The Shrewsbury and Telford Hospital NHS Trust

BOARD OF DIRECTORS' MEETING IN PUBLIC

Thursday 14 July 2022

SUPPLEMENTARY INFORMATION PACK

Containing additional information for agenda items

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

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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

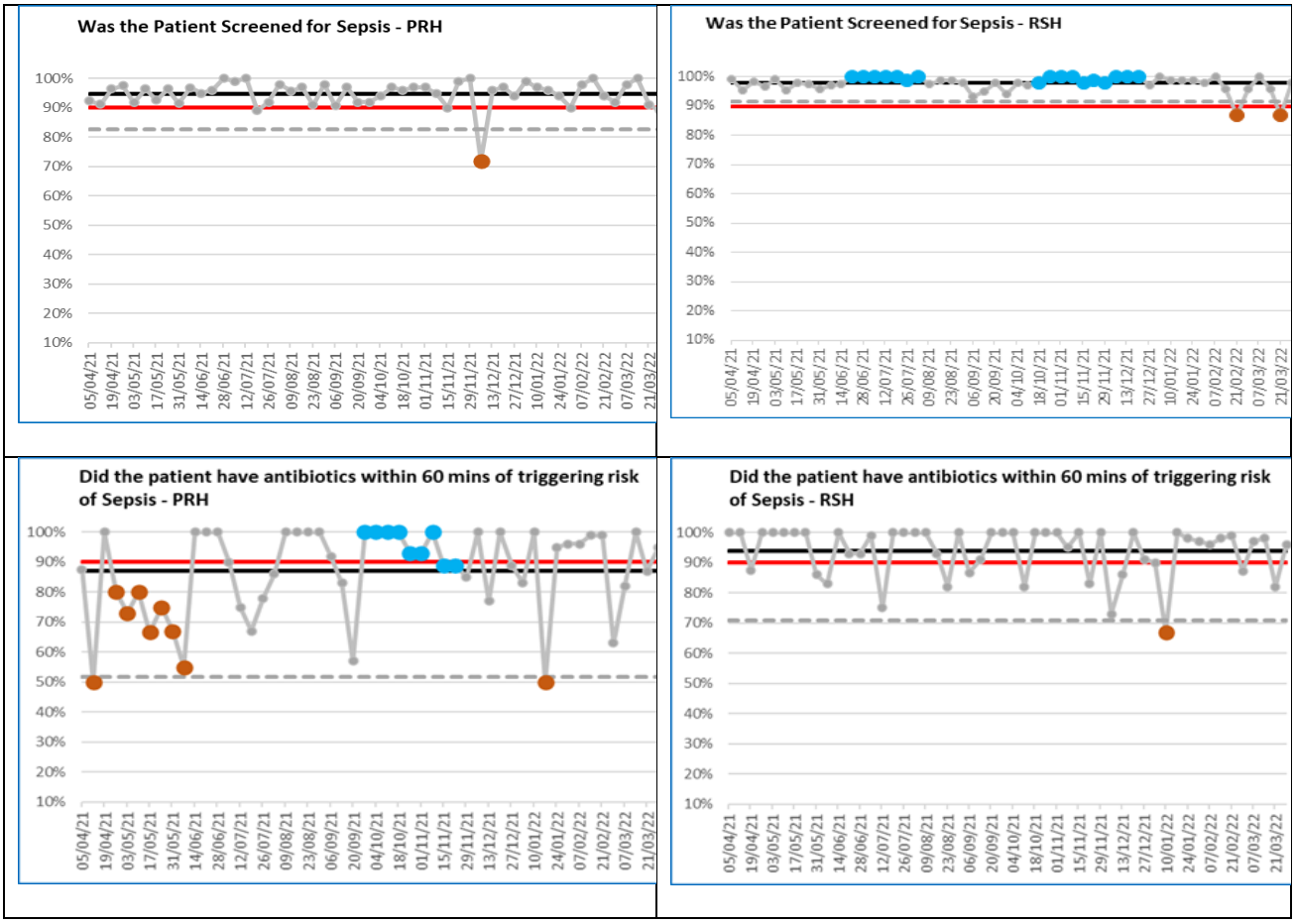
For this priority we aim to **r**ecognise deteriorating patients at the earliest opportunity and identify the most appropriate course of treatment for them to give them the best possible outcome we can. This includes identifying all aspects of deterioration and treating sepsis and Acute Kidney Injury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

What have we achieved in 2021/2022?

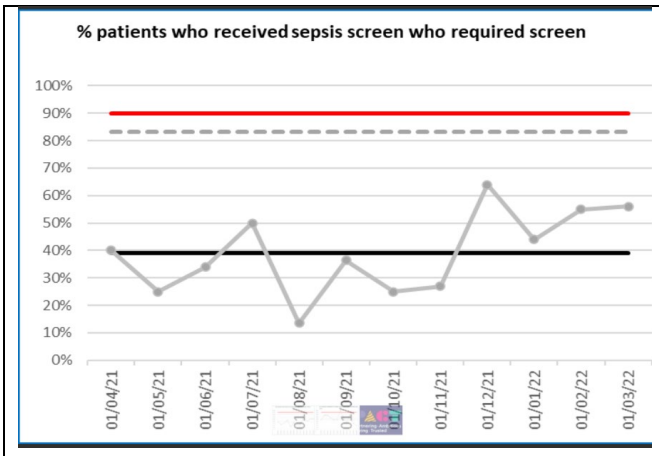
- **Further embed the use of sepsis screening tool and Sepsis Six bundle and pathway arrangements across the Trust**

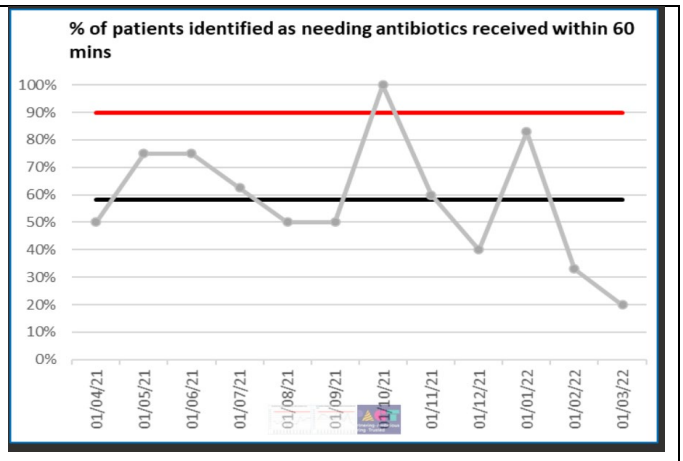
We continue to monitor sepsis screening compliance across our Emergency Departments and inpatient wards.

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

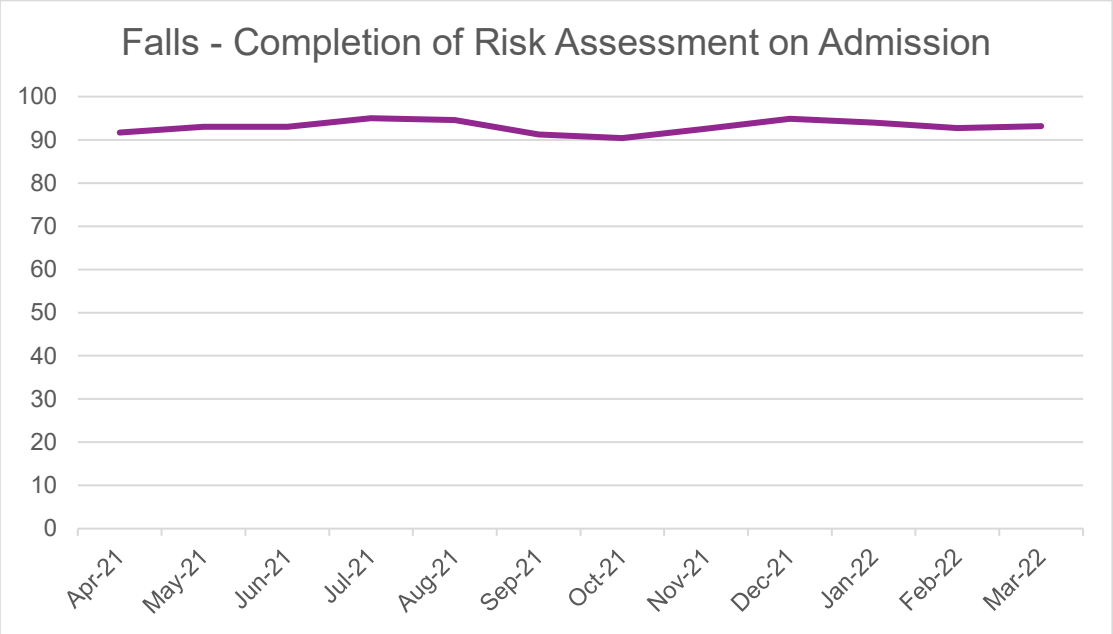
Priority 3: Inpatient Falls

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.

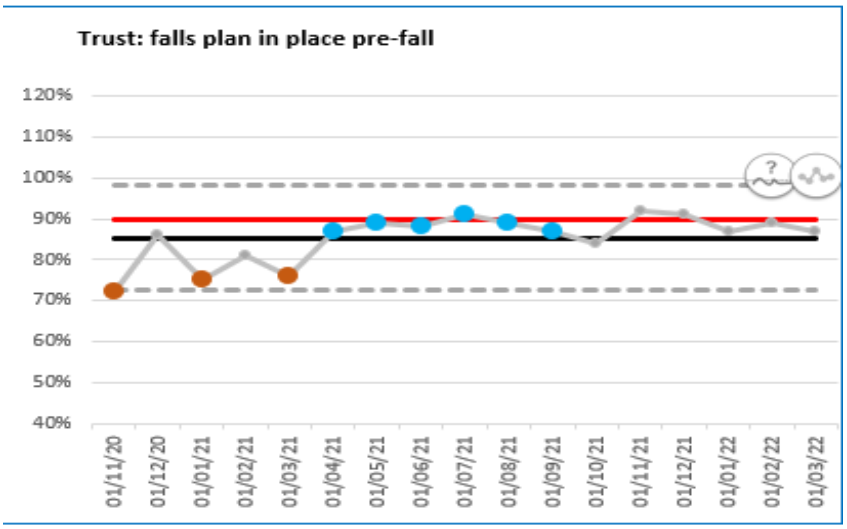
What have we achieved?

- 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

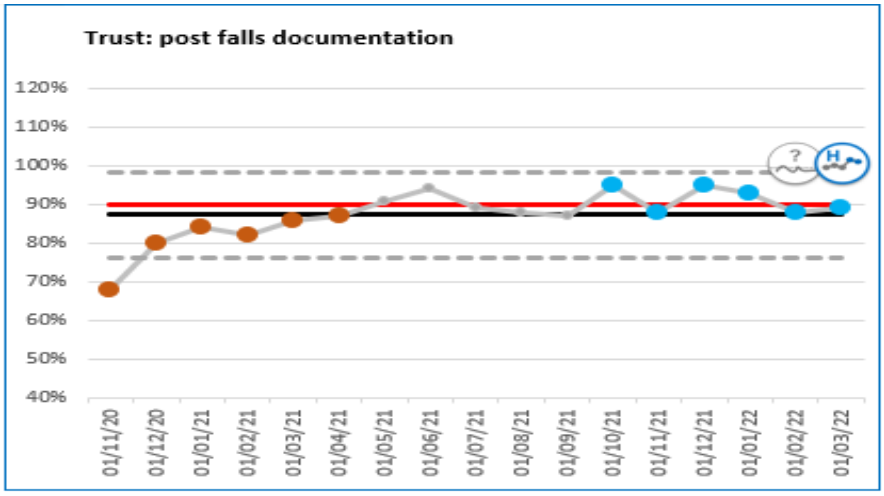
  In 2021/22 93% of patients admitted to the Trust had a falls risk assessment completed on admission.



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).

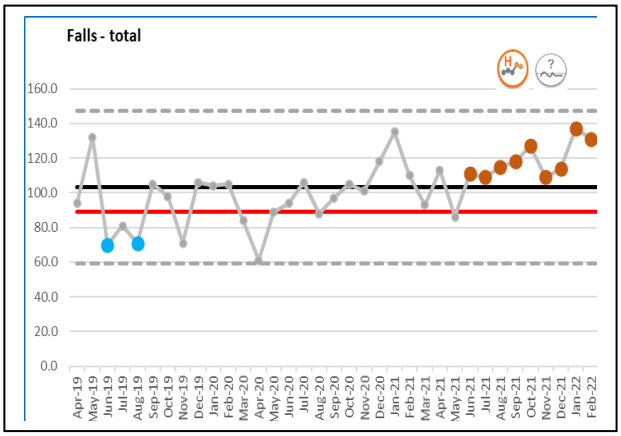
- The falls prevention plan has been further extended to include a number of workstreams aimed to prevent falls and ensure that all staff within the trust 'think falls'
- The quality team continue to review any patient that has fallen in the Trust, a feedback letter is provided to the individual staff 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

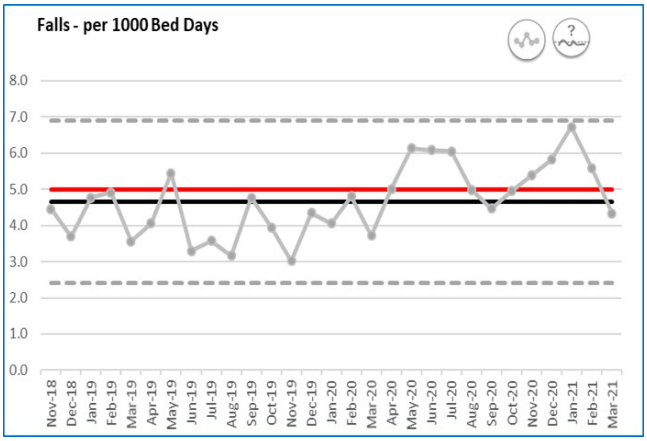
How will we know if we have succeeded?

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.

