmann Applanation tonometers (4777)	• Daily checks to take place
35	Casenotes & Stamp Audit - Ophthalmology 2021 (June 2021 patients) (4943)	• Improvement in documentation was noted when compared to 2017 • A re-audit is planned
36	ENT operation notes - re-audit (5031)	• Good uptake of electronic operative note system with clear improvement in compliance of documentation of operation procedure • Good verbal feedback from all clinical staff including nursing on availability and clarity of op notes largely contributing to it being on clinical portal as soon as it is completed
37	Frequency of visual fields in chronic open angle glaucoma re-audit (4775)	• Meeting standards
38	Improving post-operative care with the introduction of a new electronic operation note system (4729)	• Audit has resolved all previous issues with operative documentation
39	Macular oedema (diabetic) - ranibizumab - NICE TAG274 (re-audit) (5065)	• Reduction in central macular thickness (oedema) was noted in all patients treated with anti VEGF injections • Management plans were in accordance with national standards
40	Maxillofacial Trauma Documentation Audit (4899)	• The audit highlighted areas of poor documentation. This has been discussed at clinical governance. • A re-audit is planned
41	Patient satisfaction of OMFS telephone consultations in response to COVID-19 pandemic (4518)	• High satisfaction with telephone consultation despite relatively new form of patient interaction. • Identified higher satisfaction with review rather than new patient consultations

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
42	Post-tonsilletomy care (4656)	• Poor analgesic management post op, putting additional pressure on allied services. Amend discharge leaflet to encourage to take paracetamol, ibuprofen (over the counter) and codeine and Difllam will be provided by the Trust
43	Primary BCC excisions re-audit (4752)	• Revealed that success rates are within standards
44	Use of key performance indicators (KPI's) in paediatric Audiology clinics (data collection from December 2020 – February 2021 (5005)	• The information can be used as a way of reinforcing positive feedback to the team on the tests undertaken and can be shown in various formats. Emails can be sent to staff, regarding testing quality, individually, as a site, or as a service overall
SURGERY - MSK		
45	Achilles Tendon audit (4416)	• The audit highlighted whether braces were effective, therefore an audit will take place to look at this.
46	Acute Knee Injury Management in ED (4795)	• A new protocol for referral of knee injury patients to the knee clinic has been implemented in A&E
47	AKI & Femur # (4796)	• Showed good practice, no concerns identified.
48	Blue Book Audit Series (4704)	• Still some delay from arrival in ED to transfer to ward. Re-audit to review details in a larger group of patient data- to be gathered prospectively
49	Blue Book Re-Audit series (4778)	• Still difficulties in time from arrival in ED to transfer to ward. This is a Trust wide issue; this will be addressed as part of the future fit programme
50	Casenote Orthopaedic PRH 2020 (4419)	• The audit was mainly compliant; however, the audit identified some areas for improvement. The Impact of COVID after return of services/ward is evident.
51	Cervical Collar prescription audit (4798)	• Good audit showing details of documentation could be improved.
52	Change in NOF length of stay during COVID (4970)	• Audit showed good compliance, no concerns identified
53	DVT Prophylaxis for Femoral Trauma (4757)	• The audit showed good compliance with VTE assessment and prophylaxis.
54	Fascia Iliaca Block Audit - re-audit (4689)	• There has been a considerable improvement in proportion of patients receiving blocks
55	Fascio-iliac block in hip fractures (4717)	• The majority of patients either appropriately receiving FIB in the emergency department or had documentation of contraindications
56	Hip Fracture Pathway Audit (4966)	• The proforma is being utilized correctly to capture patient's lifestyle leading up to the fracture • The main areas that need improvement are completion of the checklist at the end of the SHO section, and completion of the registrar section – this will be highlighted at future inductions.
57	Hip Fracture Proforma Audit (4965)	• The audit showed minor documentation issues, these will continue to be discussed at induction. • A re-audit is planned

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
58	Outpatient satisfaction survey - fracture clinic 2021 (4921)	• Despite Covid related restrictions and demand on services, patients are still overall happy with service • If waiting times are increased, explain why, apologies and warn patients in advance by writing the wait time on fracture clinic board.
59	ReSPECT re-audit (5015)	• We do reasonably well, but always room for improvement – needs constant reminding. This was discussed at governance. • Plan to re-audit
60	Theatre utilisation - Service quality improvement (4732)	• Team briefing to now start at 8h30 daily. After the presentation, the teams are more aware and are starting the briefing on time.
61	Virtual fracture clinic: audit of patient & clinician perspectives (4608)	• Almost half the patients were discharged following VFC review, the remaining patients were booked to see an appropriate sub-specialist at a time fitting to their injury needs
62	VTE Prophylaxis audit (4690)	• VTE assessments done but sometimes not documented on vital pack • A re-audit has been undertaken
63	VTE Prophylaxis audit re-audit (4964)	• The majority of patients had their VTE assessment completed on the day of admission • Continued topic for induction
64	VTE Prophylaxis for Lower Limb Immobilisation (4797)	• Overall good provision of VTE prophylaxis in #clinic but documentation could improve • Plan to review in departmental teaching and re-audit
SURGERY - SURGERY, ONCOLOGY & HAEMATOLOGY		
65	30-day mortality rate for palliative patients – 254 (4848)	• Audit results are well within the accepted range • A re-audit has been undertaken
66	3rds and weekly checks audit – 294 (5042)	• All patients had a 3rd check carried out at the correct point
67	5 fraction head and neck audit – 306 (5075)	• Change protocol for head and neck receiving 5# to have Daily CBCT if they are rapid arc and daily KV pair alone if they are planned conformally
68	6 DOF couch corrections – 241 (4767)	• The results are very re- assuring as they show that after a 6DOF correction has been made the patient still remains very stable and there is little to no movement inside the immobilisation shell which shows that there is minimal intrafraction motion
69	6DoF audit form – 293 (5041)	• Based on these results we can determine that 6DoF checks can be deemed unnecessary on a weekly basis, with only 0.5% of fractions treated on a 4DoF Linac without prior knowledge • A review of the protocol has been completed and has now been updated to reflect the recommendations
70	Accurate scanning in Pre-treatment department – 262 (4856)	• The audit showed that on the whole the process of scanning in CT was successful • A re-audit has been carried out

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
71	Acute Lower GI Bleeding Audit (4669)	• There is a need to adopt the current guidelines for the management of lower GI bleeding with an emphasis on developing protocoled local Trust guidance based on the presence or absence of shock (shock index) as well as incorporating the bleed severity and re-bleeding risk scores. This is currently being addressed.
72	Ant alignment tattoo – 270 (4972)	• From the data collected there is no benefit of giving a patient an ant alignment tattoo for head and neck treatment. Therefore, head and neck patients will now be aligned using bony landmarks such as xiphoid process and not receive ant alignment tattoos
73	Ant alignment tattoo 6-month re-audit confirmation – 307 (5076)	• Ant alignment tattoo is no longer needed for head and neck patients, and this does not need to be re-audited again unless there is a change in setup/immobilisation
74	Archeck measurement audit – 305 (5074)	• The audit showed good compliance with the standards • A re-audit is planned
75	Assessment of rate of sepsis post transrectal ultrasound (TRUS) guided biopsy (4994)	• Full audit cycle completed showing significant improvement in our rate of sepsis. This was achieved by the implementation of a Strict Infection Control Policy.
76	Audit mapping tool – 303 (5072)	• The audit showed good use of the mapping tool • A re-audit is planned
77	Bladder cancer: diagnosis and management - NG2 (4887)	• T1G3 patients were discussed cystectomy following MDT guidance • Mainly compliant, no major concerns.
78	Bladder filling prostate audit – 248 (4792)	• Additional water consumption has proven to be beneficial during this audit. Going forward, it is recommended that patients continue to hydrate with a further 500ml or 750ml prior to their CT scan
79	Breast imaging audit – 256 (4850)	• Findings of this audit show that 75% of the patients reviewed required daily imaging to confirm the isocentre and confirm geometric accuracy. It is recommended that the protocol for 5 fraction breasts be changed to daily imaging. This has now been implemented.
80	Breast Telephone follow up Jul-20 to Jan-21 – 237 (4763)	• In total 91% of the patients reported either a grade 1 erythema reaction or no erythema reaction relating to their radiotherapy treatment • Pain was not documented, which has highlighted a need for further training on patient assessment. However, further discussions with staff showed missing data was due to patients having no pain
81	Casenote Oncology 2020 (4740)	• The audit showed inconsistencies with recording with basic documentation. This was addressed by giving a presentation to provide further education.
82	Cervix patients treated start of radiotherapy-end of brachytherapy – 268 (4862)	• 5 out of 6 patients received their treatment within the required window • A re-audit has been carried out.
83	Change of practice for localisation of impalpable breast cancer (4319)	• The audit showed improvement in patient flow and experience. • Magseed localisation has resulted in cost saving of £34,000 for the service.

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
84	Communication form – 297 (5045)	• Further MSCC/ Palliative meetings are planned to discuss the audit findings.
85	Competence Audit trt – 285 (4987)	• Electronic Records are sufficient and paper records no longer need to be copied and stored going forward • The Matrix is accurate and up to date
86	Completion of routine QC of IT systems – 238 (4764)	• Need a system to routinely examine failures and feed back into QMS – a system has been developed for producing non-conformities & concessions
87	Consent – 300 (5048)	• Just over half of the forms were incorrect. A regular has been set up to discuss this with consultants.
88	Consent audit – 236 (4762)	• 100 % had the treatment site, site specific benefits/risks of treatment and patient specific benefits/risks documented • The audit showed concerns with the remote consent process – The document QAP 2.3-PTX has been updated to reflect this.
89	CT scanning data – 281 (4983)	• The audit showed that on the whole the process of scanning in CT was successful. All documents were correctly stored, for the right patient
90	CT scanning process – 274 (4976)	• An improvement since the last audit
91	DIBH clip match Vs bones – 240 (4766)	• No concerns identified. Will require further discussion for best practice going forward
92	DPDs required – 291 (5039)	• The audit showed good compliance; however, it highlighted some concerns with training. A training pack for DPD new starts has been produced.
93	Drugs cupboard LA1 temp – 280 (4982)	• Improvements noted on last audit, mostly compliant
94	Drugs cupboard temperatures – 247 (4791)	• 100% compliance in pre-treatment • Staff have found a way to remember the checks and this process was working in March 2021 – all days checked, repeat audit to check this continues • A re-audit has been carried out.
95	Electronic signatures – 242 (4768)	• System of electronic signatures is not robust in its current form. After speaking to staff, they were unsure of the legal requirement. This was checked with society of Radiographers and staff updated.
96	Endoscopy Unit Patient Satisfaction Questionnaire (16) - re-audit (4749)	• 100% of patients would recommend the service to friends and family
97	Familial Breast Cancer 2021 - CG164 (4926)	• Imaging is being arranged as appropriate • Chemo prevention is being offered as appropriate
98	General imaging audit Nov 2021 – 282 (4984)	• The vast majority of patients have all their imaging recorded fully
99	Gentamicin dosing in TRUS biopsy (4825)	• The Gentamycin dose for prostate biopsy patient is in line with recommended Trust guideline
100	Gulmay Documentation – 292 (5040)	• 2 out of the 5 documents required very minor changes and changes have now been made.

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
101	Gynae vacbag audit – 301 (5070)	• Superintendents to consider whether to continue to scan and treat these patients with a vac bag. Further consideration may be to review how Vac bags are used to increase immobilisation
102	Haematology telephone consultant satisfaction survey (4754)	• 86% of patients happy to continue with telephone consultations • 97% of consultations met with patients' expectations
103	Head and neck patients on treatment – 295 (5043)	• No issues identified all patients followed correct procedures for treatment • A re-audit is planned
104	IGRT related nonconformities – 288 (4990)	• Palliative protocol is being rewritten to help with understanding
105	IGRT training needs of radiographers – 252 (4846)	• The audit identified training needs, and these have been addressed.
106	Image protocol form – 278 (4980)	• A feedback questionnaire has been released to all staff to identify areas of improvement that they wish to see within the form • Memo to inform staff ALL patients need an image protocol form, and they need 2 signatures on the document for approval
107	Imaging modality used for palliative patients – 296 (5044)	• Improvements to palliative imaging protocol to make clear what imaging to be taken for palliative spine patients with Post or Ant + Post treatment fields is underway
108	IMC imaging audit Aug 2021 – 271 (4973)	• Due to 90% of patients imaging that deviated from the current protocol, a change to the current protocol is recommended to allow staff to follow the protocol for these patients.
109	Is a Pre-operative Group & Save essential for Elective Breast Surgery? – A 5-year retrospective re-audit (4002)	• The audit found that traditional practices continued to be followed. A copy of the audit results has been sent to the pre-op assessment team, along with the previous audit.
110	IV bloods – 276 (4978)	• Posters added to clinic rooms reminding doctors of the need for blood when referring for radical radiotherapy
111	Linac Imaging QC audit 2021 – 267 (4861)	• Imaging QC generally working well • Mostly provides reassurance of existing systems – most work is being performed to schedule, and the tests performed generally work acceptably.
112	Mortality rate – 283 (4985)	• The overall figures for 6 and 12 months for mortality are well within the requirements
113	MSCC patient treated with Radiotherapy 2020 – 257 (4851)	• At radiotherapy 100% of patients' treatment delivered within 48hr window • 23.5% of MSCC patients were treated out of hours, 37.5% of those patients the CT handover log not filled in. A reminder has been sent to staff.
114	Multiple fraction bone treatments – 249 (4793)	• Audit shows that the bone concession process brings no benefit. This has been removed from intranet, and staff informed.