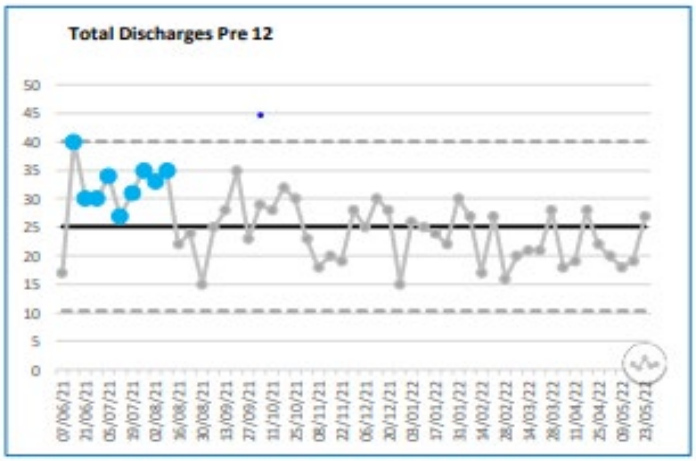
- **Improve communication for handover and transfers of care throughout the Trust**

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.

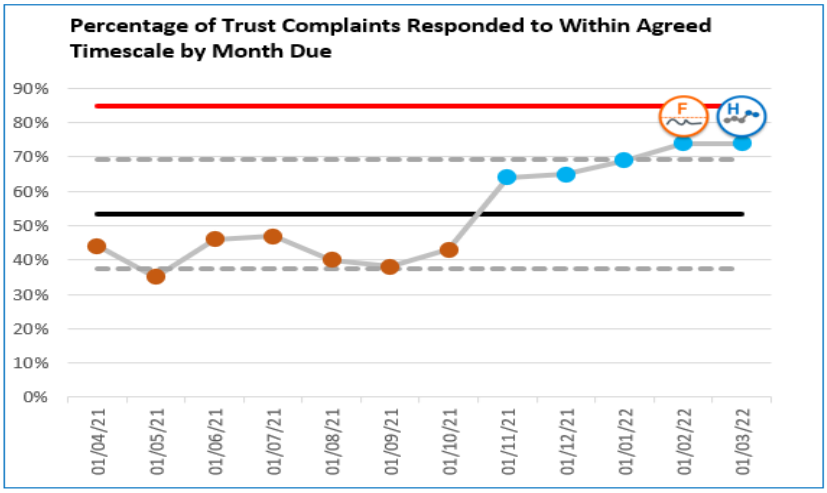
What have we achieved in 2021/2022?

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.

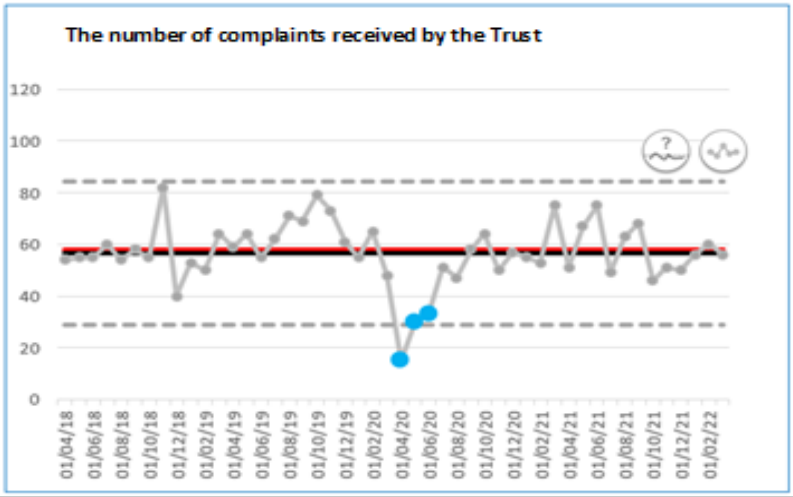


Table 1: Number of Complaints

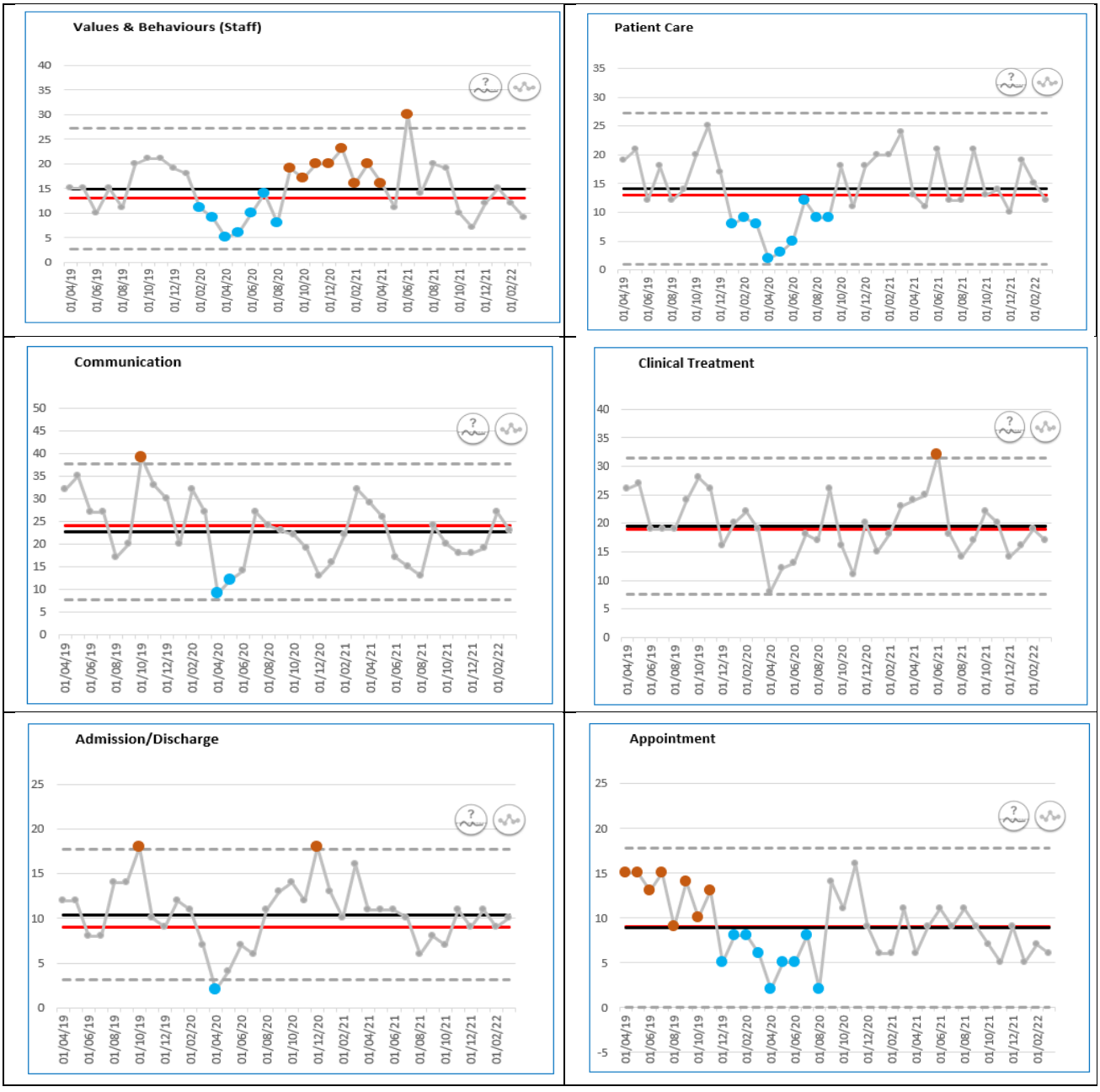
Year	Number of Complaints
2017/2018	600
2018/2019	680
2019/2020	760
2020/2021	587
2021/2022	688

- **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.

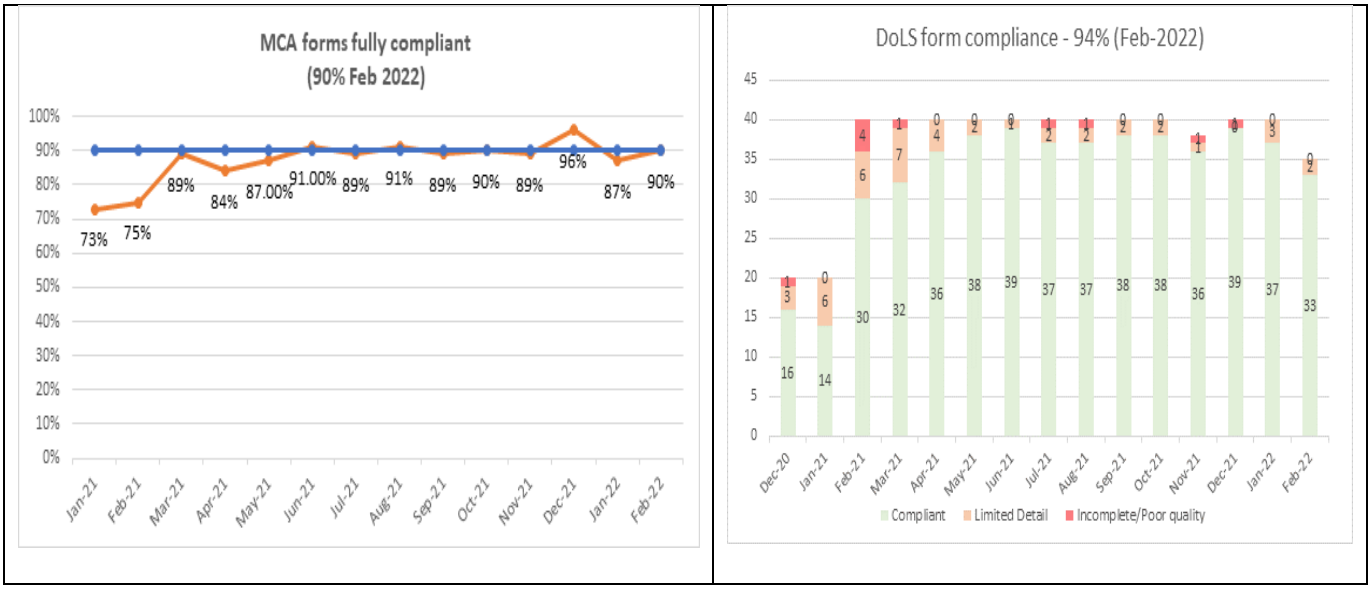
During 2021/2022 the Trust has made appointments to help further support its staff caring for patients with mental health issues. A mental health nurse has been appointed in the Paediatric Unit to support the provision of care to children and young people on the ward and in the ED and a substantive Lead 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.

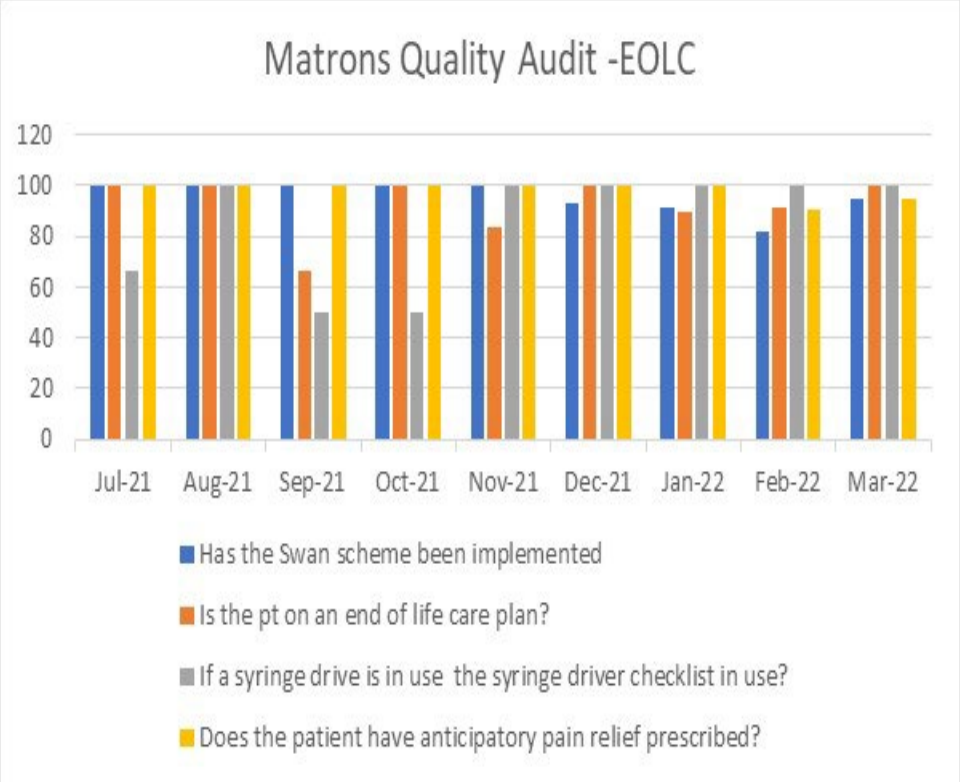
- **Ensure clear and timely identification of patients**

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)

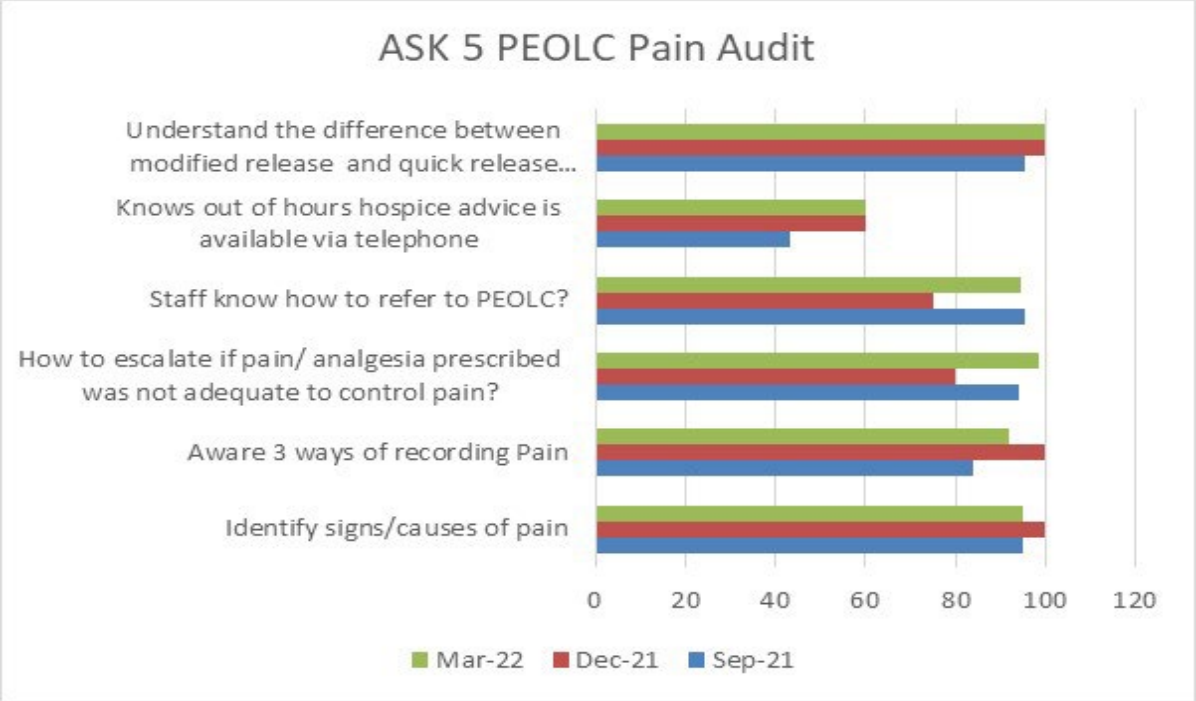
"It was lovely to have contact with Diane from the Palliative Care team on Saturday and Sunday. It felt like I had continuity as Di and her team had been seeing me all of the previous week. Over the weekend they were able to help the ward team to get me on the right dose of drugs to get my pain controlled 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
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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

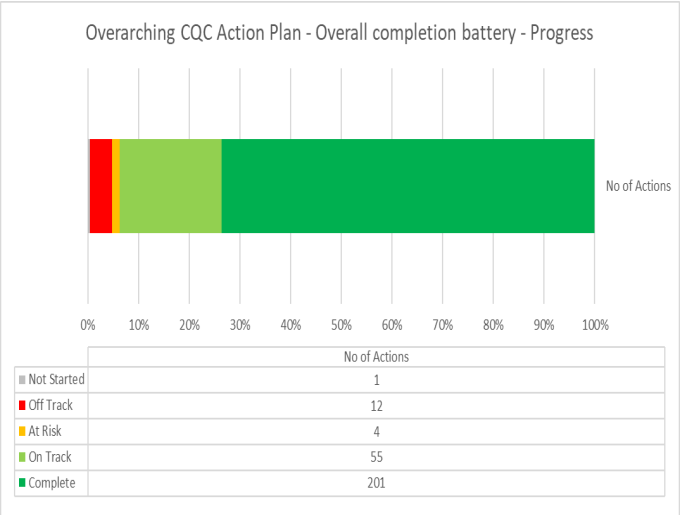
The CQC Inspection from July 2021 was published in November 2021. The "Must" and "Should" actions in relation to the latest CQC inspection are shown:

		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

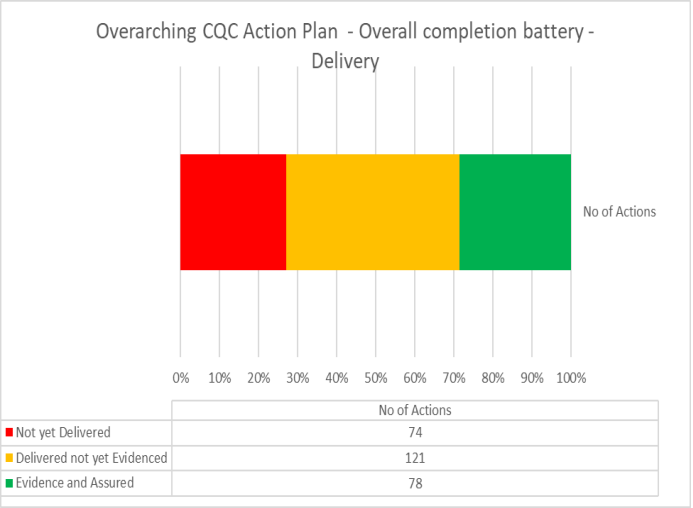
Medical Care has a total of 22 "Must Do" and 26 "Should Do" actions. Urgent and Emergency Care has 17 "Must Do" and 13 "Should Do" actions. There are 24 "Must Do" and 16 "Should Do" actions in relation to EoLC. Maternity had 3 "Must Do" and 16 "Should Do" actions as a result of the most recent CQC inspection.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

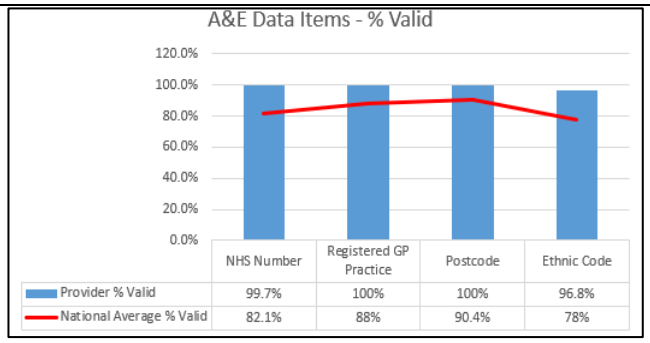
The Shrewsbury and Telford Hospital NHS Trust have continued to contribute to a number of Urgent Public Health Measures Studies including PRIEST, ISARIC, GENOMMIC and RECOVERY many of which have been able to provide answers and treatments for patients with COVID-19. This year saw the Trust open as a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

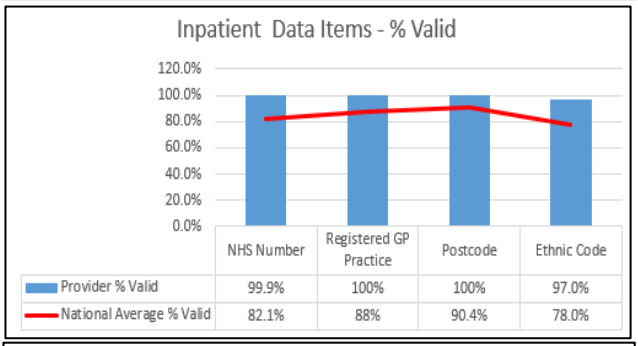
The Trust continues to be part of the West Midlands Research Training collaborative (WMRTC) providing free training sessions locally and across the region including Principal investigator Masterclass, an NIHR accredited course, Fundamentals of research, Good Clinical Practice and Investigator Site File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

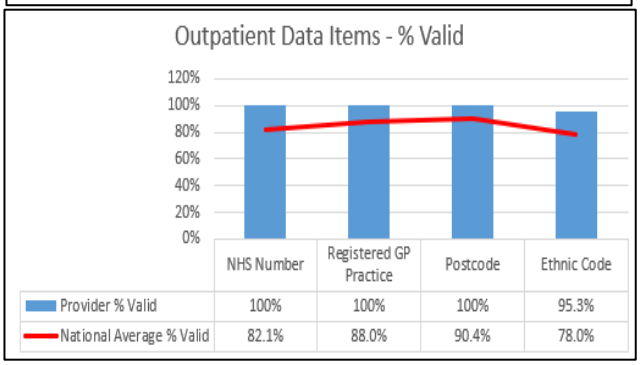
In 2021/2022 the Research and Innovation Department have undertaken a scoping exercise to assess and explore the contribution for Patient and Public Involvement and Engagement (PPIE) in research. This scoping exercise has now finished, and agreement is in place for the development of up to six PPIE groups 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.

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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.

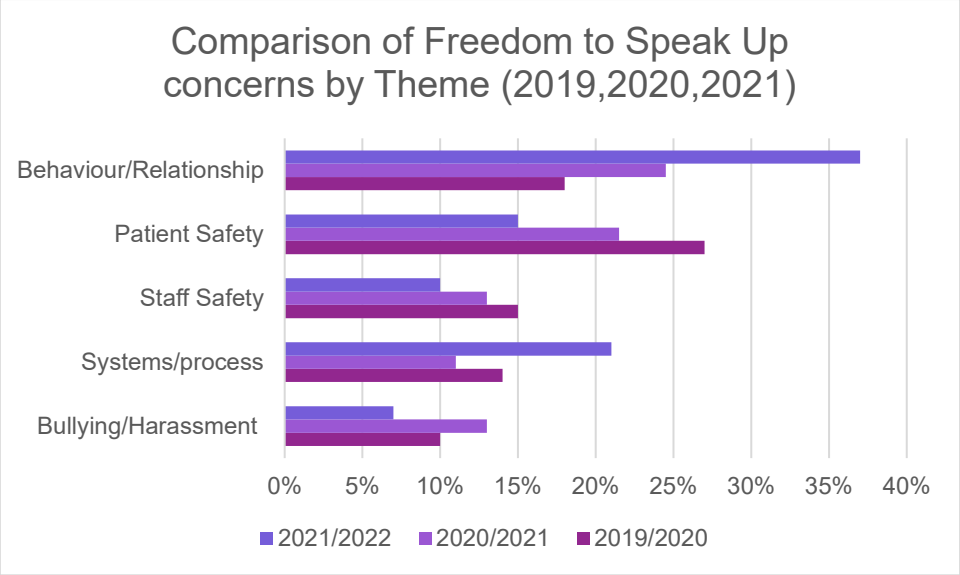
The Trust continues to ensure that staff across the organisation are enabled to speak up about their concerns. In 2021/22 the Lead Freedom to Speak Up Guardian (LFTSUG) and Guardians (FTSUG) continued with their engagement plan of raising awareness to as many teams as possible within the Trust.

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.

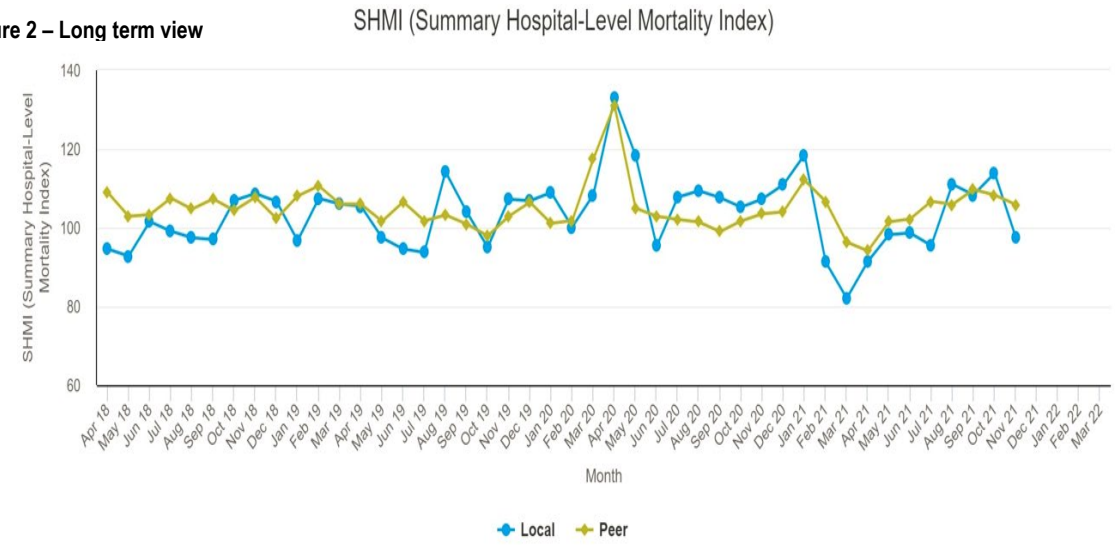
Indicator	**Summary Hospital-Level Mortality Indicator**			
Domain	**Preventing people from dying prematurely**			
SATH 2021/22	**Peer Comparator 2021/22**	**2020**	**2019**	**2018**
97.65	105.89	110.83	101.64	99.83
Data Source CHKS, Insight for Better Healthcare, HES data used against peers January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

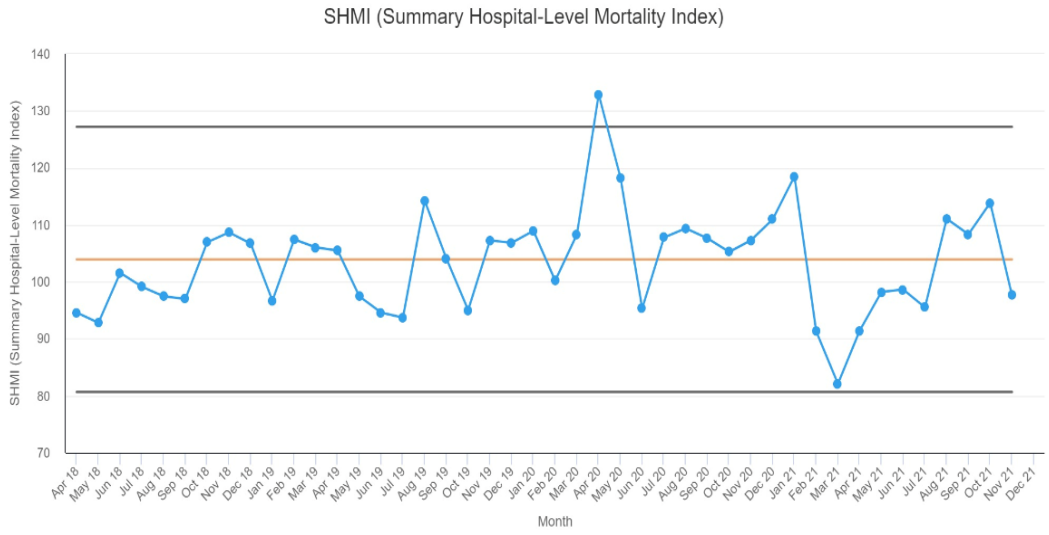
The Shrewsbury and Telford Hospital NHS Trust considers this data is as described as it is taken from a well-established national source. The SHMI data for 2021/2022 shows that the index for the Shrewsbury and Telford Hospital NHS Trust is 97.65 which is in the “as expected” banding.