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
115	Non conformities Aug-20 to Nov-20 – 234 (4760)	• The data is comparable with previous audits and benchmarks very well against the national data available in Safer Radiotherapy, it provides evidence of a strong reporting culture • A re-audit has been carried out
116	Non conformities Jan-21 to Jul-21 – 263 (4857)	• The audit highlighted areas to increase awareness, actions have been commenced to address issues where possible
117	Off-protocol book – 266 (4860)	• Highlighted the need to adopt the West Midlands lymphoma. This has now been adopted.
118	Pacemaker protocol – 272 (4974)	• The protocol was working correctly in the majority of cases
119	Patient feedback 2020 – 250 (4794)	• The majority of feedback was positive from Radiotherapy patients
120	Patient outcomes post nurse led ascitic drain insertion (4232)	• 100% compliance with the protocol • High patient satisfaction
121	Post-orchidectomy tumour markers (4826)	• Need to improve compliance in checking post operative tumour markers if results are abnormal in pre op sample • To improve documentation of discussion regarding prosthesis and sperm banking in appropriate patients
122	Pre TRT-Competency – 251 (4845)	• Staff competencies are maintained within the system
123	Prost 20# rectum in PTV60 review – 253 (4847)	• 98% of the images checked were appropriate to treat on • Staff have completed further training.
124	Prostate hypofractionation – 284 (4986)	• NHS England 70% target met across the period audited • A re-audit is planned
125	Prostate matching Audit – 277 (4979)	• This audit has proven that prostate CBCT matching by all trained radiographers is up to a high standard. Since this audit was in response to changes in working practice and the results are conclusive, there is no need to repeat this audit unless there is sufficient need in the future
126	Prostate process audit Sep-20 – 235 (4761)	• A number of concerns were related to a change in workflow going from paper to paper light – consultants electronically approving OAR's, use of journal. Since audit more training has been given and these non-conformities are becoming less frequent • Small errors in documentation have now been corrected and updated
127	Prostate treatment – 245 (4789)	• All treating, imaging and reviewing actions were seen to be carried out correctly by competent staff • Handover of LA1 had not been signed for correctly on 3 occasions. Staff have been reminded on a newsletter.
128	Quality documents within the QA system – 302 (5071)	• 2/161 documents are outside of their review period without concession covering them. These documents have been reviewed but as guidelines keep changing, they have not been finalised yet

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
129	Quality records – 264 (4858)	• All sections of the QAP were accurate apart from section 4.6. This has been updated to reflect current practice.
130	Radiation doses for endovascular aortic repairs performed on mobile & fixed C-arm fluoroscopes (4219)	• The audit highlighted an important area to focus on IF performing this type of procedure with fixed c-arm in the future.
131	Radiotherapy Engineering PMI Breakdown 298 (5046)	• A review of the remote access log indicates that the engineers are not engaging in this system. A reminder has been issued.
132	Rectum ptv – 299 (5047)	• Several changes will be brought in (after training) to help to reduce the number of untreated setups and also decrease the amount of time taken to treat. • The possibility of a maximum bladder size at pre-treatment CT is being considered.
133	Remarking patients CT – 286 (4988)	• Identified that practice should change to reduce the discrepancies between scanned and treated positioning
134	Renal & Ureteric Stone - re-audit (5059)	• We have ensured that patients presenting with a suspected renal or ureteric stone receive CT scans within 24 hours of presentation to our care
135	Reporting minor non-conformities – 244 (4788)	• Radiographer reporting and engagement is demonstrated across the year. To improve engagement, send report to physics to ensure Radiotherapy management has seen summary.
136	Review CT-related QC performed – 239 (4765)	• Revised system of monthly checks working essentially as intended. • Maintenance & development of a new system will be on-going.
137	Review of audit process – 259 (4853)	• Matrix amended to include staff who gained experience of audit without formal taught course. Audit training to be addressed separately.
138	Review of concessions – 258 (4852)	• No concessions issues were identified.
139	Review of primary and recurrent transurethral resection of bladder tumour as a quality improvement exercise (4800)	• The audit highlighted the need to improve our detrusor muscle, documentation and Mitomycin rate in TURBTs. • A re-audit is planned
140	Review of QA documents – 255 (4849)	• All documents are reviewed, date has been extended on some to allow completion.
141	Review of the 2021 management meeting minutes – 304 (5073)	• All protocols were followed, and the management review and objectives are carried out as intended
142	Review of the use of signatures for treatment using electronic signoff – 243 (4787)	• Signatures on the treatment sheet matched the password protected sign off in Aria in 99.2% of treatments
143	Review procedure to check compliance – 287 (4989)	• Not all patients will be seen every week. This is mentioned in the QAP but how the patients are scheduled has changed and this will need amending in time to reflect more accurately when patients are seen, for example prostate and breast patients

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
144	Scanning CT documents – 260 (4854)	• The audit showed that on the whole the process of scanning in CT was successful. • A re-audit has been carried out.
145	Scanning of treatment documents – 261 (4855)	• Some scans are not good enough quality or scanned incorrectly, further training was given to staff • Results from the audit show that 100 % of the documents were stored as the correct patient • A re-audit has been carried out.
146	Scanning treatment documents – 275 (4977)	• 4 documents were not scanned which is a smaller proportion than in the last audit but still an issue • This audit will need to be repeated to ensure that corrections are happening, the process is now more robust but there is still the potential to not scan original documents or scan into the wrong patient. These issues will need to be addressed before we can have confidence that the system is robust enough for us to stop checking all treatment packs for all patients • A re-audit has been carried out.
147	Scanning treatment documents – 289 (5037)	• Improvement on previous audits. • The process is now more robust but there is still the potential to not scan original documents. To ensure the process is robust long term, a random spot check audit to be carried out.
148	Scanning treatment documents update – 265 (4859)	• Results from the audit show that 100 % of the documents were stored as the correct patient. • Some actions are not being done by everyone – further guidance has been issued • A re-audit has been carried out.
149	Shoulder Protocol Audit – 246 (4790)	• The use of this shoulder protocol will benefit the patients by providing clearer images for treatment.
150	Signatures for CT checks – 290 (5038)	• Generally, the quality of the forms was good with all “Yes” “No” or “Not applicable” being circled however they were some instances where this was not then countersigned by a member of staff. • A reminder email has been sent to staff.
151	Surgical Casenote Audit 2020 (June 2020 patients) (4875)	• Discussion following presentation regarding all ward round leaders to take time to look at written documentation of ward round and feed back to F1/CT regarding completeness of entry. • A re-audit is planned
152	Systematic Error Correction (SE) form – 279 (4981)	• SE forms are being filled out consistently and corrections are being authored, approved and new moves transcribed prior to #4. Some information on the forms is missing however, this does not impact patient safety • A feedback questionnaire has been released to all staff to identify areas of improvement that they wish to see within the form • Reminder for staff to fill out form to completion, details of # number and ensuring ‘checker completed’ box is ticked appropriately

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
153	Tenofovir disoproxil for the treatment of chronic hepatitis B - TAG173 (4896)	• In 100% patients, the prescription of Tenofovir was done according to the guidelines which indicates that we are appropriately prescribing the medication in the right patients with Hepatitis B mentioned in guidelines. • It is suggested to make a stamp or sticker which could be stick to the first-time prescription paper of Tenofovir. That stamp or sticker will mention boxes for Discussion regarding medical condition, the medication, Handouts given and NICE mentioned
154	Topograms site audit – 269 (4971)	• Topograms missed initially on 18 patients. The findings were discussed at IGRT group meeting
155	Urology treatment times – 273 (4975)	• Machines are running behind and patients are delayed for treatment. Treatment appointments to be extended by 5 mins for prostate patients.
MEDICINE – EMERGENCY MEDICINE		
156	ED Blood Culture audit (4804)	• Highlighted good practice on a whole, but also areas for improvement requiring further education and monitoring. Further training of staff in progress. • Elements in practice require further improvements to reduce blood culture contamination and improve patient outcomes. Further audit post education and ongoing monitoring alongside biochemistry monthly reports
157	Fractures (non-complex): assessment and management - NG38 (4929)	• The audit results showed that the standards for Ottawa knee, Ottawa ankle and foot rules, and non-surgical management of unimalleolar ankle fractures were met • The department is not compliant with RCEM pain in children guidelines. A national audit is underway to review the process.
158	Human and animal bites: antimicrobial prescribing - NG184 (4945)	• Overall compliance with guideline was good. However, there is no documentation of adverse effects of antibiotics being discussed with patients. This has been highlighted at clinical governance.
159	Insect bites and stings: antimicrobial prescribing - NG182 (4940)	• The audit showed we are compliant with NICE guidelines
160	RCEM 2020 IPC QUIP (4843)	• IPC are in the process of updating policy to reflect changes. New posters and comms ordered by IPC team and will be delivered on arrival. ED team informed of changes via Safe Today call and daily handover
161	Sixth audit cycle of requests for x-ray at the point of triage (4759)	• There has been an improvement since the previous audit • A training package has been introduced to improve practice.
MEDICINE		
162	Acne vulgaris audit regarding primary care referrals for further management (4823)	• The referral process according to NICE guidelines is not being followed by over half of the referrals received. • It seems that moving forward updating local guidelines and the creation of a referral proforma for acne vulgaris combined with general practice education and teaching on acne vulgaris severity could prove to help in reducing

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
		the current incongruity between primary care and the dermatology department. A referral proforma for acne vulgaris has been created
163	Assessment of adequacy of completion of ReSPECT forms and doctors' training on completion of Re-SPECT forms (4600)	• The completion of the ReSPECT form was good with all the specific categories in the form appropriately completed in over 95% of the cases. • Where the patient has no capacity there needs to be improvement in documentation of discussions and completion of MCA form. Enforce renal junior doctors training on MCA with evidence of training
164	Assessment of delirium in dementia patients (4597)	• To continue to deliver delirium awareness/ Dementia through dementia training/workbooks • To move to using the 4AT delirium assessment as best practice instead of CAM (recommended in the geriatric Medicine National speciality report)
165	Availability of biochemical results and self-monitored blood glucose readings in diabetes OPD clinics (4050)	• Improved pre-clinic biochemical result availability likely due to altered clinic letter template with reminder for blood tests to be done
166	Discharge Summary Audit (4686)	• Presentation and practical, hands-on session with Escript at the beginning of F1 training – ideally by a junior who uses it regularly
167	First Fit proformas re-audit (Aug-20 to Feb-21) (4758)	• Overall things have improved - waiting times are much less and information gathered from the proforma has been useful
168	Headache / Lumbar Puncture (4716)	• Use of lumbar puncture proforma is variable and clear documentation of person performing the procedure was lacking. Procedures/documentation Workshop for junior doctors organised in the month of March, where 48 doctors across both sites attended
169	Medical Casenote 2020 (Nov-19 & Jul-20 pts) (4620)	• Medical history information is well documented throughout trust • Poor compliance with patient's name and unit number being present in all pages relating to admission. To reinforce importance of documentation at induction
170	PD Peritonitis re-audit (4828)	• PD peritonitis rates are lower than the national standards • In order to address culture negative rates, discussions with the microbiology department have been conducted. The measures introduced includes an extended period of centrifugation of effluent samples and enhanced means of culturing the samples. Further, differential white cell counts of the effluents are being sought • RCAs of all peritonitis episodes are undertaken within the department and patient and staff training systems are in place to address any findings.
171	Proactive Intravenous Iron Study (PIVOTAL) (4751)	• Revision of Anaemia and iv iron policies for HD patients. • Date for change in practice set in advance, ensuring that the service is prepared for change

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
172	Quality of consent forms in the renal department (4918)	• Information leaflet **must** be given to patient for patients' safety issues and also to avoid litigation. Patient information leaflets are updated. They have been made easily accessible on the Trust's intranet. • Set up plans for regular training on consent-related issues
173	Renal Alteplase issues (4831)	• New pathway document drafted for the benefit of the Access Team
174	Renal HD quality standards audit (Feb-21) (4750)	• Improved performance of the service across a number of areas • A business case for dialysis capacity has been agreed.
175	Renal Unit Patient Questionnaire (4514)	• Patients identified problems with heating issue. New Air conditioning units fitted which can become heaters when unit is cold, can be manually controlled on the unit • Patients stated they wanted more information. Information on blood results is now included in patient monthly review letter
176	Renal Virtual Clinic Patient Satisfaction Survey 2020/21 (4838)	• A small percentage did not feel supported by the telephone clinic - reasons not clear (may be some prefer personal touch, hearing impairment, phone call made late with no explanation). Patient offered choice at the point of clinic consultations. Review clinical indications for Face-to-Face meetings
WOMEN & CHILDREN'S		
177	Care of infants, children and young people with life limiting or life-threatening conditions approaching the end of life re-audit (4355)	• Overall, there was improvement in the management of distressing symptoms, management of hydration and nutrition • A staff resources pack will be introduced containing written information for families covering care of body, legalities and post mortem
178	Case Note Audit: joint case note entry neonatal unit Ockenden action 4.97a (4834)	• The NNU were fully compliant with this aspect of local action for learning 4.97. The audit for daily clinical records using a structured format is reported separately
179	Case Note Audit: joint case note entry neonatal unit Ockenden action 4.97b (4835)	• The neonatal unit team at SaTH provided structured case note reviews for every patient, care day and case note entry for infants receiving intensive care and are fully compliant with the Ockenden recommendation 4.97. • In addition, the neonatal team often provide at least twice daily entries for infants receiving respiratory support including those care days that are not defined as intensive care
180	Casenote Audit - Paediatrics 2020 (4607)	• VTE documentation in the notes is poor • Documentation of admission notes is good • Areas of concern were discussed at governance
181	CLABSI (Central Line Associated Bloodstream Infection) in babies (4881)	• To review practice with Trust IPC and explore practice in other neonatal units

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
182	Colposcopy patient satisfaction survey 2020 (4544)	• Good sample of patient's cross site. Good feedback on colposcopy experience for patients • A re-audit has been carried out
183	Effective & adequate VTE prophylaxis following admission in gynaecology ward (4806)	• The audit highlighted several areas for improvement. These have been discussed and a memo sent to staff.
184	Gynaecology Casenote audit 2020 (4605)	• The audit showed good documentation of Nursing/medical notes, drug chart and discharge summary • A re-audit has been carried out
185	Improving the organisation of patient notes on the gynae ward (4606)	• The majority of staff working on the gynae ward are not happy with the organisation of the notes. Introduction of new notes system on Gynae Ward
186	Introduction of a Handover Proforma: A review of current content practice (4529)	• To adapt nursing handover proforma to include the same detail and content but made clearer to facilitate completion of multiple handover • Education regarding the implementation of the nursing proforma has been provided
187	Management & outcome of neonatal hypoglycaemia using BAPM framework (4478)	• **100%** of babies with risk factors were identified at birth and the special care pathway was followed • Approximately **34%** of cases first feeding time **was not documented.** Handover proforma to post-natal ward now contains a space to note time of first feed • A patient leaflet 'Protecting your baby from low blood glucose levels' has been developed
188	Management of patients diagnosed with HSP (4739)	• The audit highlighted good practice • Guidelines have been updated to incorporate management flow charts and patient passport
189	Maternal SSRIs – length of stay and adverse effects (4293)	• Signs and symptoms can be difficult to define, and the updated guideline will provide information. The guideline has been updated to reflect the outcome of the audit • Parent Information Leaflet to be given to mothers antenatally with check at NIPE – symptoms, signs and signposting for who to call if concerns is being developed.
190	MRI completion and the use of the play therapy service (4354)	• The audit showed good compliance, no concerns identified
191	Newborn heart murmur follow-up (4386)	• This clinic is safe and timely and should continue in the best interests of the babies
192	Perinatal Optimisation for Preterm Babies' (4722)	• Overall good rates of temperature control in preterm babies • Areas of concern have been highlighted to management
193	Post-menopausal bleed 28-day target and guideline compliance (4816)	• Pipelle biopsy and hysteroscopy conducted in line with guidance 100% compliance • 28 day target not met due primarily to delay in result management (letters/action of results). This has been escalated to management to liaise with the admin team.