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:

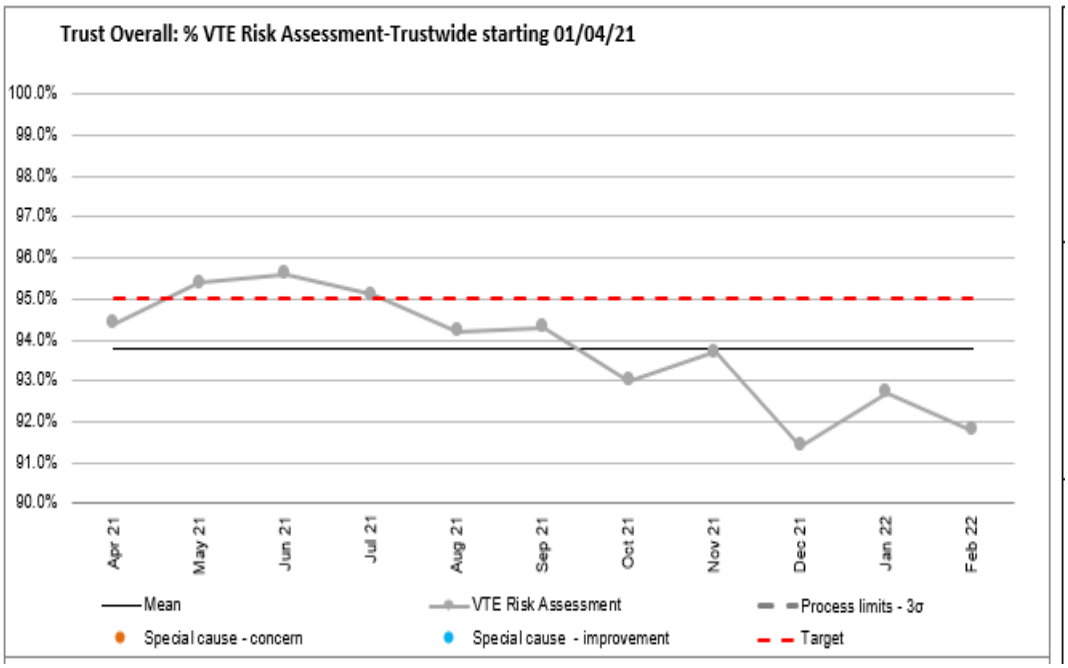
- Continue our cultural and leadership improvement journey
- Review our people plans at divisional and corporate level to ensure improvements and take action
- Complete Quarterly Pulse Survey for Staff so we can review progress and keep on track
- Work together – team based conversations

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

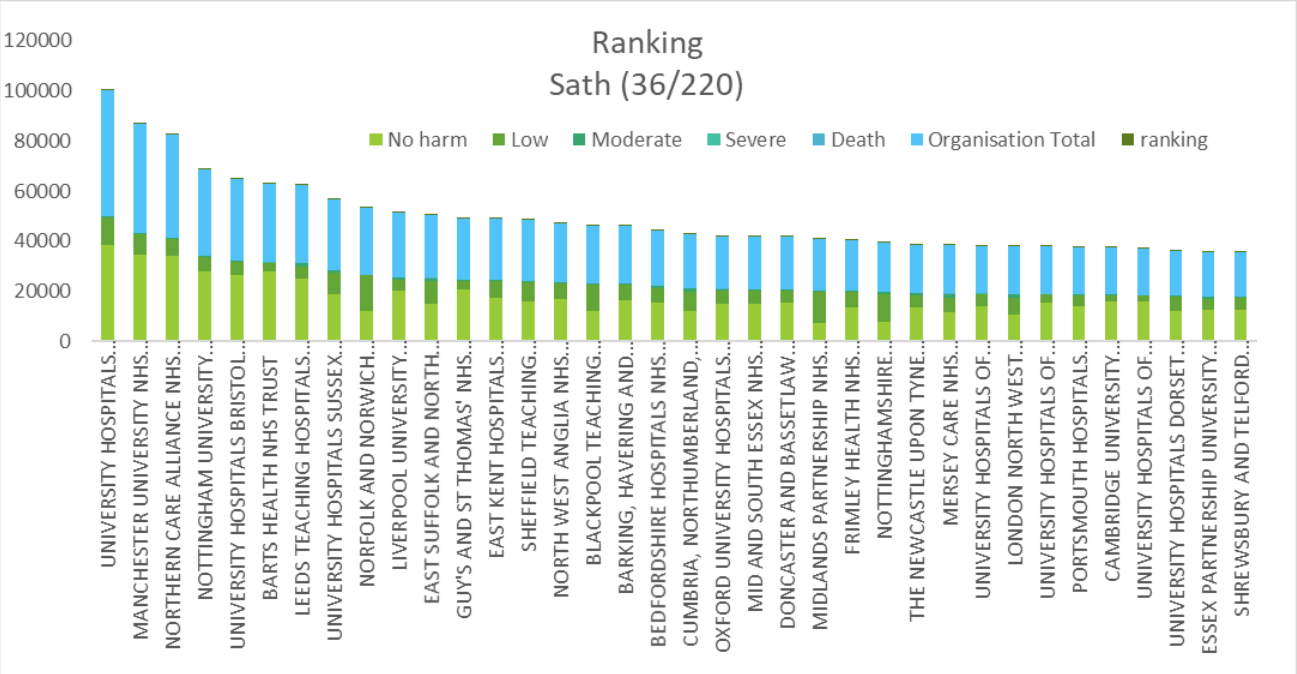
i) Rate of incidents reported per 1000 bed days
ii) Rate of incidents that resulted in severe harm or death per 1000 bed days
iii) Number of incidents resulting in severe harm or death
iv) % of severe harm or death over number of reported incidents.

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.

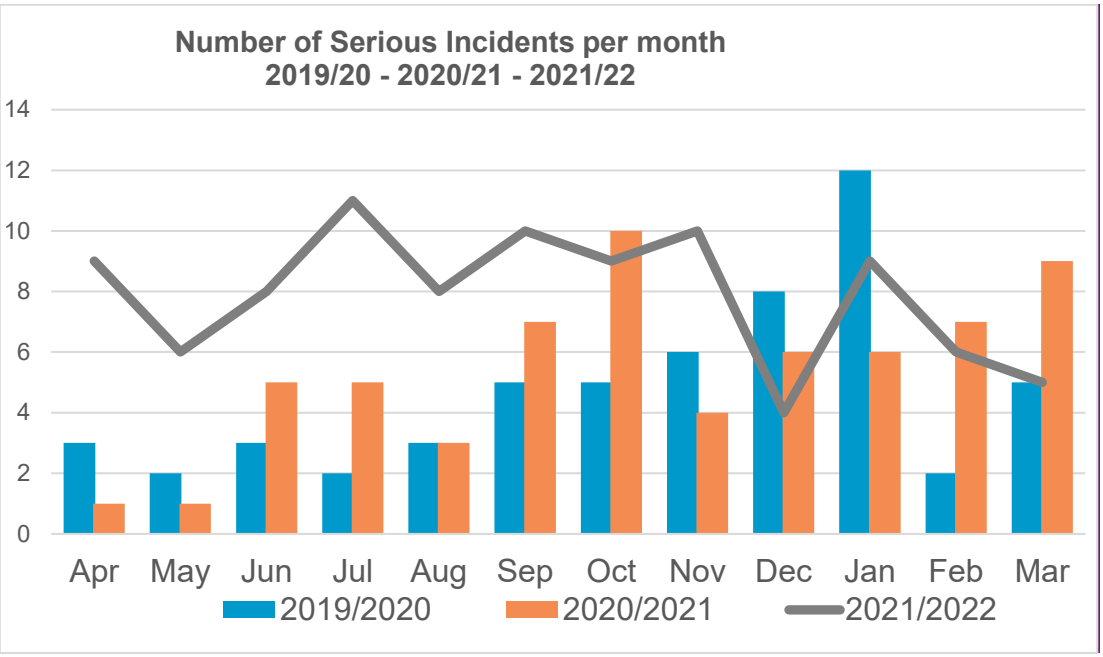
Alert Identifier		Alert Title	Issue Date	Closure Target Date	Date Closed	Open/ Closed
NatPSA/2021/002/NHSPS		Urgent assessment/treatment following ingestion of 'super strong' magnets	20/05/2021	19/08/2021	16/08/2021	Closed
NatPSA/2021/003/NHSPS		Eliminating the risk of inadvertent connection to medical 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

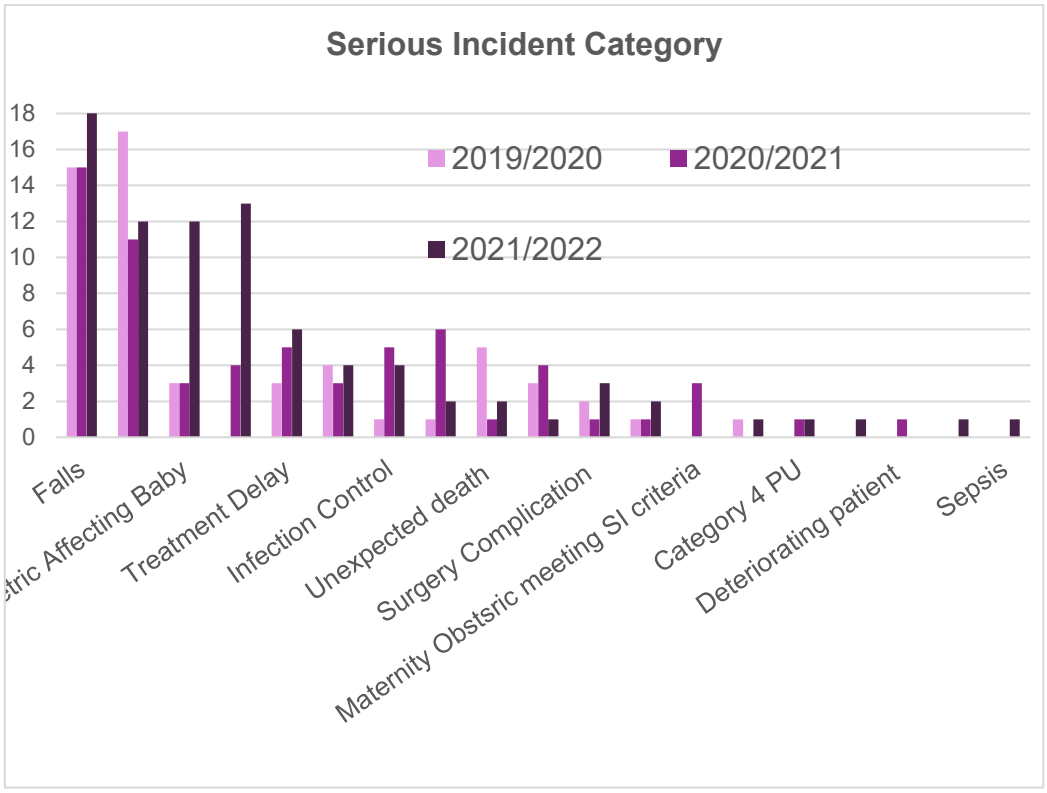
All patient safety incidents are reported on the hospital electronic incident management system (Datix). All patient safety incidents are reported, monitored and reviewed to identify learning that will help prevent reoccurrence. During 2021/2022 the Trust saw an increase in the number of serious incidents 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

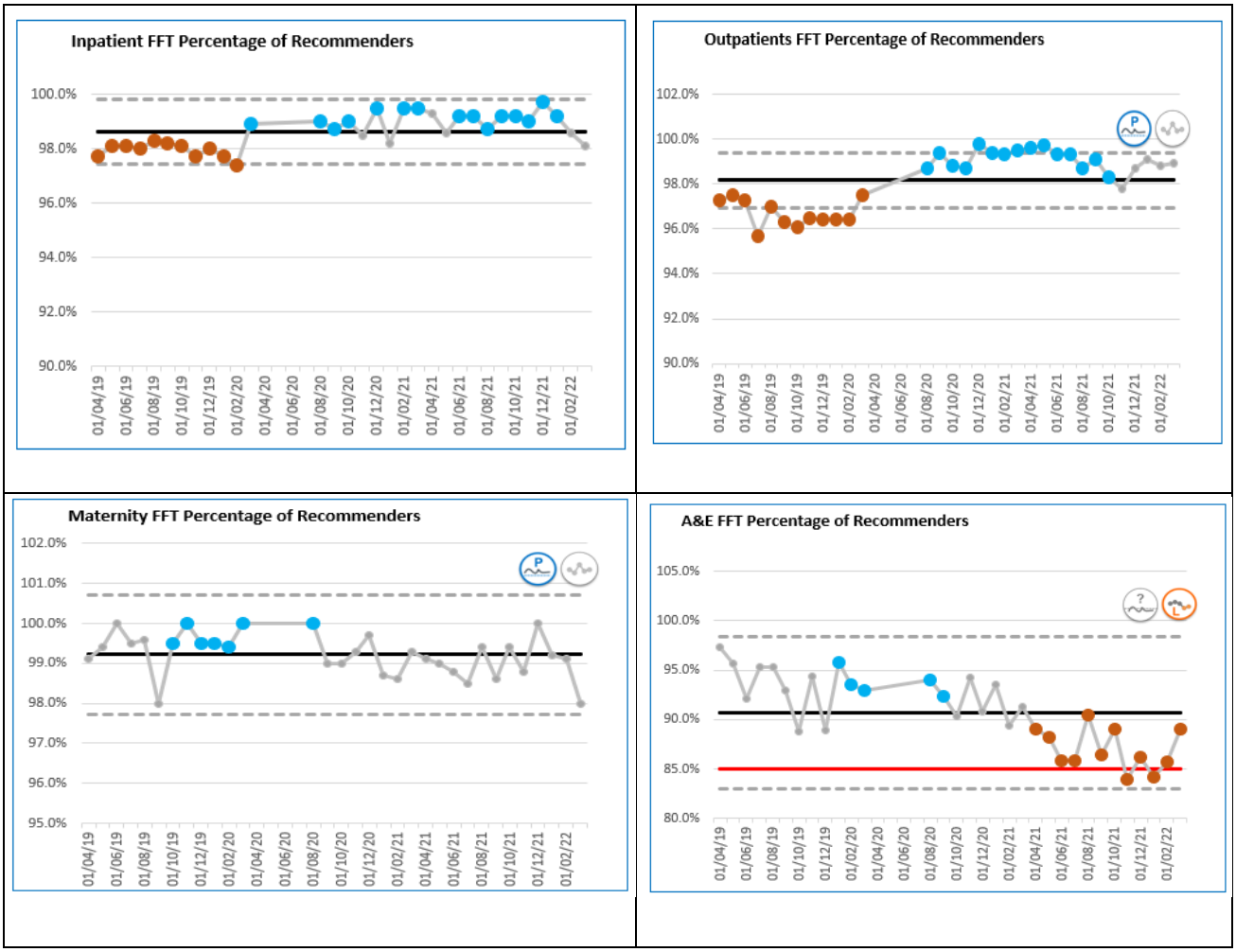
Friends and Family Test

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?'***

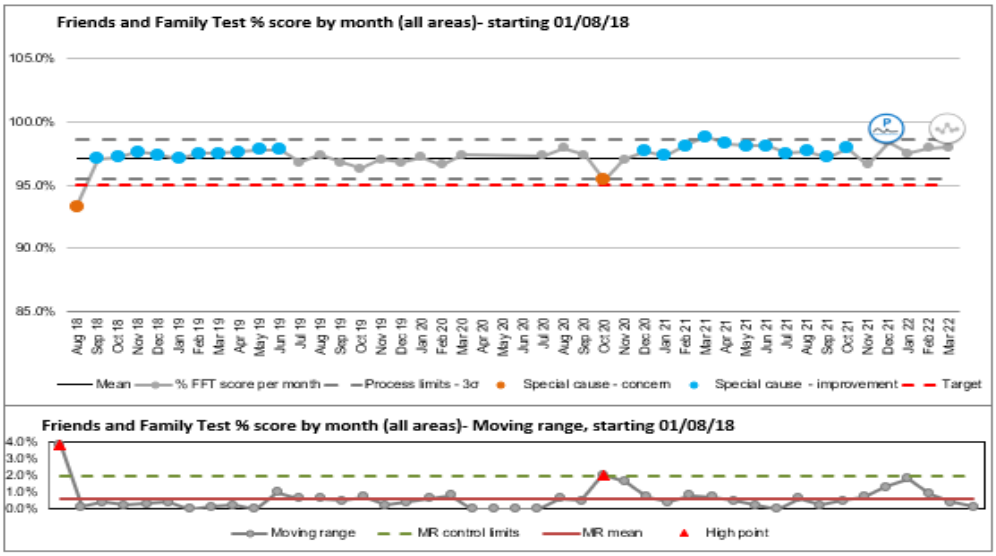
A total of 46,075 Friends and Family Test cards were completed and returned during 2021/22, this was an increase from the previous year when reporting paused due to Covid-19 in 2020/21 (29,359 responses), and in-comparison to 2019/20 when 43,094 Friends and Family Test cards were completed and returned. 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.

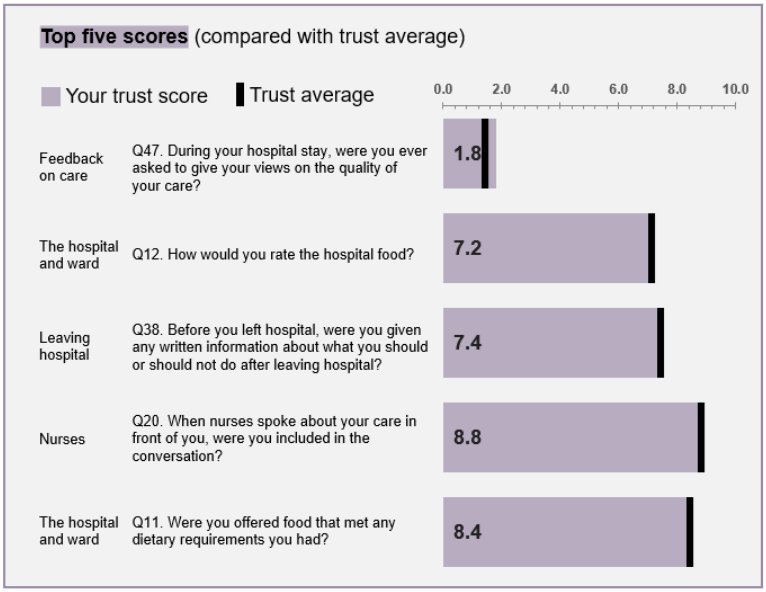
Of the Friends and Family Tests completed, 97.8% of respondents said they would be ‘’extremely likely’’ or ‘’likely’’ to recommend the Trust’s services to their family and friends, demonstrating an increase compared to 2020/21 (97.2%) and 2019/20 (97.1%).

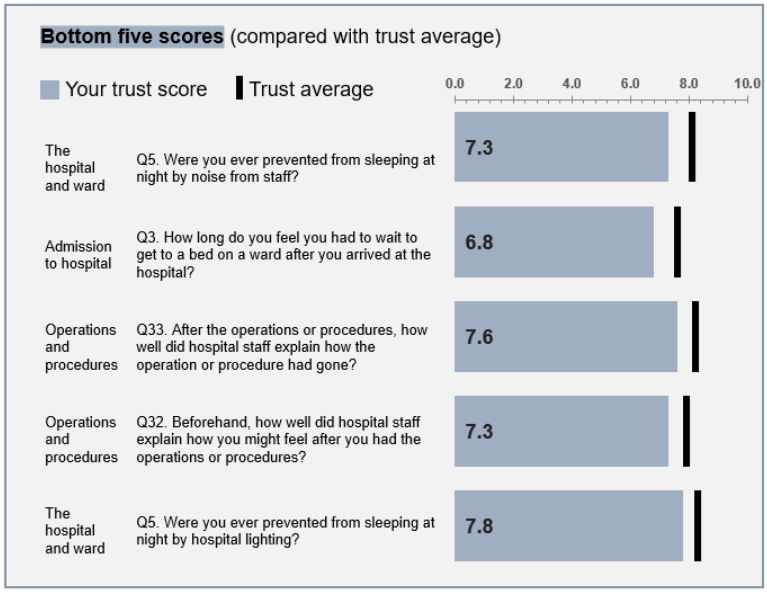


National Inpatient Survey

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**

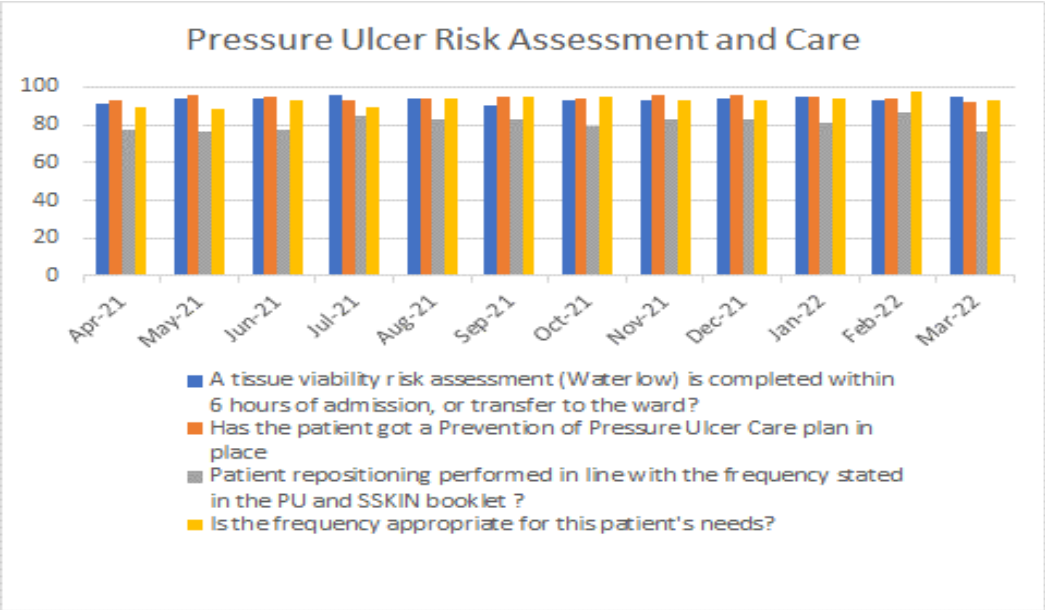
**Data taken from the Integrated Performance Report*

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

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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

PUTTING PATIENTS FIRST
YOU MATTER

NHS
The Shrewsbury and Telford Hospital
NHS Trust

PALS, Complaints and Patient Experience Annual Report

The Shrewsbury and Telford Hospital NHS Trust

2021/22

Partnering
Ambitious
Caring
Trusted

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

Executive Summary

Patient experience is fundamental in all that we do, and it is the responsibility of each individual working within the Trust to reflect the Trust values, ensuring that the patient is at the centre of all decision making.

Listening to patients experience of care and learning from their feedback is essential in enabling the Trust to deliver effective, safe, responsive, and kind care. The Trust learns from feedback through a number of sources, including engaging with people accessing services, surveys, patient stories, Friends and Family Test (FFT), the Patient Advice and Liaison (PALS) Team, through complaints, and the compliments we receive. Listening to what matters most to our patients and the people important to them.

The Trust is committed to patient experience, patient safety and clinical effectiveness to provide patients with high quality care. Through working with patient and carer representatives and realising our ambitions for the Patient and Carer Experience (PaCE) Panel in the year ahead, we will continue to build upon the achievements that have been made to improve patient experience, actively seeking and encouraging patients' feedback to identify opportunities for improvement and to continually endeavour to provide a good experience for everyone accessing services within the Trust.

I would like to thank the patient and carer representatives, and everyone who has taken the time to share feedback on their experience to enable us to listen, learn and respond. This is how we will continue to discover what is important to the community we serve and enable us together to shape services that will improve the experience of our patients.

Hayley Flavell, Director of Nursing

PARTNERING

Working effectively together with patients, families, colleagues, the local health and care system, universities and other stakeholders and through our improvement alliance.

AMBITIOUS

Setting and achieving high standards for ourselves personally and for the care we deliver, both today and in the future. Embracing innovation to continuously improve the quality and sustainability of our services.

CARING

Showing compassion, respect and empathy for our patients, families and each other, caring about the difference we make for our community.

TRUSTED

Open, transparent and reliable, continuously learning, doing our best to consistently deliver excellent care for our communities.

Contents

1. Introduction

The Shrewsbury and Telford Hospital NHS Trust (the Trust) aims to provide excellent care for the communities we serve. To do this, we must provide care that is responsive to individual patient preferences, needs and values. The patient experience agenda within the Trust is underpinned by the four Trust values, which were developed in partnership with staff, patients, the people important to them and the wider community. The Trust welcomes feedback from patients and the people who are important to them to ensure a partnering, ambitious, caring, and trusted service is delivered upon every visit to our hospitals.

The Covid-19 pandemic has had a vast impact on the NHS, the effects continue to be experienced in services across the Trust and wider NHS. The Trust is working to recover activity in addition to new ways of working introduced during the pandemic to support patients such as virtual activity and patient initiated follow up to provide the appropriate care and support.

The Trust recognises that every individual member of staff can impact upon the experience a patient, or someone important to them receives. Gaining insight into patients' current experience and receiving feedback on both what was done well and what could be improved is critical to ensuring a high quality, person-centred service is provided to every patient who accesses services within the Trust.

Value	What it means	How it underpins the patient experience agenda
Partnering	Working effectively together with patients, families, colleagues, the local health and care system, universities and other stakeholders and through our improvement alliance.	We work with patient and carer representative groups, local partner organisations and protected characteristic groups who provide a voice of their lived experiences. Working in partnership to co-develop improvements and help us to deliver the best viable experience when accessing services.
Ambitious	Setting and achieving high standards for ourselves personally and for the care we deliver, both today and in the future. Embracing innovation to continuously improve the quality and sustainability of our services.	We implement new and innovative improvement activities based upon patient and community feedback. We measure the success of these activities, report on this, and listen to what people have to say about them to increase transparency.
Caring	Showing compassion, respect and empathy for our patients, families, and each other, caring about the difference we make for our community.	We have values-based conversations with our patients, the people who are important to them, and our colleagues to empower people to be talked to and listened to as an equal and be treated with honesty, respect, and dignity.
Trusted	Open, transparent, and reliable, continuously learning, doing our best to consistently deliver excellent care for our communities.	We seek feedback from patients and the people who are important to them to learn and improve. We share regular updates to demonstrate how feedback has been used to create positive changes within the hospitals.

The PALS, Complaints and Patient Experience Annual Report will provide an overview of the work that has been carried out across the Trust to improve patient and carer experience over the last year (2021/2022).

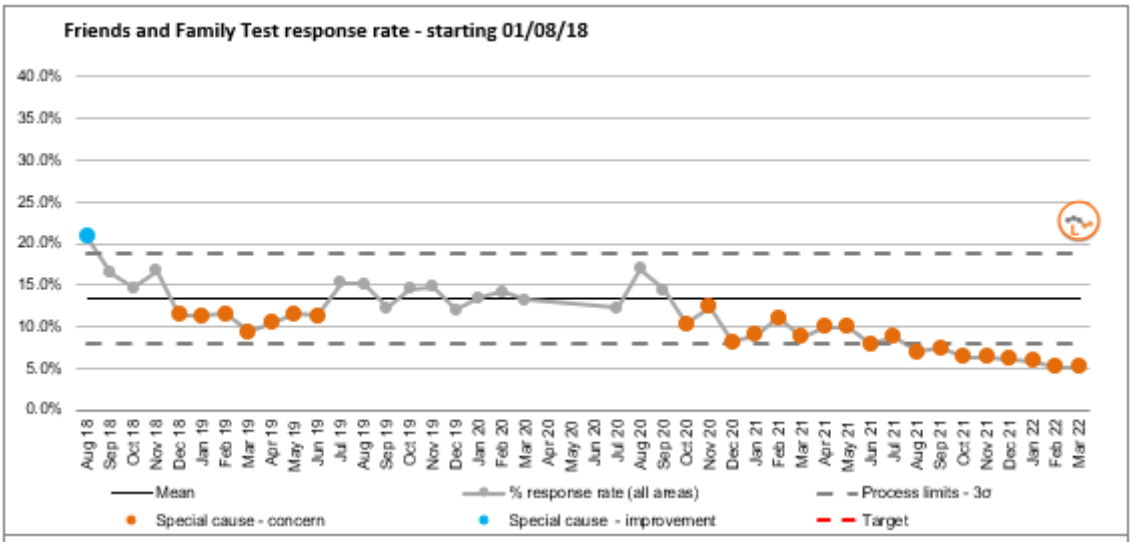
2. Friends and Family Test

The Friends and Family Test (FFT) is a national survey, 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. The FFT also includes a section for free text and this feedback can be used by managers to initiate improvement and share how feedback is used on 'You Said, We Did' posters.