TABLE 4 – Trust Local Audits 2021-22 (196)		
No.	**Audit Title**	**Key actions/improvements following audit**
194	Prescription errors in paediatrics (4811)	• Allergy and intolerance completed in 100% • Where documentation fell below standards, these concerns were discussed at induction.
195	Sickle Cell acute painful Crisis and Analgesia (4841)	• To ensure timely administration of analgesia & documenting effectiveness of analgesia given, education sessions will be put in place for nursing staff
196	UNICEF Baby friendly initiative (BFI) - neonatal unit tool (4356)	• Detailed curriculum and lesson plans that include learning outcomes and training schedules have been compiled and approved by UNICEF • Education days are in the process of being scheduled. • A re-audit is planned.

Clinical Audit Outcomes

The reports of 196 clinical audits were reviewed by the provider and a compliance rating against the standards audited agreed. However, 10 (5%) local audits demonstrated significant non-compliance with 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. These audits are listed in table 5.

Table 5: Audits demonstrating significant non-compliance with standards audited

Table 5 – Audits demonstrating significant non-compliance with standards audited	
Audit title	**Recommendations – actions**
Acne vulgaris audit regarding primary care referrals for further management (4823)	• Improvements have been agreed and are being trialled • Prior to re-auditing the proforma will be trialled amongst the GPs within the area to try to minimise inappropriate referrals. It is planned that this will be combined with acne education for GP's, allowing professionals to assess acne severity correctly also reducing inappropriate referrals. A scale of severity will be created and distributed to GPs within the SATH trust area. An update of local guidelines involving secondary care clinicians will increase the chances of national guidelines being followed. Research has shown that teaching alongside a template or set of guidelines had an increase in the chance of successfully improving the quality and appropriateness of referrals. • Overall, greater awareness of the guidelines and the severity of acne will benefit both primary and secondary services with the referral process and better outcomes. Use of templates in referrals were shown to be effective in improving referral quality. Implementation of the aims to cut down referrals and clinic/appointment times for both primary and secondary care will help to achieve the required improvements
Acute Lower GI Bleeding Audit (4669)	• Aide-mémoire has been developed to encourage formal use of bleed severity and re-bleed risk calculators developed. Also, audit findings have been disseminated to all Emergency Department and surgical junior

Table 5 – Audits demonstrating significant non-compliance with standards audited	
Audit title	**Recommendations – actions**
	doctors - Creation of memory aid posters which have been displayed in relevant areas.
Care after Death - May 2020 (4520)	• It is now mandatory for all ward based clinical staff in adult areas to have completed the End-of-Life Care eLearning training, which includes care after death. All registered nurses will take responsibility for delivering care after death in line with the current policy. The training and development team have agreed to record all End of Life care training sessions separately from April 2022. • Review of completion of e-learning is ongoing to ensure compliance • Some of the planned face to face training during 2020 and 2021 had to be cancelled due to the restrictions relating to the COVID 19 pandemic. However, the Palliative and End of Life Care team now have a training schedule for 2022/2023, venues have been booked and dates released on the trust training diary. • The eLearning modules have been updated in 2022 and will be uploaded onto the trust intranet by the communication team by April 2022. This training continues to be mandatory for all clinical staff • All policies relating to palliative and End of Life Care are updated in line with the dates agreed by the Palliative and End of Life Care steering group
Communication form – 297 (5045)	• Education and dissemination programme is in place to raise compliance with completion of this form
Discharge Summary Audit (4686)	• A Trust wide training session on Escript has been developed • A video tutorial is being developed on YouTube
Hip fracture physiotherapy rehabilitation. (4836)	• A prioritisation system used at RSH will be introduced to PRH to improve compliance • Team training is being delivered to ensure that data is entered into the portal consistently across both hospital sites
Obstetric theatre cases re-audit 2019 (4885)	• The audit showed that only 42% of women were followed up post-operatively due to being discharged prior to being seen by the Anaesthetist. Introduction of a paper-based system for improving this was trialled but was unsuccessful. From March 2022 information will be documented on an updated electronic patient management system (Badgernet). This aims to increase follow up by prompting the Anaesthetist to follow up the patient by including this in a work list.
Policy for the use of the Recommended Summary Plan for Emergency Care and treatment (ReSPECT) form - May-21 (4772)	• Appointment of a clinical lead for ReSPECT is being progressed. • The updated ReSPECT policy has been introduced and is live on the intranet. • Teaching about the ReSPECT conversation and the completion of the ReSPECT form is given during statutory updates and online teaching is available via eLearning. Further steps are being taken to ensure that this is mandated for all medical staff and recommended for all nursing staff and Allied Health Professionals. A link to the website is now available via a ReSPECT app.

Table 5 – Audits demonstrating significant non-compliance with standards audited	
Audit title	**Recommendations – actions**
	• Mental Capacity assessments of patients who were deemed to be lacking was not well documented (64% missing MCA assessment). This is an ongoing issue with lack of completion despite training. The use of an updated, more concise Mental Capacity Act form will be used for assessing capacity. This will be complemented by increased focus on this area during training
Sickle Cell acute painful Crisis and Analgesia (4841)	• Areas for improvement included timely administration of analgesia & documenting effectiveness of analgesia given. Education sessions are now in place for nursing staff, and a plan has been developed to deliver sessions on ongoing basis to both junior medical staff and nursing staff
The Deteriorating Patient (Jul-Dec 2016) (3648)	• Documentation of deterioration of patients in the medical and nursing notes did not mee the required standard. The Deteriorating patient policy was updated and deteriorating patient stickers in medical notes have been introduced to facilitate recognition of Early Warning Scores (EWS) of 5 or above, requiring action.

Research and Innovation

The Trust ambition remains to ensure that research is an integral part of patient care across all of the services we deliver and is therefore committed to embedding a culture of research to benefit patients, their loved ones, staff and the communities we serve. It is recognised that research is an essential part of providing world class care and that research active organisations have better patient outcomes and the Trust has developed a Research Strategy to address the needs of our patients and wider community.

The number of patients that have been recruited to participate in research during the financial year of 2020/21 was 825 (for studies approved by a Research Ethics Committee and the Health Research Authority). Whilst this is a significant decrease in the previous year's recruitment this is due to re-opening studies across the Trust which we put on hold during the pandemic, whilst also continuing to adapt to new ways of working, changes in service provision and multiple changes in study delivery. The portfolio of trials available to recruit to, and their complexity change every year.

Table 1:

Research Activity 2021/2022	Number of Studies
New research projects open in year	21
Total number of research projects open in year*	142

**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*

During the 2021-22 year the Trust continued to support and submit a number of research grant applications, to national funding bodies.

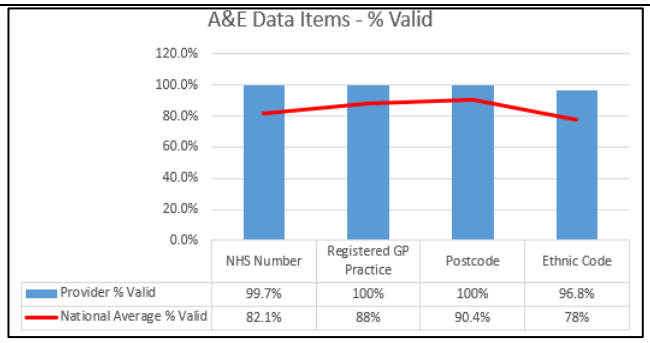
The Shrewsbury and Telford Hospital NHS Trust have continued to contribute to a number of Urgent Public Health Measures Studies including PRIEST, ISARIC, GENOMMIC and RECOVERY many of which have been able to provide answers and treatments for patients with COVID-19. This year saw the Trust open as a site for a national Vaccine study in Pregnant women, for COVID-19. This is ongoing and is continuing to recruit.

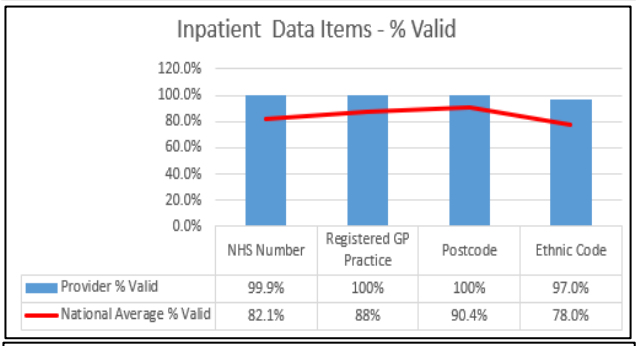
The Trust continues to be part of the West Midlands Research Training collaborative (WMRTC) providing free training sessions locally and across the region including Principal investigator Masterclass, an NIHR accredited course, Fundamentals of research, Good Clinical Practice and Investigator Site File Training.

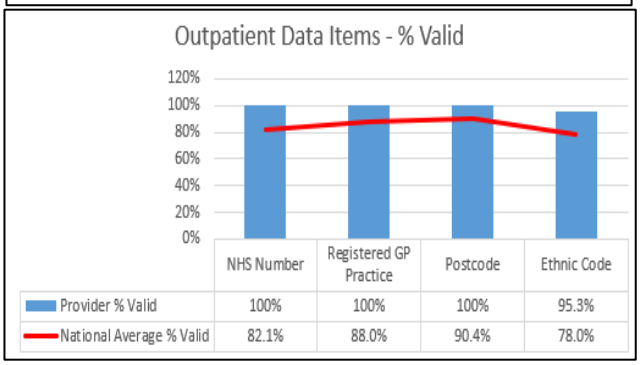
In 2021/2022 the Research and Innovation Department have undertaken a scoping exercise to assess and explore the contribution for Patient and Public Involvement and Engagement (PPIE) in research. This scoping exercise has now finished, and agreement is in place for the development of up to six PPIE groups for research across the organisation in the next 12 months. In 2022/2023 there are a number of strategic developments with the launch of the Shrewsbury and Telford Hospital NHS Trust fellowships, in which substantively employed staff will be awarded allocated funding to develop research ideas, in conjunction with Keele University. In addition, a number of honorary roles have been made available with the University of Keele. These are both new developments which are being competitively appointed to and are aimed at not only strengthening collaborations with local Health Education Institutions (HEIs) but also increasing income to the Trust, development opportunities for staff and also long-term benefits for the communities we serve.

NHS Number and General Medical Practice Code Validity

The Shrewsbury and Telford Hospital NHS Trust submitted records during 2021/2022 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.







The data quality measures are reported in the Data Quality Maturity index (DQMI) reported by NHS Digital. The data reported has been sourced from Secondary Uses Services (SUS). CDS Dataset for APC, OP and AE

Reporting period is January 2022 (latest data available).

Percentage of records which included valid NHS Number was:

- 99.7% for A&E
- 99.9% for Inpatients
- 100% for Outpatients

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 2021/2022.
0.8% reduction in capturing the Ethnic code for all three datasets compared to 20/21.

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. This is facilitated via NHS Digital. Compliance with the DSP Toolkit requires organisations to demonstrate that they are implementing the ten data security standards recommended by the National Data Guardian Review as well as complying with the requirements of the General Data Protection Requirements (GDPR). All organisations that have access to NHS patient data and system must use this toolkit to provide assurance, on a yearly basis, that they are practising good data security and that personal information is handled correctly.

Changes introduced for the 2020/2021 toolkit included:

- A more 'business as usual' approach was used for some evidence items.
- Extra evidence items on backups and requirements
- Technical evidence items moved to mandatory from non-mandatory particularly items covering Cyber Essentials (CE).
- Cyber Essentials on site assessment became a non-mandatory requirement for 2020/2021

Due to the Coronavirus pandemic, NHS Digital extended the usual submission date for 2020/2021 from 31st March 2021 to 30th June 2021. For the 2020/2021 the Shrewsbury and Telford Hospital NHS Trust self-assessment status was increased from "***Standards not met***" *to "****Approaching standards***" (previously known as "Standards not fully met" (plan agreed)) due to the improvement plan which was submitted, approved and accepted by NHS Digital.

The improvement plan put in place included:

- Data Quality reporting and the implementation of a dedicated data quality group,
- Data Awareness / Data Protection training and the mandated 95% compliance rating
- 3 improvements to Digital Security processes

The Trust is due to submit their 2021/22 submission on 30th June 2022 and will report its attainment levels within the 2022/23 Quality Account.

Learning from Deaths

Learning from Deaths remains a key component of the Trust 'Getting to Good' Improvement Programme. Progress towards this programme is monitored through the Trust Learning from Deaths Group.

The Corporate Learning from Deaths Team who work closely with the Divisional Quality Governance Teams established within the new Quality Governance Framework which was implemented in January 2022. This collaborative working with the Divisional Quality Governance Teams has supported the rapidly developing Learning from Deaths agenda and will ensure completion of mortality reviews within the Trust. The Trust now has a standardised approach to reporting and provide consistency of the Learning from Deaths across the Divisions and the wider Trust.

During 2021/2022, 615 mortality reviews were completed in relation to the 1930 deaths. Of these 222(11.5%) were completed using the SJRPlus tool. It should be noted that NHSE/I suggest that reviewing 15-20% of all deaths using the SJRPlus should provide sufficient data to identify relevant themes and trends for learning within an organisation. The percentage of cases for review will incorporate those flagged for SJR during Medical Examiner scrutiny or through mortality screening and random sampling.

The implementation of SJR and the use of the SJRPlus system has enabled findings and outcomes to be reviewed and detailed reports to be provided to maximise the learning opportunities and improve care for all our patients.

Over the past 12 months, 2021-2022 there has been considerable improvement work carried out building on the mortality improvement targets identified in last year's Quality Account.

Improvements for 2021-2022

1. Implementation of an on-line mortality screening tool

In collaboration with clinicians, the Learning from Deaths Team have developed an online mortality screening tool to support the identification of cases by clinicians for mortality review within the Trust. In January 2022, the paper-based mortality review tool was withdrawn, and the new on-line screening tool was implemented. This has been positively received by clinicians as of the end of the 31st of March 2022 it has facilitated mortality screening for 213 deaths to compliment Medical Examiner scrutiny.

2. SJR-Plus Training

A programme of training to support clinicians to review deaths using the SJR Plus has been provided with over 40 senior clinicians attending the training in the last year, this was positively received. A series of masterclasses are planned for 2022/2023 which will provide reviewers the opportunity to refine skills and share experiences with colleagues, thereby aiming to improve the quality of mortality reviews and maximise learning opportunities. The training continues to be available from NHSE/I and future training availability in 2022/2023 is being scoped including the potential for on-line training sessions.

3. Learning from Deaths Webpage

A Learning from Deaths intranet webpage has been developed and is now available. This provides direct access to the mortality screening tool and the online SJRPlus as well as a variety of resources to support the Learning from Deaths agenda.

4. Mortality Triangulation Group

A weekly Mortality Triangulation Group was established in 2021 to provide oversight and scrutiny of all Trust deaths. Membership includes the Assistant Director of Nursing Quality Governance, the Medical Examiner Service Manager, the Corporate Learning from Deaths Leads and the Head of Legal Services, thus providing a direct link to HM Coroner's Services. The group provides oversight of deaths across the Trust and facilitates improved triangulation of cases for review, considering other reviews that may be required including patient safety and complaints, thereby maximising available learning opportunities. MTG aims to avoid duplication of reviews or investigations, ensures appropriate internal or external referral as required, and facilitates improved clarity for the bereaved. Themes and trends noted within MTG following Medical Examiner scrutiny and any additional SJRs identified via the on-line screening tool are reported to the monthly Trust Learning from Deaths group. This work will develop alongside the wider introduction of the new Patient Safety Incident Response Framework (PSIRF) in line with nationally agreed timescales.