A national standardised question is asked:

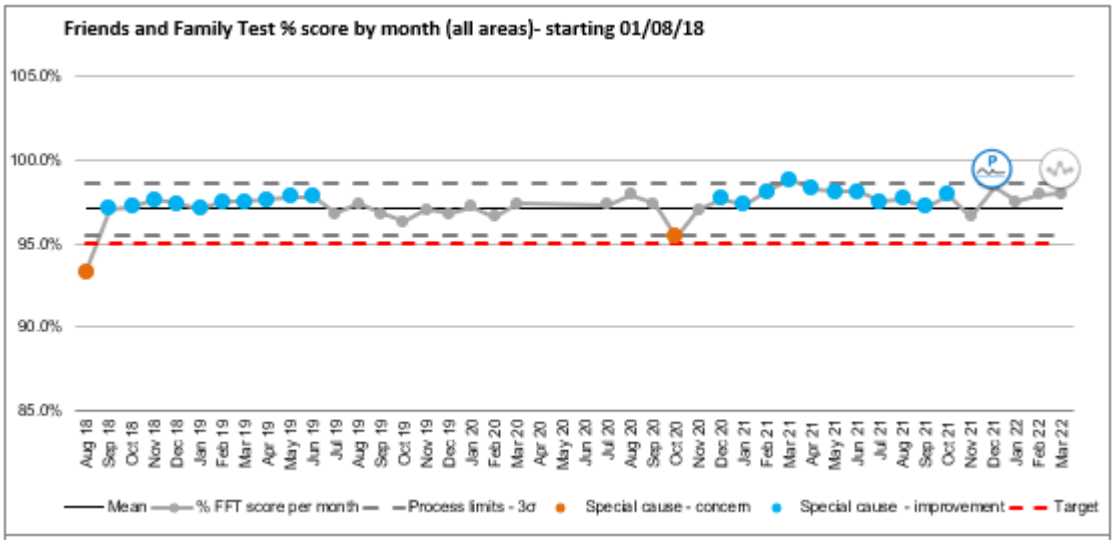
'Thinking about [the area accessed], overall how was your experience of our service?'

A total of 28,648 FFT cards were completed and returned during 2021/2022. This was a decrease from the previous year when reporting paused due to Covid-19 in 2020/2021 (29,359 responses), and in comparison to 2019/2020 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 response rate continues to be monitored closely to provide assurance that patients are being provided with an opportunity to provide feedback on their experience. The 4.8% response rate for 2021/2022 (inpatient and A&E) decreased on the previous year. 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.

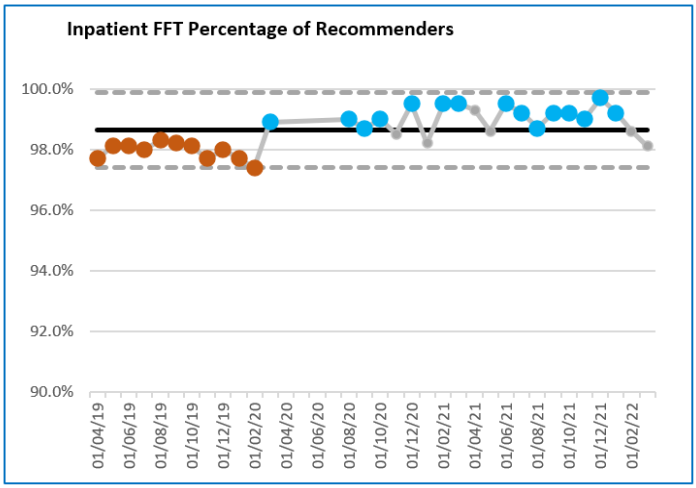
Friends and Family feedback can be provided through completion of paper cards, through volunteer collection by telephone within A&E, and feedback can also be provided via the Trust website. The Trust does not have a text messaging facility to support FFT collection. Seeking to increase Friends and Family response rates a QR code to the survey has been incorporated in patient discharge summaries from March 2022.

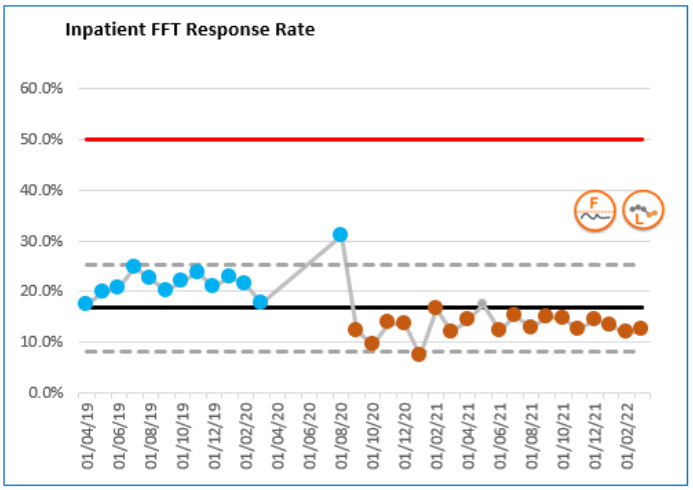


Of the FFTs completed, 98% of respondents rated their experience as very good and good (between April 2021 and March 2022), which is above the target, and demonstrates a slight increase in comparison to 2020/2021 (97.2%) and 2019/2020 (97.1%). Currently, performance can be expected to vary between 97.2% and 99.1%, which falls within the usual range of variation.

Inpatient FFT

Total Responses	Response Rate	Likely to Recommend
11,912	**13.9%**	**99%**
April 2021 – March 2022	April 2021 – March 2022	April 2021 – March 2022





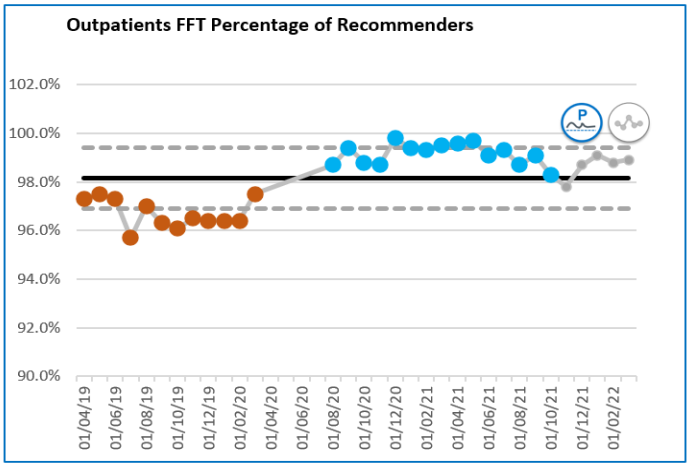
Recommendation Rate: There has been an improvement in the percentage of people who would rate the service good and very good since March 2020. Currently, performance can be expected to vary between 98.1% and 99.7%, providing assurance that the target can consistently be achieved.

Response Rate: The response rate for 2021/2022 (13.9%) has decreased in comparison to the preceding year 2020/2021 (15%). Currently, monthly performance can be expected to vary between 11.8% and 17.5%, reflecting a low special cause concerning variation.

Outpatient FFT

Total Responses
9,557
April 2021 – March 2022

Likely to Recommend
98.7%
April 2021 – March 2022



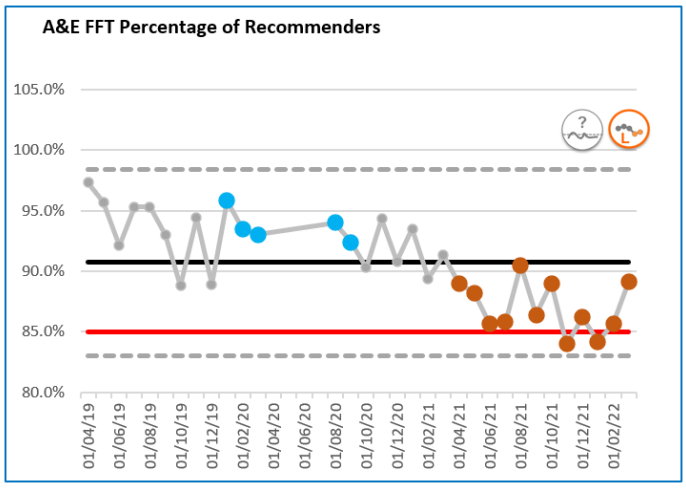
Recommendation Rate: The percentage of people who provided positive feedback on their experience when accessing the outpatient service in 2021/2022 (98.7%) remains consistent with the previous year (99.1%). Currently, performance can be expected to vary between 97.8% and 99.7%, providing assurance that the target can be consistently met.

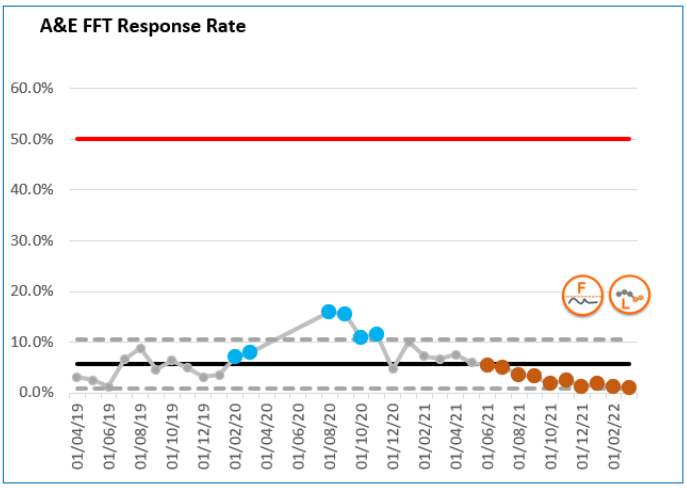
A&E FFT

Total Responses
5,122
April 2021 – March 2022

Response Rate
3%
April 2021 – March 2022

Likely to Recommend
87.3%
April 2021 – March 2022



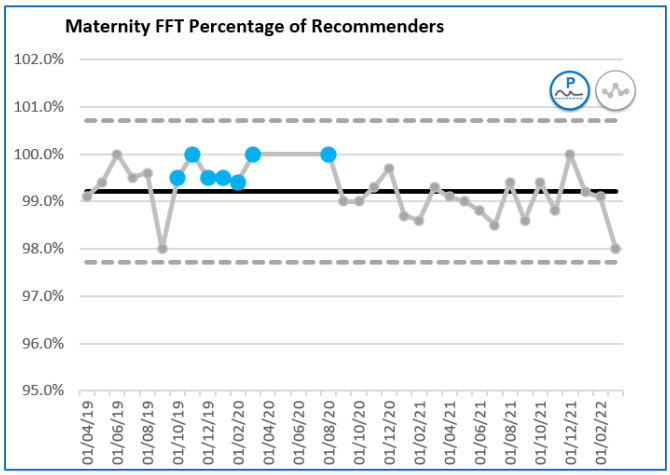


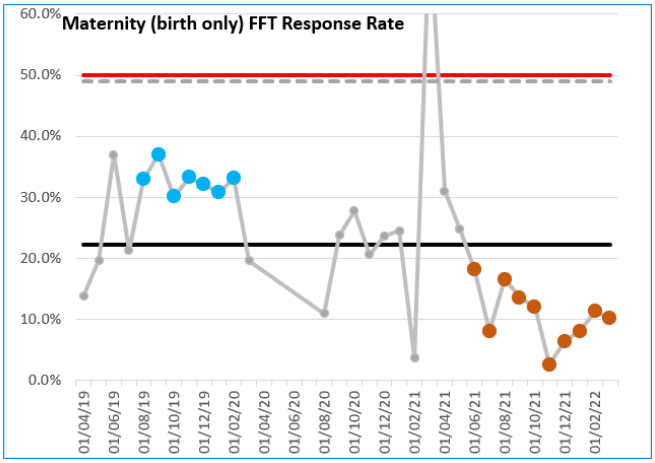
Recommendation Rate: The percentage of patients who provided positive feedback on their experience when accessing the departments for treatment (87.3%) is lower when compared to the previous year (91.9%).

Response Rate: The response rate of 3% has significantly deteriorated in comparison to 2020/2021 (12.87%) and is slightly lower than 2019/2020 (4.87%). During 2020/2021 volunteers were introduced to support obtaining FFT responses following A&E treatment, the reduction in volunteers continuing to support this activity has potentially contributed to the reduction in response rate.

Maternity FFT

Total Responses	Response Rate	Likely to Recommend
2,057 April 2021 – March 2022	**5.5%*** Birth only April 2021 – March 2022	**99.0%** April 2021 – March 2022





Recommendation Rate: The percentage of patients who would rate their experience of the maternity service as good and very good (99.0%) is comparable to the previous year (99.3%). Currently, monthly performance ranges between 98% and 100%.

Response Rate: The response rate of 5.5% has deteriorated in comparison to 2020/2021 (23.8%). Currently, monthly response rates can be expected to vary between 2.6% and 31%.

3. National Surveys

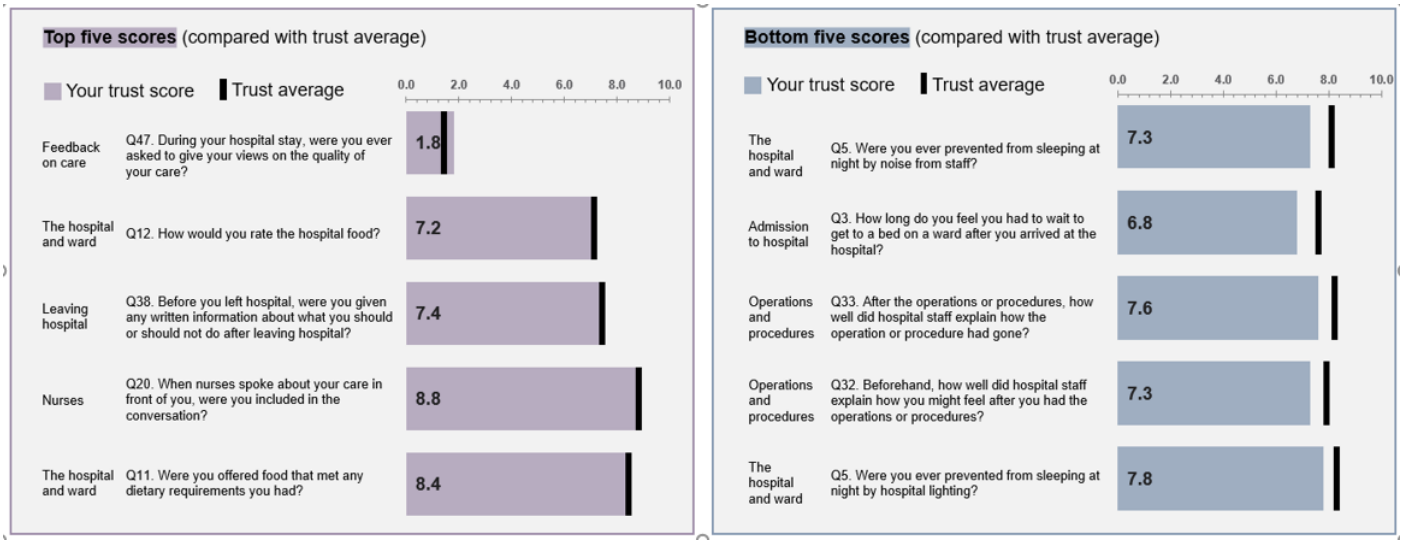
National Inpatient Survey

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 cannot be directly compared to the previous year, patients providing feedback on their experience in 2019 scored the Trust 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 gave 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.