Planned Improvements for 2022/2023

The Trust Learning from Deaths Group has continued to develop during 2021/2022, it has met monthly with the Executive Lead being the Co-Medical Director who co-chairs with the Clinical Lead for Learning from Deaths. It has established appropriate representation within the Trust and from partner provider organisations within the system.

Key priorities for 2022/2023 include:

- To establish a reporting template for the Divisional Quality Governance teams to support appropriate accountability for Learning from Deaths at Trust level and within the Division and to facilitate the dissemination of learning.

- A Learning from Deaths dashboard, is being developed and will be implemented in 2022-2023 for integration into performance reporting and monitoring. This will provide a visual picture to demonstrate transparency and context around Learning from Deaths . The Dashboard will include indicators such as number of deaths, SHMI data, hospital occupancy, number of mortality reviews, palliative care coding and depth of coding. The inclusion of Medical Examiner (ME) data will reflect the process from ME scrutiny through to SJR and a summary of learning identified through the SJRPlus.

Improvements for 2021-2022

- **Implementation of an on-line mortality screening tool**

In collaboration with clinicians, the Learning from Deaths Team have developed an online mortality screening tool to support the identification of cases by clinicians for mortality review within the Trust. In January 2022, the paper-based mortality review tool was withdrawn, and the new on-line screening tool was implemented. This has been positively received by clinicians as of the end of the 31st of March 2022 it has facilitated mortality screening for 213 deaths to compliment Medical Examiner scrutiny.

- **SJR-Plus Training**

A programme of training to support clinicians to review deaths using the SJR Plus has been provided with over 40 senior clinicians attending the training in the last year, this was positively received. A series of masterclasses are planned for 2022/2023 which will provide reviewers the opportunity to refine skills and share experiences with colleagues, thereby aiming to improve the quality of mortality reviews and maximise learning opportunities. The training continues to be available from NHSE/I and future training availability in 2022/2023 is being scoped including the potential for on-line training sessions.

- **Learning from Deaths Webpage**

A Learning from Deaths intranet webpage has been developed and is now available. This provides direct access to the mortality screening tool and the online SJRPlus as well as a variety of resources to support the Learning from Deaths agenda.

- **Mortality Triangulation Group**

A weekly Mortality Triangulation Group was established in 2021 to provide oversight and scrutiny of all Trust deaths. Membership includes the Assistant Director of Nursing Quality Governance, the Medical Examiner Service Manager, the Corporate Learning from Deaths Leads and the Head of

Legal Services, thus providing a direct link to HM Coroner's Services. The group provides oversight of deaths across the Trust and facilitates improved triangulation of cases for review, considering other reviews that may be required including patient safety and complaints, thereby maximising available learning opportunities. MTG aims to avoid duplication of reviews or investigations, ensures appropriate internal or external referral as required, and facilitates improved clarity for the bereaved. Themes and trends noted within MTG following Medical Examiner scrutiny and any additional SJRs identified via the on-line screening tool are reported to the monthly Trust Learning from Deaths group. This work will develop alongside the wider introduction of the new Patient Safety Incident Response Framework (PSIRF) in line with nationally agreed timescales.

Planned Improvements for 2022/2023

The Trust Learning from Deaths Group has continued to develop during 2021/2022, it has met monthly with the Executive Lead being the Co-Medical Director and chaired by the Clinical Lead for Mortality. It has established appropriate representation within the Trust and from partner provider organisations within the system.

Key priorities for 2022/2023 include:

- To establish a reporting template for the Divisional Quality Governance teams to support appropriate accountability for Learning from Deaths at Trust level and within the Division and to facilitate the dissemination of learning.
- A Learning from Deaths dashboard, developed by NHSE/I is being developed and will be implemented in 2022-2023 for integration into performance reporting and monitoring. This will provide a visual picture to demonstrate transparency and context around Learning from Deaths. The Dashboard will include indicators such as number of deaths, SHMI data, hospital occupancy, number of mortality reviews, palliative care coding and depth of coding. The inclusion of Medical Examiner (ME) data will reflect the process from ME scrutiny through to SJR and a summary of learning identified through the SJRPlus.

Implementing the Priority Clinical Standards for 7 Day Hospital Services

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 remains in progress.
Standard 6: Access to Consultant-directed Interventions
Interventional Radiology, discussions continue 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 was 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, a programme of work led by the Associate Medical Director has taken place with all Clinical Directors focussing on Standards 2 and 8 to establish the status of meeting these requirements for each speciality. The conclusion of this programme of work was that surgical and some Women's and Children's specialities do not have resident timetabled activity to facilitate meeting 6 hour/14-hour consultant review (Standard 2). Services delivered at both hospital sites do not have daily ward rounds for all non-derogated patients (Standard 8) during some weekdays and at weekends.

It was identified that resolution of the workforce gaps to meet Standard 2 would require limited investment and current working practice, in many incidences, means that the standard is met if not specified in job plans. Standard 8 would require a significant investment in the consultant workforce in many specialities that are duplicated across the two hospitals and the strategic developments within HTP, with single site Emergency practice, delivers this opportunity. In Women's services, as a consequence of significant investment, resident consultant presence 24 hours has delivered a significant change in working practice with the immediate availability of resident consultants.

Encouraging Staff to Speak Up

In 2021/22 Freedom to Speak Up arrangements at the Shrewsbury and Telford Hospital NHS Trust continued to mature with the Freedom to Speak Up Lead (FTSU) post now fully embedded in the organisation supported by one FTSU GuardianLGBT

. The FTSU team is supported by a network of FTSU ambassadors who promote FTSU and signpost to the Guardians. There are 39 FSTU ambassadors whose experience ranges from a variety of clinical and non-clinical backgrounds and who represent the diversity of the workforce across our Trust, they undertake these roles on a voluntary basis in addition to their substantive posts.

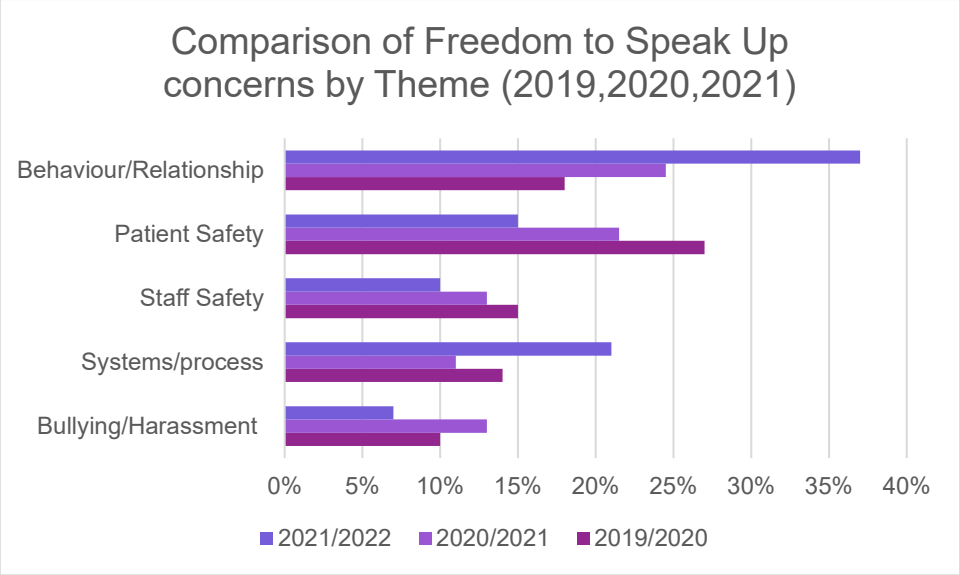
The Trust continues to ensure that staff across the organisation are enabled to speak up about their concerns. In 2021/22 the Lead Freedom to Speak Up Guardian (LFTSUG) and Guardians (FTSUG) continued with their engagement plan of raising awareness to as many teams as possible within the Trust.

In total the team have completed 858 visibility visit, team awareness sessions and drop-in sessions throughout the year as well as attending the Junior Doctor Forums; Corporate Induction; Student Inductions and Director of Nursing Band 7 Weekly meetings on a regular basis. Whilst promoting the FTSU mechanism, most importantly the FTSU team are promoting and educating colleagues on the importance of speaking up in general and highlighting the many routes available in the Trust to speak up.

In 2021/22, the FTSU team received 369 concerns, an increase of 67 concerns from the previous year, representing an increase of 22% from 2020/2021. A Year-on-Year comparator can be seen below:

	Q1	Q2	Q3	Q4	Total	Increase	National Average Increase
2021/22	100	113	90	66	**369**	↑22%	Not Yet Available
2020/21	41	82	103	78	**302**	↑109%	26%
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 2021/2022 of the concerns raised 37% to behaviours/relationships which was a significant increase from the previous year; 15% related to patient safety; 21% to systems and processes; 10% staff safety; 7% to bullying and harassment. Of those speaking up 30% were nurse, 28% were administrative/Clerical/Cleaning/Catering/Ancillary Workers) 19% were Allied Health Professionals, 8% were Healthcare Assistants, 7% midwives and 7% doctors.



In 2021/22 the FTSU team continued close working with a variety of colleagues across the Trust including the Executive Team; Non-executive directors, Senior nursing team; Staff Side; Workforce; Organisation Development; Medical staff, Guardian of Safe Working; Education Team; and Junior Doctor Forums. The Chief Executive and Director of Nursing also began a series of drop-in sessions across both the main sites to encourage staff to raise concerns and increase their visibility.

The National Guardian, Dr Henrietta Hughes attended a Board Development Day in June 2021 and Dr Chris Turner gave two masterclasses on Civility and Respect. The Trust also had a very active speak up month in October 2021.

Planned improvements for the 2022/23 include: the mandating of the new FTSU e-learning, speak up, listen up and follow up; Civility and Respect programme working with the Head of Culture and Dr Chris Turner; an Inclusion Ambassador to support colleagues from our BAME community to have their voices heard; a review of processes through the refreshed guidance published by NHSE/I and NGO gap analysis case review tool. 2022/23 will also include a refreshed Vision and Strategy postponed from the previous year to incorporate the Board review of speaking up arrangements; a policy review as per publication of the new NHSE/I guidance and triangulation of data with patient safety and HR identifying hotspots and themes more readily.

Guardian of Safe Working

The Shrewsbury and Telford Hospital NHS Trust Guardian of Safe Working (GoSW) remains a member of and regularly reports to the Medical Leadership Team which enables issues to be raised and dealt with in a timely and proactive way.

In the past year there has been a focus on:

- Supporting junior doctors in training by maintaining visibility via attendance at forums, junior doctors' induction, and at drop-in sessions.
- Continuing to champion safe working hours through regular meetings with the Medical Staffing Improvement team.

- Ensuring compliance with reporting systems as mandated in the Junior Doctor Contract to enable junior doctors to report variations in their work schedule.
- Working in collaboration with the Director of Medical Education, the education team, Supervisors and Divisions to ensure that the identified issues within exception reports, concerning both working hours and training hours, are appropriately addressed.
- Implementing an improved exception reporting reminder service to provide clinical supervisors with further guidelines on addressing reports.

2.3 Reporting against Core Quality Account Indicators

Since 2012/13 NHS Trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. These core indicators align closely with the NHS Outcomes Framework (NHSOF). The majority of core indicators are reported by financial year, e.g. from 1st April 2021 to 31st March 2022, 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.

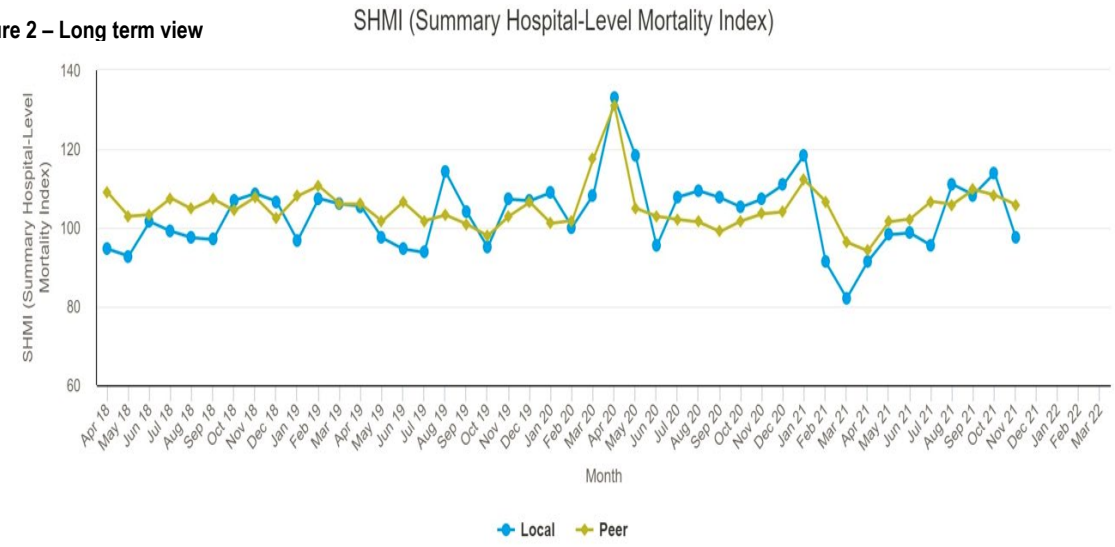
Indicator	**Summary Hospital-Level Mortality Indicator**			
Domain	**Preventing people from dying prematurely**			
SATH 2021/22	**Peer Comparator 2021/22**	**2020**	**2019**	**2018**
97.65	105.89	110.83	101.64	99.83
Data Source CHKS, Insight for Better Healthcare, HES data used against peers January 2021 to November 2021				

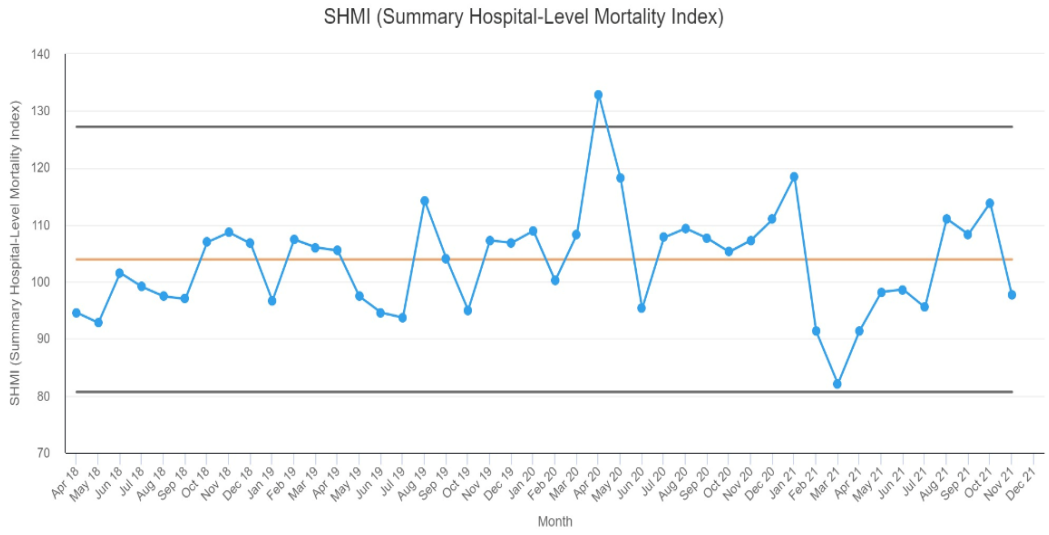
The Shrewsbury and Telford Hospital NHS Trust considers this data is as described as it is taken from a well-established national source. The SHMI data for 2021/2022 shows that the index for the Shrewsbury and Telford Hospital NHS Trust is 97.65 which is in the “as expected” banding.

The Trust's overall mortality metrics for 2021/22 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.

SHMI: SaTH vs Peer January 2021 to November 2021 November
SaTH 97.65 vs Peer 105.89

Figure 2 – Long term view





The in-hospital SHMI for the Shrewsbury and Telford Hospital NHS Trust has been generally below peer comparator up until November 2021. This is demonstrated in the short term and long-term view.

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 2020**	**SATH 2019**	**SATH 2018**
20.54%	37.3% (rolling 12 months)	70.72%%	7.73%	21.54%	23.81%	22.51%
Data Source – CHKS - FCE (Finished Consultant Episode) deaths with palliative care code Z515. Based on peer distribution Jan 2022. HES data used against Peer						

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

Patient Reported Outcome Measures (PROMs)

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

The two procedures are:

- Hip replacement
- Knee replacement

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

Indicator	Patient Reported Outcome Measures EQ 5D Index (case-mix adjusted health gain)						
Domain	**Helping people to recover from episodes of ill health or following injury**						
	SATH 2021/2022	**National Average 2021/22**	**Highest Score Trust 2020/21**	**Lowest Score Trust 2020/21**	**SATH 2020**	**SATH 2019**	**SATH 2018**
Hip Replacement	No data available	No data available	No data available	No data available	No data available	0.475	0.43
Knee Replacement	No data available	No data available	No data available	No data available	No data available	0.373	0.32
Data Source – HED. There is no data available for 2021/2022							

The Shrewsbury and Telford Hospital NHS Trust considers this data is accurate as it is taken from a national source. No data is available for 2021/2022 at 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 2021/22	**Highest Performer**	**Lowest Performer**	**SATH 2020/21**	**SATH 2019/20**	**SATH 2018/19**
0-15	13.85%	16.67%	11.93%	12.91%	13.57%	12.659
16 and over	8.53%	9.17%	7.5%	8.82%	8.44%	8.872%
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. This will link into our improvement work in 2022/2023 in relation to Priority 5: Right Care, Right Place.

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 2020/2021 are included in the Quality Account.

Indicator	Responsiveness to Inpatients' Personal Needs					
Domain	**Ensuring People have a Positive Experience of Care**					
SATH 2019/20	**National Average 2020**	**Best Performing Trust 2020**	**Worst Performing Trust 2020**	**SATH 2019**	**SATH 2018**	**SATH 2017**
72.9%	74.5%	85.4%	67.3%	62.8%	63.8%	67.1%
Data Source - NHS digital. Data set 4.2, forms part of the NHS Outcomes Framework Indicators. Patient experience measured by scoring results of a selection of questions from the National Inpatient Survey, based on the Hospital stay: 01/11/2020 to 30/11/2020, survey collected between January and May 2021 and included patients meeting the eligibility criteria and were discharged from the Trust during November 2020						

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

Following actions implemented to address concerns raised in the 2019 survey the Trust saw improvements in these aspects in the most recent survey e.g. food provision. Based on the National Inpatient Survey the Trust will continue to take action to improve the experience of patients in our care. This will include implementing actions to reduce noise at night on our wards. The Trust is recruiting patient and carer representatives to establish Speciality Patient Experience Groups to support improvement work at a local level and areas of improvement identified from the national survey will be included in these workstreams.

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 2021**	**Best Performing Trust 2021**	**Worst Performing Trust 2021**	**SATH 2020**	**SATH 2019**	**SATH 2018**
43.7%	66.9%	89.5%	43.6%	51.2%	53.5%	52.5%
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 2021.*						

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 percentage of staff who would recommend the Trust as a provider of care to their friend or family declined in 2021 by 7.5%, nationally there was also a 7.4% decline in the average for this question in the national staff survey. The Trust has continued to implemented actions to improve the quality of its staffs' experience of working at the Trust throughout 2021/2022, actions include:

In 2022/2023, key steps in relation to improvement actions include:

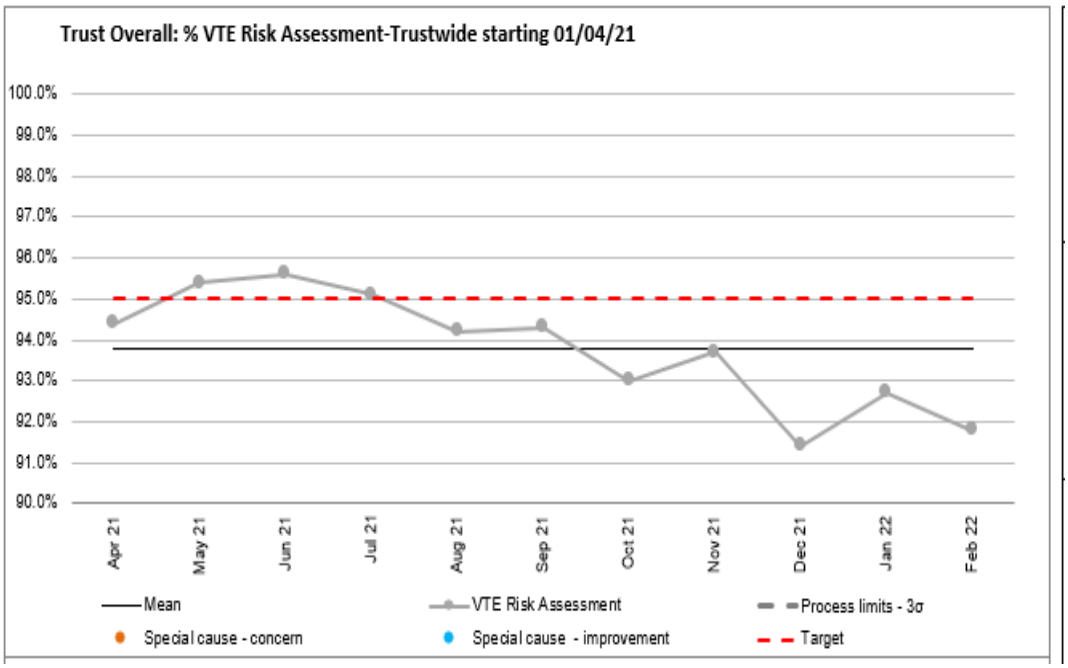
- Continue our cultural and leadership improvement journey
- Review our people plans at divisional and corporate level to ensure improvements and take action
- Complete Quarterly Pulse Survey for Staff so we can review progress and keep on track
- Work together – team based conversations

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 national submission VTE submission was paused in Quarter 4 of 2019/20 due to the COVID-19. The Trust has continued 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 2021/22	**National Average 2020/21**	**Best Performing Trust 2020/21**	**Worst Performing Trust 2020/21**	**SATH 2020/21**	**SATH 2019/20**	**SATH 2018/19**
93.8% (Until Feb 22)	No National data available	No National data available	No data available	94.5%	94% (Apr 20-Mar 21)	95.81%
Data Source - https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-2019/20 for data Apr 2018- Dec 2019. As of December 2019, the national VTE return was stopped. The Trust however reinstated the monitoring of VTE. The 2021/22 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 Trust performance for VTE has been consistently under the 95% target since August 2021. This has been due to the pressure within the system and the overwhelming numbers of patients coming into the Trust. In addition, there has been the high volumes of staff sickness due to COVID-19. The Medical Director, in collaboration with the Director of Nursing has put an action plan in place in February 2022 to improve the overall performance of VTE assessment.

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 data table below identifies the 12 month position as reported to NRLS, along with the most recent comparators.

The number and, the rate of patient safety incidents reported within the Trust during 2021/22 and the number and percentage of such patient safety incidents that resulted in severe harm or death are shown

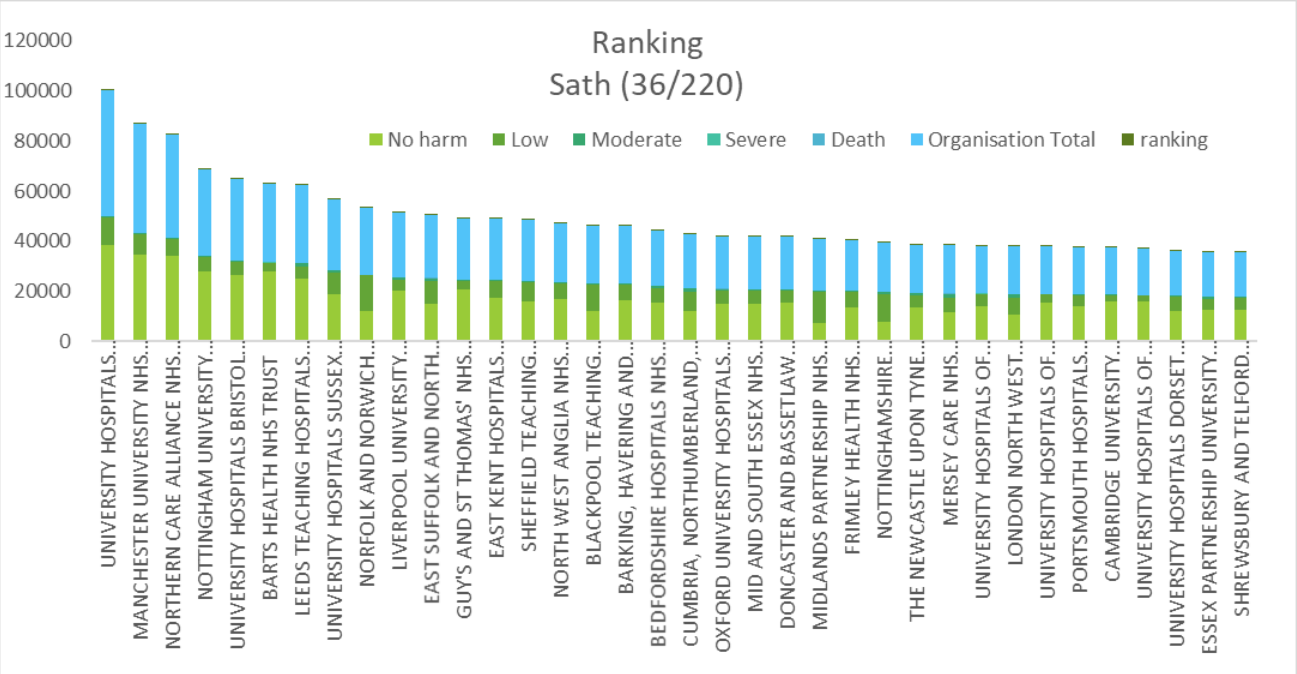
i) Rate of incidents reported per 1000 bed days
ii) Rate of incidents that resulted in severe harm or death per 1000 bed days
iii) Number of incidents resulting in severe harm or death
iv) % of severe harm or death over number of reported incidents.

Indicator	Patient safety incidents and the percentage that resulted in severe harm			
Domain	Treating and caring for people in a safe environment and protecting them from avoidable harm			
	SATH 1st April 2021-28 Feb 2022	SATH 2019/20	SATH 2018/19	SATH 2017/18
Number of Patient Safety Incidents	17802	7199	6316	4398
Rate of Patient Safety Incidents per 1000 Bed days	68.45	57.9	54.8	35.93
Percentage of Patient safety incidents which resulted in severe harm or death	0.32%	0.22	0.16	

Data Source - *For incidents occurring in England from 1 April 2021 to 28th February 2022. and were submitted to the National Reporting and Learning System (NRLS)* https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/28-february-2022/

The Shrewsbury and Telford Hospital NHS Trust considers this data to be accurate as it has been generated from the National Reporting and Learning System (NRLS). All patient safety incidents are monitored by the National Reporting and Learning System (NRLS). There is no data for this period in relation to National Average Best and Worst Performing Trusts as reporting is annual and is next due in September 2022. The graph below identifies that Shrewsbury and Telford Hospitals are ranked 36 out of 220 Trust in relation to patient safety incident reporting.

1st April 2021 to 28th February 2022.



A daily report of all incidents across the Trust is circulated to all Executive Directors and Divisional Senior Management Team and Divisional Governance Leads. All patient safety incidents reported as moderate or above are validated by the Quality Governance Teams and Senior Divisional Clinical Team/Governance Leads at the weekly Rapid Review Meeting.

Review, Action and Learning from Incident Group (RALIG) which meets weekly to scope more serious incidents and determine those which meet the Serious Incident reporting threshold based on the National Serious Incident Review Framework. RALIG also reviews and signs off completed investigations. Learning from Serious Incidents and developing a Safety Culture continues to be a Priority for 2022/23 and is discussed earlier in the report.

Rate of Clostridium Difficile

Clostridium difficile (C.difficile) is a bacterium found in the gut which can cause diarrhoea after antibiotics. The Clostridium difficile rate per 100,000 bed days for 2021/2022 is shown, this figure is based on the Trust data rather than externally validated as this was not available at the time of collating the Quality Account.

Indicator	**The rate per 100,000 bed days of Trust apportioned cases of C.Difficile Infection that have occurred 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 2021/22	SATH 2020/21	SATH2019/202	SATH 2018/19
12.6	13.64 (Trust data)	19.44	7.03
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.

The nationally agreed target set by NHSE/I for the Trust for 2021/2022 was no more than 49 cases of Clostridium Difficile, there were 33 cases in total meaning the Trust achieved this for the year.

All Clostridium Difficile cases attributed to the Trust continue to have a Root Cause Analysis (RCA) Investigation undertaken. Antibiotics usage, timely obtaining of stool samples and isolation continue to be the remain the most commonly attributed issues associated with Clostridium difficile cases and the Trust sees very few cases that suggest transmission in hospital, with only one outbreak involving 2 patients in 2021/22.