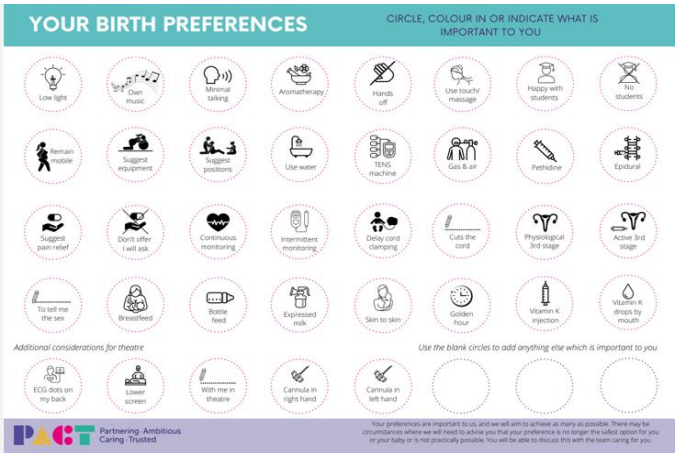
		2021	2019	2021 Band
Section 4: Your labour and birth				
Q. C3	At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?	9.2	9.2	Better
Q. C4	During your labour, did staff help to create a more comfortable atmosphere for 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

A User Experience (UX) System has been developed and introduced in Maternity to support improvement work. The system is an engagement tool that captures ideas for improvement based on a specific theme through engagement to improve user experience. The approach was co-developed with Maternity Voice Partners (MVP) and has led to a number of improvements, examples of these are:

In response to feedback posters have been developed to remind service users that staff are always available to listen and support people with any questions they may have to help them make choices that are right for them.

In response to feedback birth preference cards have been developed, the cards are explained to women at 28 weeks to enable them to reflect and consider their preferences, cards are then completed with the Midwife at 32 weeks and reviewed as required. The card stays with women throughout the birthing process to ensure that preferences are known by staff.



Partnering · Ambitious Caring · Trusted

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). In the Cancer Dashboard questions 6 of the 7 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%

With support of Macmillan, the Living With and Beyond Cancer Team created a programme of initiatives to enable and empower people affected by cancer throughout their treatment and beyond. Working with patients, to develop innovative tools to promote safe self-management, supporting recovery and survivorship. These innovations include developing 'My Passport to Living Well', regular Living Well Sessions and resources available through an online platform. The initiatives were designed with patients and, where appropriate, encourage patient volunteers to take an active role in the delivery. This work led to the team winning the Integration and Continuity of Care Award in the Patient Experience Network National Awards 2020-2021 for the support and resources provided for people affected by cancer.

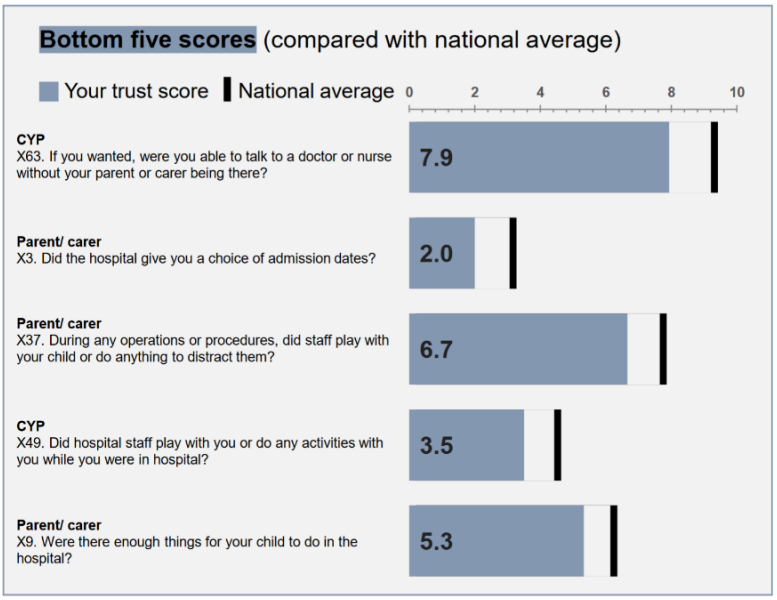
Comparing the Trust overall scores between 2016 to 2020 identified 3 questions that demonstrate a statistically significant difference in the table below. The one area identifying a decline relates to General Practice staff.

		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

National Children and Young People's Survey

The National Children and Young People's Survey was undertaken between January and May 2021 and included patients meeting the eligibility criteria and were discharged from the Trust between the 1st November 2020 and 31st January 2021. The Trust had a response rate of 26%, which was 2% above the national average; and, performed 'about the same' as other Trusts for the majority (62) of questions. Three questions scored somewhat worse than expected, however no questions scored worse than expected, or much worse than expected. The Trust scored 'much better than expected' for 1 question, 'better than expected' for 1 question and 'somewhat better than expected' for 1 question.

The questions in which the Trust scored higher and lower compared to the national average are listed in the tables.



National Urgent and Emergency Care Survey

The National Urgent and Emergency Care Survey was undertaken between November 2020 and March 2021 and included patients meeting the eligibility criteria who were treated in Urgent and Emergency Care services during September 2020. The Trust had a response rate of 33.47%, which was 3% above the national average. The Trust performed 'about the same' as other Trusts for the majority (30) of questions, no questions scored better than most other Trusts, however 8 questions scored worse than most other Trusts.

		2020	2018	Band
Arrival at A&E				
Q.12	Were you informed how long you would have to wait before being examined?	3.1	3.1	Worse
Doctors and Nurses				
Q. 17	Did the doctors and nurses listen to what you had to say?	8.4	8.8	Worse
Care and Treatment				
Q. 31	Do you think the hospital staff did everything they could to help control your pain?	6.6		Worse

Tests				
Q. 29	Did a member of staff explain the results of tests in a way you could understand?	8.2	9.0	Worse
Environment and Facilities				
Q. 35	Were you able to get suitable food or drinks when you were in A&E?	5.7		Worse
Leaving A&E				
Q. 41	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?	6.7	7.2	Worse
Respect and Dignity				
Q. 46	Overall, did you feel you were treated with respect and dignity while you were in A&E?	8.7	8.8	Worse
Experience Overall				
Q. 47	Overall…	7.8	7.7	Worse

The Urgent and Emergency Care Team introduced Civility Saves Lives during 2021/2022 to improve communication and team performance. Sessions explore team culture, roles, communication and the vision of the team as it has been demonstrated that when a team values and respects members they achieve improved outcomes. Patient stories, captured from patients and people important to them, who have accessed the service have been captured to share examples of feedback with the team during workshops.

The Trust did demonstrate a statisticaly significant improvement in 3 questions when compared to the preceeding Urgent and Emergency Care Survey undertaken in 2018, these were:

		2020	2018
Arrival at A&E			
Q. 5	Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the A&E staff?	8.6	7.8
Waiting			
Q. 14	Overall, how long did your visit to A&E last?	6.9	6.2
Tests			
Q. 30	If you did not get the results of the tests when you were in A&E, did a member of staff explain how you would receive them?	6.2	4.0

4. Internal Feedback

Feedback Hub

The Feedback Hub centralises all feedback-collection methods to increase accessibility and ease-of-access for users who wish to share their feedback. To improve visibility a link to the feedback hub is now available from the homepage on the Trust website. The Trust will continue to promote the webpage as a way of seeking patient, carer and visitor views. The number of interactions with the Feedback Hub totalled 1,193 in 2021/2022, reflecting common cause variation.

Feedback is shared anonymously with the relevant manager and Matron, to enable them to cascade to their team. Star cards are also sent to members of staff who are individually

recognised, to celebrate their achievements in creating a positive patient experience. If the person consents, feedback can also be shared on the Trust website, or on social media, to enable more staff within the Trust, and external members of the community, to hear examples of good practice.

Local Surveys

A local inpatient survey was developed, in response to the 2019 Adult Inpatient Survey (results published in 2020), in order to monitor and focus on the areas identified for improvement within the Trust. This gives an overall picture of how the Trust is performing throughout the year, in addition to providing a breakdown of the results at a Ward and Divisional level in order to give more detailed and meaningful data.

Surveys are sent monthly (via post) to a randomly-selected sample of 1000 patients, aged 18 or over, who had spent at least one night in hospital during the sample month. Data is analysed on a quarterly basis to ensure the response rate is sufficient in making the data meaningful.

Similarly a local A&E survey has been completed each month since March 2020, 500 surveys are posted to patients who have attended the A&E Departments. The latest local inpatient and A&E survey results have not yet been released to enable an overview of 2021/2022 to be included in the annual report.

Gather

The Trust uses an electronic survey and audit tool known as Gather. The tool enables staff and volunteers to use mobile devices to collect data at the point of care. This information is displayed within the ward quality dashboard and triangulated with quality, safety and workforce data. Data is gathered by the Ward Manager and Matron, with additional checks undertaken each month by a peer to provide additional validation. During 2021/2022 a total of 3,460 feedback responses from patients were captured across the Trust.

Surgery, Anaesthetics and Cancer

There were a total of 1204 patients surveyed throughout the quality metrics process across 11 clinical areas within the Surgical Division, between April 2021 and March 2022. The majority of patients responded that the Nurses (99.65%) and Doctors (99.51%) were kind; and 98.94% were happy with the care they had received.

96.95% said the Nurses answered the call bell promptly when it was used; and 97.94% of respondents said their pain had been addressed. Patients reported when asked that Nurses (99.92%) and Doctors (98.83%) had washed their hands before caring for them. Respondents said the Nurses had checked their wristband before administering any medication (99.57%), and a similarly high proportion said their medication had been fully explained to them (96.01%).

When asked if they felt involved in decisions about their care, 96.65% said they did; although, 6.91% of respondents said that Doctors had talked in front of them as if they were not there, this

demonstrates an improvement in comparison to the previous year (16.4%). 82.8% of respondents knew what the plans were in relation to discharge, or further investigation/treatment. In terms of hospital food, the majority of respondents said they were offered a choice of food (98.63%) and 95.19% were happy with the food they were given.

Medicine

There were a total of 1785 responses across 18 clinical areas within the Medical Division, between April 2021 and March 2022. The majority of patients responded that the Nurses (98.8%) and Doctors (99.4%) were kind and, 98.18% were happy with the care they had received.

93.27% said the Nurses answered the call bell promptly when it was used and, 97.28% of respondents said their pain had been addressed. When asked if the staff had washed their hands before caring for them, patients confirmed that they had seen the Nurses (99.3%) and Doctors (98.46%) do this. 98.42% of respondents said the Nurses checked their wristband before administering any medication, however only 89.07% said the medication had been fully explained to them.

When asked if they felt involved in decisions about their care, 93.99% said they did, 7.26% of respondents said that Doctors had talked in front of them as if they were not there, however, this reflects an improvement on the previous year (14.8%). 25.59% of respondents did not know what the plans were in relation to discharge, or further investigation/treatment. In terms of hospital food, 98.17% of respondents said they were offered a choice of food and a high proportion (94.42%) said they were happy with the food they were given.

Urgent and Emergency Care

There was a total of 350 responses between April 2021 and March 2022. Respondents said the Nurses (100%) and Doctors (99.75%) were kind; and a similarly high proportion were happy with the care they had received (99.45%).

99.13% said the Nurses answered the call bell promptly when it was used; and 99.2% of respondents said their pain had been addressed. The majority of respondents observed the Nurses (99.75%) and Doctors (99.18%) wash their hands before caring for them, and confirmed their wristband was checked before administering any medication (99.45%). Respondents also said their medication had been fully explained to them (95.83%).

When asked if they felt involved in decisions about their care, 98.65% of respondents said they did, reflecting an improvement on the previous year (90%), however, 8.1% of patients felt Doctors talked in front of them as if they were not there. 81.43% of respondents knew what the plans were in relation to discharge, or further investigation/treatment, reflecting a significant improvement in comparison to the previous year (47.5%). In terms of hospital food, respondents said they were offered a choice of food (99.43%) and 98.55% were happy with the food they were given.

Women and Children's

There was a total of 350 responses across 1 ward using Gather within the Women and Children's Division, between April 2021 and March 2022. Respondents said the Nurses (99.1%) and Doctors (100%) were kind; and a similarly high proportion were happy with the care they had received (100%).

100% said the Nurses answered the call bell promptly and 99.1% confirmed that their pain had been addressed. All respondents said the Nurses (100%) and Doctors (100%) washed their hands before caring for them, and 99.1% confirmed their wristband was checked before administering any medication. Respondents also said their medication had been fully explained to them (98.1%).

When asked if they felt involved in decisions about their care, 96.5% of respondents said they did. There were instances where patients felt Doctors talked in front of them as if they were not there (4.4%), and 7% of respondents did not know what the plans were in relation to discharge, or further investigation/treatment. In terms of hospital food, the majority of respondents said they were offered a choice of food (99.1%) and 100% were happy with the food they were given.

The questions used to capture patient experience feedback in Gather are being reviewed to support measuring key areas for focused improvement. By listening to patients share their experience, real time feedback can be obtained to evidence and support informed improvement work.

5. Patient Stories

Patient stories can be a powerful tool, providing insight of personal experiences of care within our Trust, which can help to improve understanding and learning.

The Trust recognises the power of storytelling through enabling the listener to experience the emotion with the person sharing their story. When someone shares their story and describes their experience, the audience can engage and connect with the image that is being described, enabling them to share the emotions and feelings of the storyteller at a given moment in time.

A number of patient and staff stories, captured during 2021/2022, have been shared through the appropriate channels within the Trust. Next steps and actions are devised in response to patient stories to increase awareness and promote learning as a result of patient feedback. Examples of stories shared during 2021/2022 include:

It's Within Our Gift to Make a Difference

The storyteller describes their experience in communicating to a patient using British Sign Language (BSL). A member of the charity Signal provided additional insight and feedback from a service user perspective.

A range of steps have been taken, including developing resources to support staff in addressing the needs of d-Deaf or hard of hearing patients. A BSL patient information library has additionally been developed on the Trust website, to communicate important information such as how to access an interpreter/translation.