2.4 Looking forward: Our Priorities for Quality Improvement 2022/2023

There were 8 quality priorities identified and agreed for the next 2 years as part of the Quality Account published in 2021/2022. These 8 priorities were those included in the Trust Quality Strategy (2021 to 2024) which was approved by the Trust in March 2021. There are a number of key actions and success criteria included in each of these priorities. Progress in relation to these 8 priorities in 2021/2022 has been outlined in Section 2; the key actions in relation to these 8 Priorities for 2022/2023 are outlined below:

Priority 1	Learning from Events and Developing a Safety Culture

Priorities for 2022/2023

- Standardise the process for safety huddles throughout our wards and departments to share best practice to optimise how safety learning and awareness is shared
- Continue improvements in the percentages of staff responding positively to the relevant safety culture elements included in the staff survey
- Continue to embed our Quality Governance Framework within the Divisions across the Trust
- Continuing to develop new ways of communicating learning from both positive and negative incident through and through "learning from excellence".
- Implementation of the Patient Safety Incident Response Framework (PSIRF) in line with national guidance

Priority 2	The Deteriorating Patient

Priorities for 2022/2023.

- Develop a Sepsis and Deteriorating Patient Dashboard to triangulate all key performance indicators and use this to track and drive improvements across all relevant services within the Trust
  To include:
  - Compliance with NEWS 2, MEOWS and PEWS escalation criteria
  - Avoidable inpatient cardiac arrests in hours and out-of-hours
  - Compliance with the Sepsis screening and sepsis six bundle
  - Unplanned Intensive Care Unit admissions
  - Readmissions to Intensive Care Unit within 48 hours
  - Avoidable term admissions to Neonatal Unit
  - Serious Incidents linked with failing to recognise the deteriorating patient
  - Compliance with antimicrobial review within expected time frames
  - Monitoring of CHKS mortality data for AKI to ensure we are not an outlier

- Following on from the Systematic Review next steps are to take the analysis and outline potential improvement interventions and define a wider improvement plan which can be overseen by the Trust's Deteriorating Patient Committee.
- Revise deteriorating patient training to include soft signs of sepsis, deterioration competency assessments to all relevant clinical staff, develop & deliver an e-learning programme
- Further embed the use of sepsis screening tool and Sepsis Six bundle and pathway arrangements across the Trust to achieve 90% compliance in the inpatient areas
- Ensure all identified patients receive full antimicrobial review at 72 hours following prescribing of antibiotics

- Strengthen the Deteriorating Patient Membership and attendance to include all aspects of the Deteriorating patient and engage key staff in the improvements and reporting
- Work with the Clinical Lead to improve the processes, pathways, and training for AKI and DKA

Priority 3	Inpatient Falls

Priorities for Improvement in 2022/2023

Although we have made significant progress with our falls improvement work and have seen improvements in the number of patients having falls risk assessments completed, significantly improved our documentation and risk assessments pre and post fall and in the number of staff who have completed falls training we know we still have more to do:

- We still have further work to do on the principles of cohorting, this will be a main priority for 2022-23 alongside work to help prevent deconditioning. We are going to review our EPS Policy and risk assessment and plan to establish an Enhanced Patient Supervision Team in 2022/23 with enhanced training and skills to care for our most vulnerable patients across the Trust who often have cognitive impairment and are at a higher risk of falls.
- Ensure other key members of our multi-disciplinary teams who are involved in the care of patients who are at risk of falls have received falls training including doctors, physiotherapists, occupational therapists, and pharmacists.
- Continue to work to ensure all patients have a falls risk assessment completed on admission, a falls care plan in place and that care after a fall adheres to our falls procedure and best practice.

Priority 4	Best Clinical Outcomes

Priorities for Improvement in 2022/2023

- Further development of clinical standards for each speciality
- Consistently review and monitor clinical standards and identify areas for improvement through the development of speciality level Clinical Standards Dashboards and through reporting of these and a focus on delivery of improvements via Divisional performance Review Meetings
- Ensure that locally developed guidelines align to best practice and that we develop a clear governance process for sign off of Clinical Guidelines, Standard Operating Procedures and Clinical Policies
- Use our clinical audit programme as a force for sustained performance and improvement across our services aligning elements of the audit programme to these key clinical standards.
- Aim to ensure maximum use of this NICE guidance by:
    - Aim of achieving a target of 100% completion of templates within target timescales.

- Further strengthening links with Specialist Nurses to facilitate completion of benchmark assessment templates
- Review and strengthening of the process for incorporating new and updated NICE guidance into local guidelines.
- Further expansion of case-note audits of NICE guidance to provide assurance that guidance is being implemented as expected
- Review and refinement of the process for tracking, reviewing, and updating action plans arising from NICE guidance

Priority 5	Right care, right place, right time

Our ambition is to ensure patients are assessed and treated in the right place at every opportunity.

Priorities in 2022/2023 include:

- Further reviews and development of the IDT to streamline planning processes and to develop the Discharge to Assess model in 2022/23.
- Re-establish the Discharge Improvement Group chaired by the Chief Operating Office, to include system partners to drive the improvements required across many aspects of the discharge planning process co-ordinating improvements to ensure patients are discharged safely and efficiently and all appropriate treatments, medication and clinical discharge information are in place before discharge.
- Develop and implement the acute floor model of care, a Trauma Assessment Unit and Oncology Assessment Unit, facilitating treatment in the most appropriate and timely place and reducing the number of patients moved more than 2 times across wards during their stay in hospital unless clinical indicated
- Improve the provision of capacity within the Discharge Lounges including chair and beds, on both hospital sites to enable
- Further develop weekend working to improve discharges including the establishment of Criteria Led Discharge.

Priority 6	Learning from Experience

Priorities for 2022/2023:

- Develop and implement a Patient Engagement Strategy, creating more ways for patients to share their experiences
- Establish a Complaints Peer Review Panel. Feedback received from stakeholders during a review identified the need for transparency and challenge to attain confidence in the complaints process. A Complaints Peer Review Panel will be established to independently review a random selection of closed complaints each quarter, providing greater governance and assurance.
- Redesign the patient complaint process to:

  - Further improve the timeliness of responses with close working with Divisions to support timely investigations.
  - Adopt the framework used in relation to the serious incident management process where actions and learning are tracked through the Datix management system and reported and shared with Divisions to ensure shared learning.
- Develop and implement improvement plans in response to patient surveys and feedback (See National Survey Section)
- Increase the prominence of patient stories at key committees or training opportunities across the organisation.

Priority 7	Vulnerable Patients

Priorities for 2022/2023

- Ongoing work to achieve our safeguarding training compliance across all disciplines. Divisional trajectories for compliance to be ongoing agenda item at Safeguarding Operational Group through Divisional reporting and action plans.
- Improve compliance with Dementia screening to ensure all patients over 75 are screened on admission
- Develop a Mental Health Patient Charter
- Develop a Learning Disabilities Charter
- Deliver the Trust's Dementia Strategy and the Dementia Friendly Hospital Charter
- Recommence Patient-led assessments of environment (PLACE) and improve scores relating to Dementia-friendly environments and create Dementia friendly areas with secure, safe, comfortable, social, and therapeutic environments
- Continue to regularly audit the quality of the care provided to patients with mental health issues (including risk assessments, restrictive interventions and application of the Mental Health Act), care of patients learning disabilities and dementia to ensure patients receive safe, dignified, person centred care.

Priority 8	End of Life Care

Priorities for 2022/2023

- Continue to refine the PEoLC Dashboard to enable ongoing monitoring of key performance indicators and use this to report monthly to the PEoLC Steering Group to drive improvements
- Audit the new EOLC plan for the last days of life to provide assurance in relation to clear conversations have taken place with the patient and documentation of preferred place of care.
- Improve the percentage of patients who are in the last days of life and are cared for on the end-of-life care plan.
- Reduce the number of complaints relating to end of life care.
- Continue to use bereavement feedback data to inform our improvement actions
- Improve the results from the Annual Palliative Care Survey

- Continue to deliver and improve compliance with PEOLC training for all staff including revising the medical statutory PEOLC training
- Establish a task and finish group in the Trust to improve internal processes in relation to the Fast Track EOLC and contribute to the System Fast Track Improvement work.

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 2021/22	**National Average 2021/22**	**Best Trust 2021/22**	**Worst Trust 2021/22**	**2020/21**	**2019/20**	**2018/19**
Maximum time of 18 weeks from referral to treatment in aggregate-patients on an incomplete pathway	58.1%	64.67%	86.68%	41.3%	56.1%	75.73%	89.25%
All cancers- maximum 62 day wait for 1st treatment from urgent GP referral for suspected cancer	62.4%	62.88%	89.93%	29.49%	75.1%	73.34%	70.85%
Maximum 6 week wait for diagnostic procedure	58.25%	79.46%	99.34%	36.53%	71.8%	77.57%	99.88%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	47.5%	58.9%	83.9%	31.40%	73.4%	73.5%	71.1%
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 2021/2022 due to the COVID-19 pandemic and the requirement to maintain “high risk” pathways within the Emergency Departments. There was also challenges in relation to the safe discharge of patients from our care due to the impact of Covid-19 on community and social care provision which led to delayed discharges.

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 2021/2022 although there was a small improvement compared to the previous year. The COVID-19 pandemic has continued to have a significant impact on elective activity throughout 2021/2022. 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 2022/2023.

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

Performance against this target in 2021/2021 remained below the national target but the trust performance was similar to the national average. The Trust has continued to work with its partners across the region to ensure that suspected and diagnosed cancer patients were priorities in relation to received their treatment in a timely and safe way throughout the pandemic.

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 Divisional Senior management team take an active role in the management of these alerts within their services. Any alerts which fail to close within the specific deadline are reported to the Quality Operational Committee with an explanation as to why the deadline was missed and revised timescale for completion.

During 2021/2022 the Trust received ten patient safety alerts. None breached their due date.

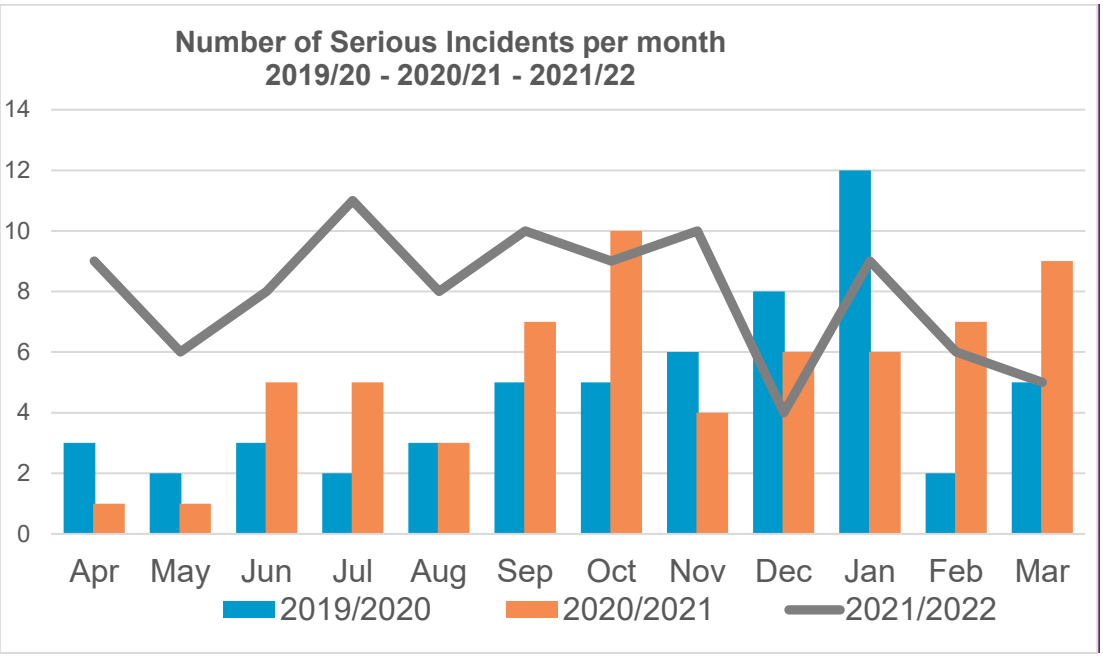
Alert Identifier		Alert Title	Issue Date	Closure Target Date	Date Closed	Open/ Closed
NatPSA/2021/002/NHSPS		Urgent assessment/treatment following ingestion of 'super strong' magnets	20/05/2021	19/08/2021	16/08/2021	Closed
NatPSA/2021/003/NHSPS		Eliminating the risk of inadvertent connection to medical air via a flowmeter	18/06/2021	16/11/2021	15/10/2021	Closed
NatPSA/2021/004/MHRA		Recall of Co-codamol Effervescent Tablets, Batch 1K10121 Zentiva Pharma UK Ltd due to precautionary risk of causing overdose	16/06/2021	21/06/2021	21/06/2021	Closed
NatPSA/2021/005/MHRA		Philips ventilator, CPAP and BiPAP devices: Potential for patient harm due to inhalation of particles and volatile organic compounds	23/06/2021	21/02/2022	28/06/2021	Closed
NatPSA/2021/006/NHSPS		Inappropriate anticoagulation of patients with a mechanical heart valve	15/07/2021	28/07/2021	27/07/2021	Closed
NatPSA/2021/007/PHE		Potent synthetic opioids implicated in increase in drug overdoses	20/08/2021	20/08/2021	20/08/2021	Closed
NatPSA/2021/008/NHSPS		Elimination of bottles of liquefied phenol 80%	26/08/2021	25/02/2022	29/10/2021	Closed
NatPSA/2021/009/NHSPS		Infection risk when using FFP3 respirators with valves or Powered Air Purifying Respirators (PAPRs) during surgical and invasive procedures	26/08/2021	25/11/2021	25/11/2021	Closed

NatPSA/2021/010/UKHSA		The safe use of ultrasound gel to reduce infection risk	14/11/2021	31/01/2022	01/02/2022	Closed
NatPSA/2022/001/UKHSA		Potential contamination of Alimentum and Elecare infant formula food products	07/03/2022	11/03/2022	28/03/2022	Closed

Serious Incidents

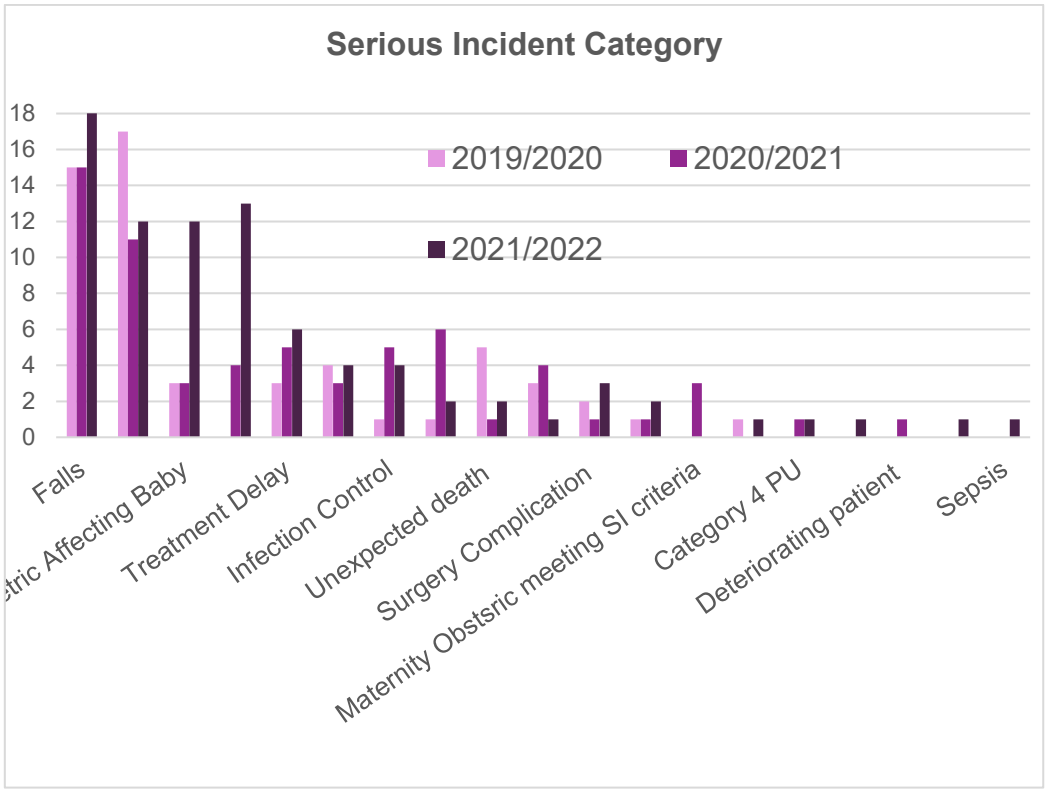
All patient safety incidents are reported on the hospital electronic incident management system (Datix). All patient safety incidents are reported, monitored and reviewed to identify learning that will help prevent reoccurrence. During 2021/2022 the Trust saw an increase in the number of serious incidents reported compared to previous years, this may demonstrate that staff have increased confidence to report incidents and concerns. In 2021/22 we were in the top quartile of reporting organisations as measured by the National Reporting and Learning System data.

Review, Action and Learning from Incidents Group (RALIG) is now well embedded and is Chaired by the Medical Director this multidisciplinary group meets weekly to review all incidents which potentially meet the threshold for an SI or Never Event and make the decision in relation to the level of investigation and the reporting of the incident as a SI. Falls, Pressure Ulcers and Hospital Acquired Infection serious incidents are reviewed at the Nursing Incident Quality Assurance Meeting (NIQAM), with cross Divisional representation, which is Chaired by the Deputy Director of Nursing.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/2020	3	2	3	2	3	5	5	6	8	12	2	5	56
2020/2021	1	1	5	5	3	7	10	4	6	6	7	9	64
2021/2022	9	6	8	11	8	10	9	10	4	9	6	5	95

*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 Incident Management Overview Report. In 2021/2022 the Trust saw an increase in the number of incidents reported as Serious Incidents, with 95 SIs reported compared to 64 in 2010/21 and 56 in 2019/20.



Never Events 2021/2022

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. In 2021/2022 the Shrewsbury and Telford Hospital NHS Trust had 1 incident 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 1 incident. 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 2021/22	National Average 2021/22	Best Performing Trust 2021/22	Worst Performing Trust 2021/22
1	2.7	1	10
Date	**Description of Never Events 2021/22 at SATH**		
20/09/2021	Wrong Site Surgery		

Learning from the Never Events in 2021/2022 included:

- Marking of all sites as per current NatSSIPs and Trust policies to be implemented immediately.
- Electronic booking forms
- Ensure that all bookings are checked prior to transcribing onto any theatre list

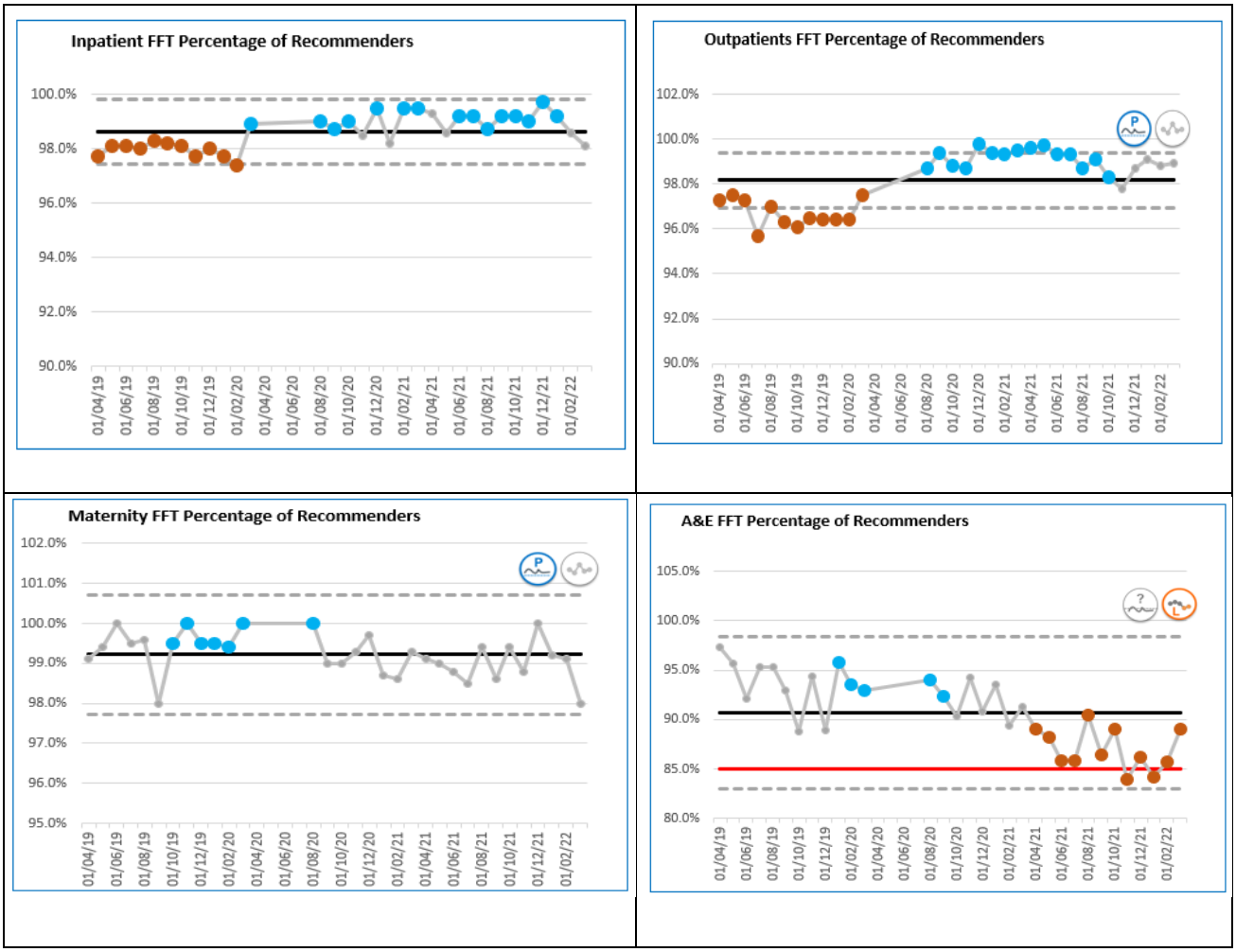
Friends and Family Test

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: ***'Thinking about [the area accessed], overall how was your experience of our service?'***

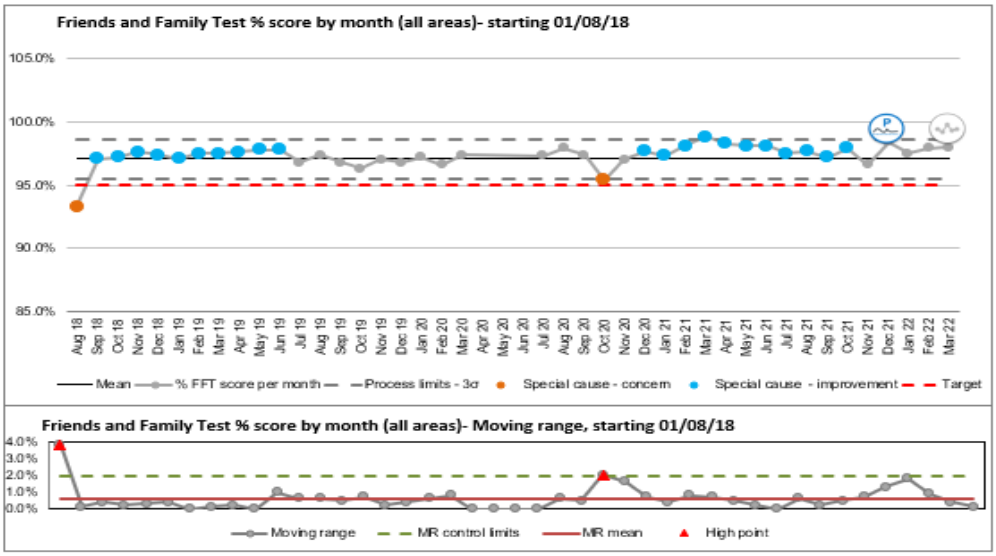
A total of 46,075 Friends and Family Test cards were completed and returned during 2021/22, this was an increase from the previous year when reporting paused due to Covid-19 in 2020/21 (29,359 responses), and in-comparison to 2019/20 when 43,094 Friends and Family Test cards were completed and returned. Whilst national reporting of the response rate ceased from 1st April 2020, the Trust has continued to monitor response rate by Ward / Department closely to provide assurance that patients are being provided with an opportunity to provide feedback on their experience. The FFT response rates across the Trust were lower in 2021/2022 in comparison to the previous year in inpatient areas at 13.8% (reduction of 1.2%), A&E at 3.4% (reduction of 11.2%) and in Maternity (birth only) at 13.6% (reduction of 10.2%). Friends and Family feedback can be provided through completion of paper cards, through volunteer collection by telephone within A&E, and feedback can also be provided via the Trust website. Improving the response rate remains a priority for the Trust to ensure that people accessing services are provided with an opportunity to feedback on their experience. To improve our response rates we are :

- Introduction of a QR code, implemented across the organisation displayed on posters
- Inclusion of QR code on patient discharge summaries
- Exploring implementation of a text-messaging system
- Electronic devices for patients to record feedback rather than paper copies
- Explore use of volunteers to support patients with completion



The overall combined Friends and Family Scores for all areas has consistently remained above the 95% target throughout 2021/22.

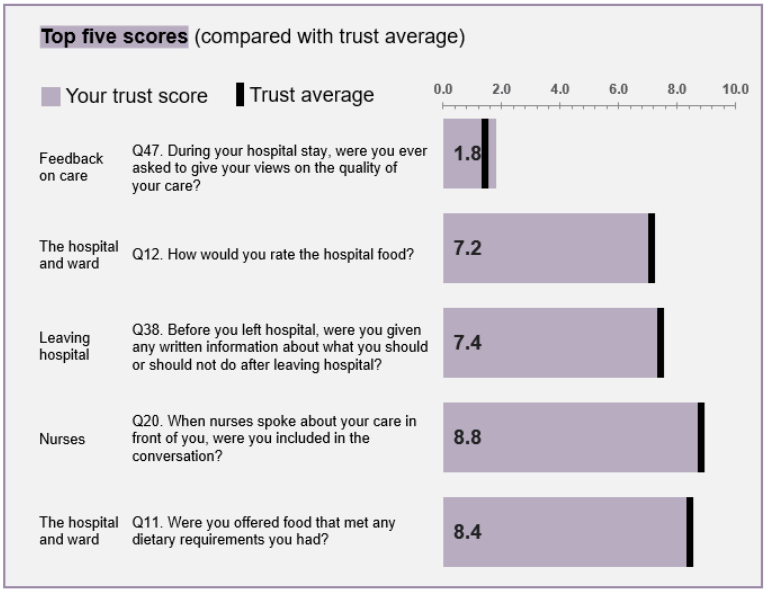
Of the Friends and Family Tests completed, 97.8% of respondents said they would be ‘’extremely likely’’ or ‘’likely’’ to recommend the Trust’s services to their family and friends, demonstrating an increase compared to 2020/21 (97.2%) and 2019/20 (97.1%).

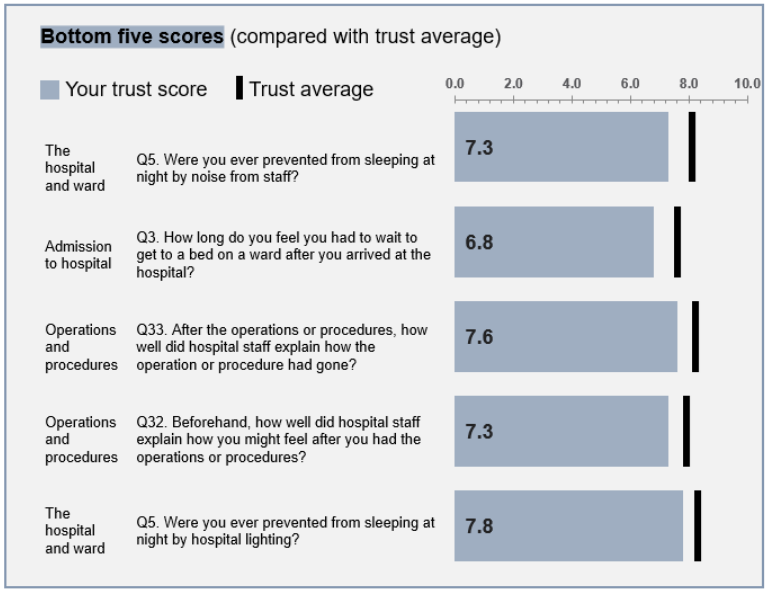


National Inpatient Survey

The National Adult Inpatient Survey was undertaken between January and May 2021 and included patients meeting the eligibility criteria and were discharged from the Trust during November 2020. The survey was significantly different to previous years due to methodology, the month of data collection, and questions used. The 2020 inpatient results are therefore not comparable with previous results.

The Trust had a response rate of 43%, which was 3% below the national average; and, performed 'about the same' as other Trusts for the majority (42) of questions. One question scored somewhat worse than expected and two questions scored worse than expected, no questions scored much worse than expected.





The questions in which the Trust scored higher and lower compared to the national average are listed in the table above. Whilst the data can not be directly compared to the previous year, in 2019 the Trust scored low in questions about food, and in 2020 questions relating to food were in the higher scores, suggesting a positive impact in response to the improvement work undertaken in food provision across the Trust.

The questions relating to operations and procedures (Q. 32 and 33) are new to the inpatient survey and will provide direction for focused improvement work. Noise at night from staff and hospital lighting at night were identified as a barrier to sleep. The Trust is recruiting patient and carer representatives to establish Speciality Patient Experience Groups to support improvement work at a local level. Areas identified within the survey results will be a focus for initial improvement work.

National Maternity Survey

The National Maternity Survey was undertaken between April and August 2021 and included women meeting the eligibility criteria who had a live birth in February 2021.

The Trust had a response rate of 62.22%, which was 10.22% above the national average. The Trust performed 'about the same' as other Trusts for the majority (40) of questions and no questions scored

worse than expected. The Trust scored 'much better' than most Trusts for 1 question, 'better' than most Trusts for 6 questions and 'somewhat better' than most Trusts for 3 questions.

		2021	2019	2021 Band
Section 4: Your labour and birth				
Q. C3	At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	9.2	9.2	Better
Q. C4	During your labour, did staff help to create a more comfortable atmosphere for you in a way you wanted?	8.0	8.2	Somewhat better
Q. C10	Were you involved in the decision to be induced?	9.0		Better
Section 5: Staff caring for you				
Q. C18	Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	8.5	7.6	Somewhat better
Q. C19	If you raised a concern during labour and birth, did you feel that it was taken seriously?	9.1	9.2	Better
Q. C20	During labour and birth, were you able to get a member of staff to help you when you needed it?	9.5	9.2	Much better
Section 6: Care in hospital after birth				
Q. D2	On the day you left hospital, was your discharge delayed for any reason?	7.8	6.8	Better
Q. D4	If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you when you needed it?	8.4	8.3	Somewhat better
Q. D8	Thinking about your stay in hospital, how clean was the hospital room or ward you were in?	9.6	9.4	Better
Section 8: Care at home after the birth				
Q. F3	If you contacted a midwifery or health visiting team, were you given the help you needed?	9.0	9.1	Better

National Cancer Patient Experience Survey

The National Cancer Patient Experience Survey was undertaken between April and June 2021 and included patients meeting the eligibility criteria who had an inpatient episode or day case attendance for cancer related treatment in the months of April, May and June 2021. The survey was voluntary due to Covid-19 and only 55 Trusts took part.

The Trust had a response rate of 63%, which was 4% above the national average. Patients receiving care and treatment for cancer within the Trust during 2020 gave an overall score of 8.7 out of 10 for their experience of care, consistent with the previous year (8.8). 6 of the 7 Cancer Dashboard questions directly related to patient care within the Trust scored 79% or higher. There were 3 questions with a statistically significant difference between 2019 and 2020, these are identified in the table below.

		2020	2019
Support for people with cancer			
Q. 22	Hospital staff gave information about support or self-help groups for people with cancer	85%	91%
Operations			
Q. 27	Beforehand, patient had all the information needed about the operation	93%	97%
Your overall NHS care			
Q. 60	Someone discussed with patient whether they would like to take part in cancer research	19%	27%

The Living With and Beyond Cancer Team have created a programme of initiatives to enable and empower people affected by cancer throughout their treatment and beyond. Codeveloping tools to support self-management and resources available through an online platform, providing information to support people in active management and recovery.

Comparing the Trust overall scores between 2016 to 2020 identified 3 questions that demonstrate a statistically significant difference in the table below. The one area identifying a decline relates to General Practice staff.

		2016	2017	2018	2019	2020	Change
Clinical Nurse Specialist (CNS)							
Q. 19	Patient given the name of a CNS who would support them through their treatment	91%	89%	92%	92%	95%	Better
Care from your General Practice							
Q. 55	General practice staff definitely did everything they could to support patient during treatment	63%	66%	63%	58%	52%	Worse
Your overall NHS care							
Q. 59	Patient felt length of time for attending clinics and appointments for cancer was about right	68%	80%	74%	76%	81%	Better

Ockenden Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust

The “Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospital NHS Trust” was published in December 2020. The report set out the emerging findings and recommendations following a review of 250 maternity cases at the Trust. Following this publication the Trust confirmed its commitment to rectifying the weaknesses identified in the review and set out how it intended to hold itself to account and monitor its progress in implementing the recommendations. In order to provide transparency and the opportunity for more public engagement, the Ockenden Report Assurance Committee was established and held its first monthly meeting in March 2021, considering progress against the recommendations and actions, in more detail. Each of the meetings of the Committee has been livestreamed in public and, to date, it has met on ten occasions. At the time of writing, 45 (86%) of the actions from the first report had been implemented, those actions outstanding are in progress and have external dependencies.

The final report of the independent review of maternity services at the Trust was published on the 30th March 2022. The report outlined repeated failures in the quality of care and governance at the Trust throughout the last two decades. The review finds included: there not being enough staff, a lack of ongoing training, a lack of investigation and governance at the Trust and a culture of not listening mothers, families or staff. It outlined 15 immediate and essential actions (IEA’s) to improve maternity services across England as well as over 66 local actions for learning for Shrewsbury and Telford Hospital NHS Trust. Throughout 2022/2023 the Trust will continue its commitment to implement all actions to ensure these improvements are achieved.

Pressure Ulcers

In 2021/2022 the number of pressure ulcers reported for the Shrewsbury and Telford Hospital NHS Trust remained similar to the previous year.

Hospital Acquired Pressure Ulcers	2021/22	2020/21	2019/20	2018/1
Total	**162**	**169**	**206**	**182**

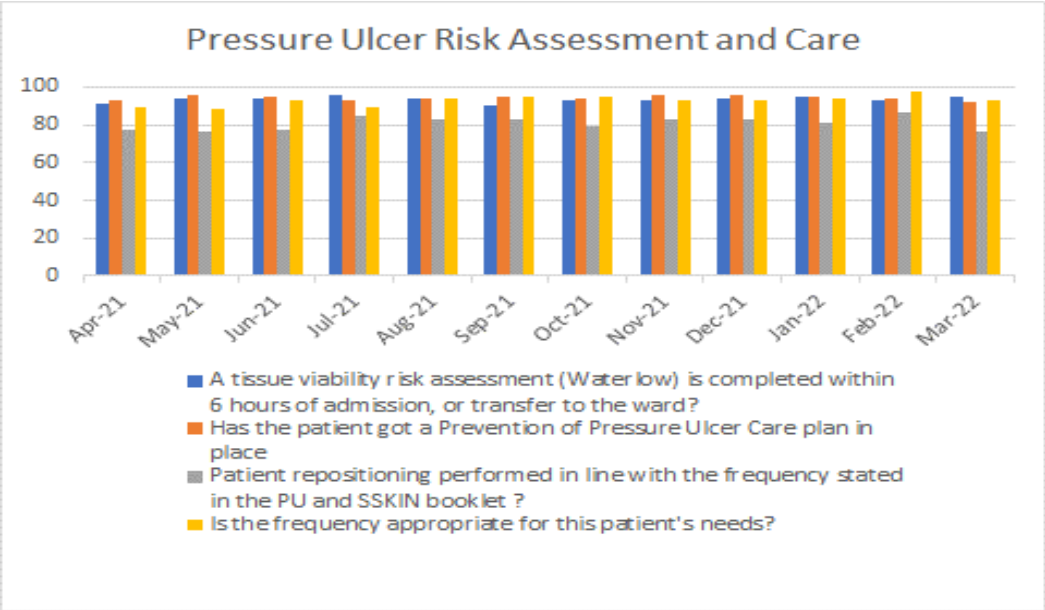
**Data taken from the Integrated Performance Report*

Summary of some of the improvement actions 2021/2022:

- Mandatory Tissue Viability Training for all Registered Nurse was implemented in 2021
- New documentation roll out in January 2022 with images of pressure ulcers and categories to help guide staff in their assessments
- Rolling annual Tissue Viability Link Nurse competency programme in place for 2022
- All category 2 or above pressure ulcers continue to have an investigation undertaken by the senior nursing team and are presented at the Pressure Ulcer Panels or NIQAM if these were reported as a serious incident.
  Common themes from these investigations include:

    - Completion of Skin assessments on admission
    - Skin assessments being completed throughout the patient's episode of care
    - Completion of MUST nutritional assessments
    - Timely requesting of pressure relieving equipment
    - Accurate categorisation of the level of pressure damage
    - Adherence to planned re-positioning regimes

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.



Infection Prevention and Control

Health Care Associated Infections (HCAI) Performance

The reduction of healthcare associated infections (HCAIs) remained a key priority for the Trust throughout 2021/2022.The Shrewsbury and Telford Hospital NHS Trust achieved all nationally set HCAI targets in 2021/2022 with the exception of MRSA.

Health Care Associated Infection	Number of Cases 2021/2022	Number of Cases 2020/2021	Number of Cases 2019/2020	Target
Methicillin Resistant Staphylococcus aureus (MRSA)	1 ↓	2 ↑	1	0
Clostridium Difficile	33 ↑	30 ↓	54	49
Methicillin Sensitive Staphylococcus Aureus (MSSA)	28 ↔	28 ↓	30	No Target
Pseudomonas aeruginosa	6 ↑	3 ↓	8	10
Escherichia Coli bacteraemia	49 ↑	36 ↓	51	122
Klebsiella bacteraemia	12 ↓	14 ↓	19	24

IPC NHSE/I REVIEW

Overall the Trust was rated as Green for infection prevention and control as an outcome of the NHSE/I visit in July 2021. Following a further visit in January 2022 the Trust retained its green status. It was noted that the culture in the organization felt different; more energized (even in a pandemic) and a strong belief in what they had undertaken to benefit patients and provide effective Infection Prevention and Control.

Section 4: Statements from External Organisations

1. HealthWatch Shropshire

"Healthwatch Shropshire were pleased to be invited in good time to provide a response to the Quality Account however due to unforeseen circumstances we did not have staff capacity to do so."

Kind Regards
Brian

Brian Rapson
Information Officer
healthwatch Shropshire

2. HealthWatch Telford

Many thanks for sending the Quality account to Healthwatch Telford and Wrekin

I have been asked by my colleagues to reply and thank all staff at Sath for the report which demonstrates the vast amount of work undertaken in a very difficult and Challenging year. We are grateful for the Quality of work undertaken often in very demanding circumstances and our thanks go out to all for the levels of professionalism displayed by staff.

We hope that the forthcoming year is less stressful and gives us the opportunity to work closely with you as we the move towards Integrated Care Services.

Kind Regards,
Barry Parnaby

Chair of Healthwatch Telford and Wrekin Board

healthwatch Telford and Wrekin

Meeting Point House | Southwater Square | TELFORD | TF3 4HS
Office Tel: 01952 739 540 Tel: 07399 296 532
Tel: 07939 986 926 | Web: www.healthwatchtelfordandwrekin.co.uk
E-mail: barry.parnaby@healthwatchtelfordandwrekin.co.uk
Twitter: @HealthwatchT_W | Facebook: HealthwatchTW
Instagram: @healthwatchtelfordandwrekin

3. Shropshire, Telford & Wrekin Clinical Commissioning Group

Date: 24th June 2022

NHS Shropshire, Telford and Wrekin CCG response to SaTH Quality Account for 2021/22

NHS 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 2021/22. The CCG remains committed to ensuring, with partner organisations, that the services it commissions provide the highest of standards in respect to clinical quality, effectiveness, patient safety and patient experience.

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. This is 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 ongoing challenges the Covid-19 pandemic has created during 2021/22 and acknowledge and commend the actions and contribution of the workforce during this difficult period of time.

In the Quality Account for 2020/21, the Trust set out eight priorities as part of the 'Getting to Good' programme's Quality Strategy. The 'Getting to Good' programme aims to support the Trust to progress towards an improved CQC rating and the Quality Strategy will span 3 years as it is recognised that key elements cannot be implemented within the first year.

The CCG acknowledge the eight priorities cover 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 2021/22. The Trust have highlighted their improvements in the eight priority areas and identified further work that is required to be carried out;

- During 2021/22 there was an increase in serious incidents reported at the Trust, with 95 reported in comparison to 64 the previous year, which could reflect a change in culture and

confidence amongst staff to report incidents and concerns however, reports are closely monitored for learning opportunities and themes. There was 1 Never Event, a reduction from 3 reported the previous year.

- There is good compliance with the sepsis screening on admission to the Emergency Department but there is further work to do on the inpatient wards to achieve 90% with patients identified as requiring antibiotics receiving them within 60 minutes.
- Despite some improvement in compliance with falls training and risk assessment documentation, there has been no reduction in falls, falls per 1000 bed days or in the number of falls which resulted in significant harm.
- 80% of patients who are being discharged have left their bedded area by 5pm but only 30% by 12 noon. The Trust have identified there is more work to do in relation to the capacity within the discharge lounge, particularly at PRH. This remains a key action for 2022/23.
- There was a 17% increase in the number of complaints, but this could be attributed to the significant reduction in activity during the period 2020/21 due to the Covid-19 pandemic. 74% of complaints were responded to within the agreed timeframe, and further improvement work is planned during 2022/23 to focus on more timely responses, reporting and analysis as well as follow up and monitoring of actions to align with the processes in place for serious incidents.
- There has been work to improve the quality of life and support the Trust offers to vulnerable patients, including patients with mental health conditions, patients with safeguarding needs, learning disabilities and dementia. Although compliance with training across Adult Safeguarding, Mental Capacity Act and Deprivation of Liberties remains below 90%, it was positive to note the appointment of a dedicated Safeguarding Trainer in 2021 to expand the provision of safeguarding training across the Trust.
- The Palliative and End of Life Care Team's overarching improvement plan to address all aspects
  of service improvement was implemented in 2021, in response to concerns raised from regulators in inspections. The PEoLC Strategy is ongoing and will be reviewed next year but Quality Metrics Audits show good compliance with monitored aspects of end of life care and training both on the wards and within the Emergency and Critical Care settings.

Whilst reviewing the Quality Account we were pleased to note many of the specific actions that the Trust has taken during 2021/22 to improve its services and the quality of care that it provides. The Trust has worked hard to address key areas to improve patient safety and has continued to strengthen learning from incidents, complaints, and feedback. The CCG would like to commend the trust for the following key achievements achieved during 2021/22:

- The Trust was inspected again by the Care Quality Commission in July 2021 and the report published in November 2021. Although the overall CQC rating did not change and remains

'inadequate', improvements were seen across Medicine and Urgent & Emergency Care. No enforcement action was taken against the Trust following the July 2021 inspection.

- A review of conditions in place against the Trust was undertaken in February 2022 and of the 60 in place, only 5 remain now.
- The development of overarching prevention plans for falls and pressure ulcers based on themes from near misses and no harm events, overseen by the newly created Quality Governance Team.
- The overall combined Friends and Family Scores for all areas has remained above the 95% target, with 97.8% of respondents being 'extremely likely' or 'likely' to recommend the Trust to their family and friends. This continues a trend of improvement since 2019/20.
- Achieving and retaining a 'green' rating for infection prevention and control form NHSE/I in July 2021 and January 2022.

There are notable areas of success as well as areas that continue to require focus and improvement and 2022/23 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 the population of Shropshire Telford and Wrekin in the healthcare they receive with the support of the Integrated Care System.

Jenny O'Connor

Senior Quality Lead

NHS Shropshire, Telford and Wrekin Clinical Commissioning Group

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