Take a moment and listen to what I need

Following a visit to his GP a patient was referred to the Trust for treatment the following day. The patient contacted the department the evening before admission to inform them that due to an injury he would require a hoist to transfer. The experience is recounted highlighting points which stood out to him during his inpatient care, identifying aspects where his needs could have been better met and areas in which he received good care.

Following this patient story being shared the subsequent actions have been taken:

- A process has been introduced to ensure that patients are greeted upon arrival to the area and updated as necessary in relation to waiting times.
- The Ward Sister and Ward Manager are completing quality checks to ensure that individual patient needs are assessed and incorporated into their care.
- The staff on duty overnight will check any equipment identified for patients being admitted the next day and ensure that it is made available in advance of their arrival.
- The Moving and Handling Team are providing additional hoist training within the area and training on supporting patients with a spinal injury.
- New patient hoists have been ordered as a replacement, the hoists are easier to manoeuvre and lift to a higher level.
- The storyteller has met with the Moving and Handling Team to discuss the impact of his experience with them, providing an opportunity for questioning and compassionate learning.
- The Moving and Handling Team are focusing the new patient handlers statutory training sessions on hoisting, in response to this experience which has been shared with the Trust.

Guidance for Blue Badge Holders

Whilst the storyteller was aware of the Trust concession for Blue Badge holders, when attending an appointment at a weekend there were no parking attendants on duty and no information available to provide advice. The storyteller searched the Trust website and found information on what to do in the event of visiting the Trust at a weekend. This led him to question what other Blue Badge holders would do if they found themselves in a similar situation and he contacted the Trust to provide feedback on his experience.

Following this patient story being shared the subsequent actions have been taken:

- A poster has been developed with the storyteller to provide guidance for Blue Badge holders visiting the Trust.
- The poster is displayed at the Parking Attendant's cabin at each hospital.
- Copies of the poster have been provided to all outpatient areas to display in waiting rooms.
- Guidance has been incorporated in the television screen show available in some waiting areas across the Trust.
- Information has been shared with the reception staff to ensure that they are able to advise visitors to the Trust on parking queries.
- An animated patient story has been captured and shared as one of a selection during Experience of Care Week in April 2021, demonstrating how the Trust responds to feedback.

First Impressions

The mother of a patient who attended the Emergency Department (ED) following advice from NHS 111 to access treatment for her 19 year old daughter. The storyteller shared her experience of the ED waiting room.

In response to the feedback a number of actions have been taken, examples of these are:

- The need to direct Head and Neck patients to the Princess Royal Hospital has been reinforced to NHS 111.
- A Trust values and behaviours workshop has been held with the ED Reception Team, facilitated by the Workforce Team.
- The Emergency Centre introduced Civility Saves Lives workshops in September 2021. The workshops highlight the importance of values and behaviours at work and the impact this has on others. The sessions are interactive and will include all staff within the Service.
- Patient stories are being used within the workshops to increase staff awareness of the impact values, behaviours and good communication has upon the experience a patient receives. This feedback has been incorporated in the workshops to reinforce the message and learning.
- A volunteer role has been introduced into the ED waiting rooms to provide visibility, assistance, and a point of contact for people waiting.

Steve's Story

The son of a patient shared his experience of struggling to maintain contact with his father, who struggled to use his mobile telephone. Outlining how opportunities for staff to explain the Swan symbol could have been better and tools such as the patient radio could be used more appropriately to benefit the patient if their needs are considered.

A number of actions have been taken in response to the feedback, some examples of this are:

- The digital story has been shared in a range of meetings across the Trust to share the feedback, raise awareness and enable learning to be taken
- 71 mobile telephones were obtained and allocated to all inpatient areas across the Trust to support improved communication
- Compassionate visiting has been reinforced across inpatient areas to provide clarity and ensure that support is in place for patients and those important to them
- A portfolio of resources to support communication with families has been developed on the Trust intranet
- The digital story has been incorporated into Championing End of Life Care training to raise awareness throughout the Trust.

An example of services working together to meet an individual's needs

Speciality leads worked together to identify the best approach to meet a young person's needs. Progress built gradually and small improvements were made, progressing to larger achievements. Steadily the young person regained more functional ability, developing methods of communication,

starting to eat, and eventually taking steps. When the stage in their recovery was right, the patient was supported in their transfer back to a partner organisation.

Two digital stories were captured to share different views of the experience, one from a staff member and one from the patient's mother. This provided greater insight and enabled learning to be taken from feedback of different perspectives.

Pam's experience of a same day discharge hysterectomy

The storyteller attended a gynaecology clinic appointment where she leaned that she would require a hysteroscopy which was offered on the same day. She describes how she felt overwhelmed with the attention she received during the procedure. The storyteller shared how she felt that it would have been helpful to be informed that she would need to have daily injections prior to the procedure. Whilst she did not struggle with this and had a family network around her, she recognises that this may not be the case for everyone. The storyteller was pleased to be able to go home the same day and was provided with a list of contact numbers to access support if needed, which was important to her.

Following the feedback being shared, actions have been taken to improve the process, some examples of this are:

- The story has been shared at the Same Day Discharge Hysterectomy Focus Group and at the Gynaecology Clinical Governance Meeting, and plans put into place to address key areas identified for development.
- The storyteller's experience has been captured in a second video that will be used to help raise awareness with patients considering receiving the same procedure. Helping them to learn through the experience of a fellow patient, using her own words to describe the experience.
- Learning taken from the feedback has led to processes being reviewed to inform patients about anticoagulant treatment pre-operatively.

The patient stories have, and are continuing, to lead a number of improvements across the Trust.

6. Third Party Feedback

Feedback Sites

People accessing services within the Trust can record their experience on the Care Opinion and NHS Choices websites. During 2021/2022 there were 58 comments posted about the Trust. Of the feedback posted 33 posts were positive experiences and positive staff attitudes, more specifically about being treated with respect and a positive experience when accessing areas such as ED, Maternity, Phlebotomy, Endoscopy, Audiology, Gynaecology, Vascular and Radiotherapy Teams. The remaining 25 were negative comments relating to wait times in Telford and Shrewsbury Emergency Departments, the estate and facilities within the area, and wait times for elective procedures. All comments have been shared with the relevant Departments/Wards.

Healthwatch

Due to visiting restrictions, no Enter and View visits have taken place within the last quarter.
As visiting is reinstated across the Trust in a risk-managed way, in recognition of local prevalence within the community, the reintroduction of Enter and View visits will continue to be reviewed in a planned approach.

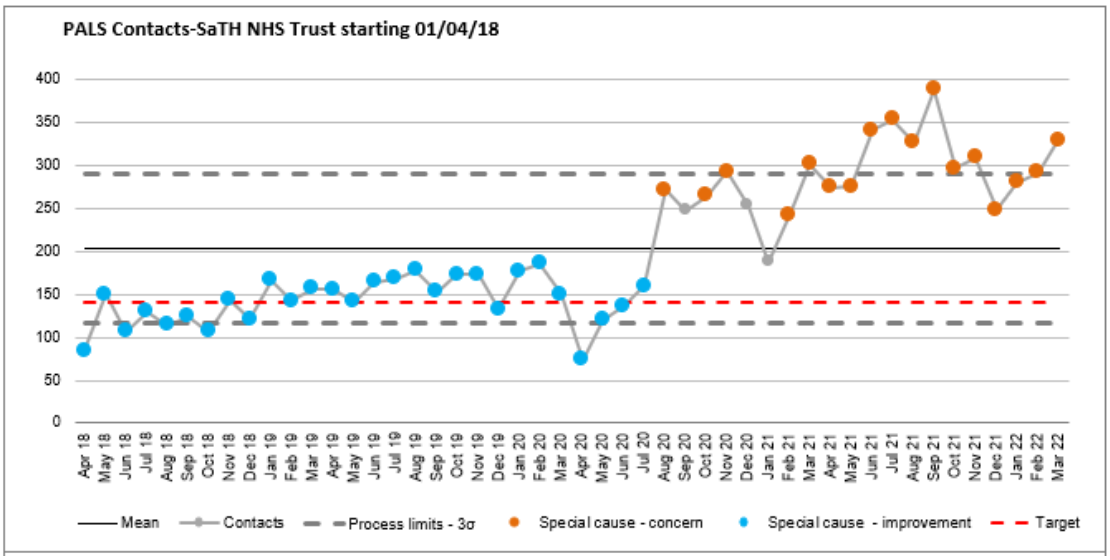
During 2021/2022 the Trust, Healthwatch and key stakeholders explored an approach to gather feedback from children and young people accessing mental health services, to learn from their experiences and how services can be developed to support them. The Healthwatch survey findings were published in quarter four. During quarter three Healthwatch and Powys CHC were invited to join the Patient and Carer Experience Panel.

7. Patient Advice and Liaison Service

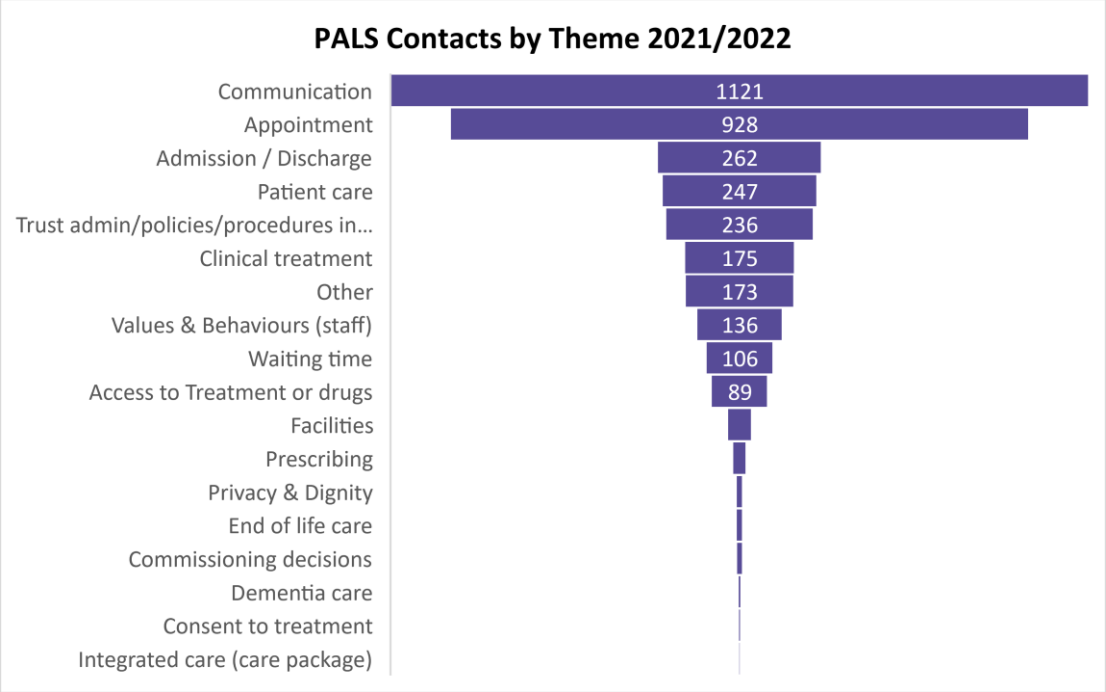
The Patient Advice and Liaison Service (PALS) are available to assist and support patients, service users and people important to patients, they can be the first point of contact for any concerns they wish to raise about their care or service they have received. With prompt action these concerns can often be resolved quickly and have positive outcomes. The PALS Team can be contacted by telephone, email or in person.

PALS Activity

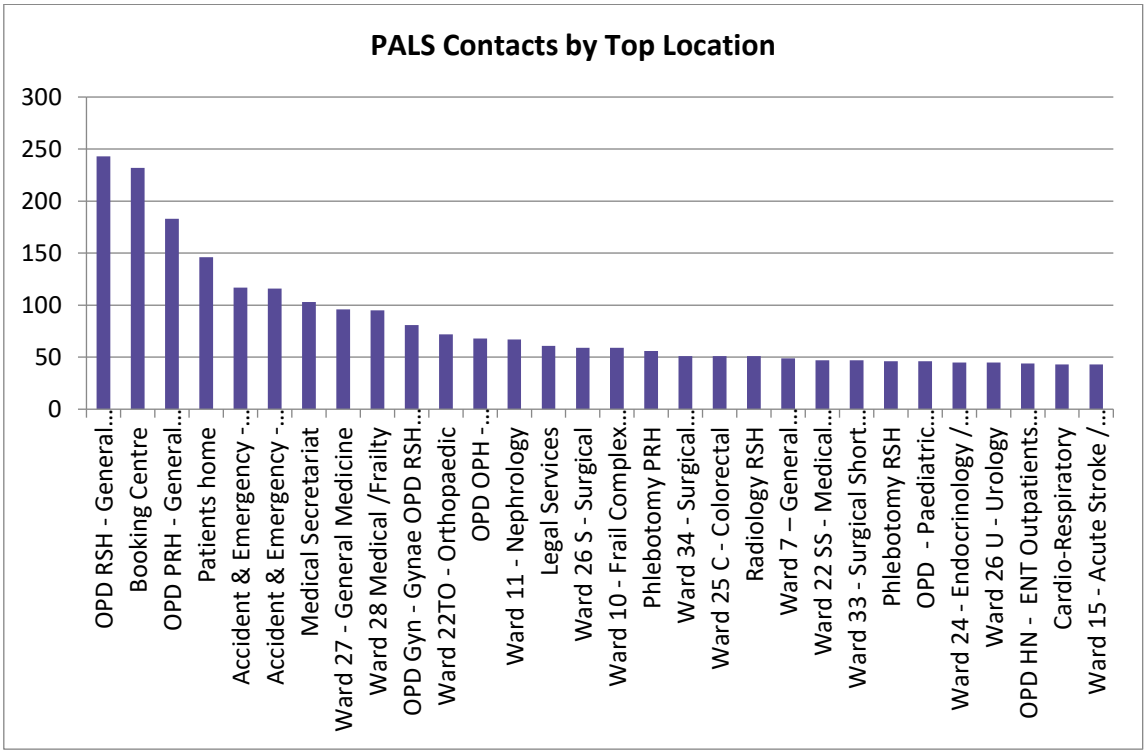
During 2021/2022, the PALS team received 3721 contacts from people wishing to receive support with raising a concern or obtain advice from PALS. The number of contacts reflects an increase of 1182 cases in comparison to the previous year, and an increase of 1769 contacts in comparison to 2019/2020.



The majority of concerns were connected to the Covid-19 pandemic, experiencing difficulty with communication whilst visitors has been restricted, and concerns relating to delayed appointments as a result of the backlog that has built during the pandemic.



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

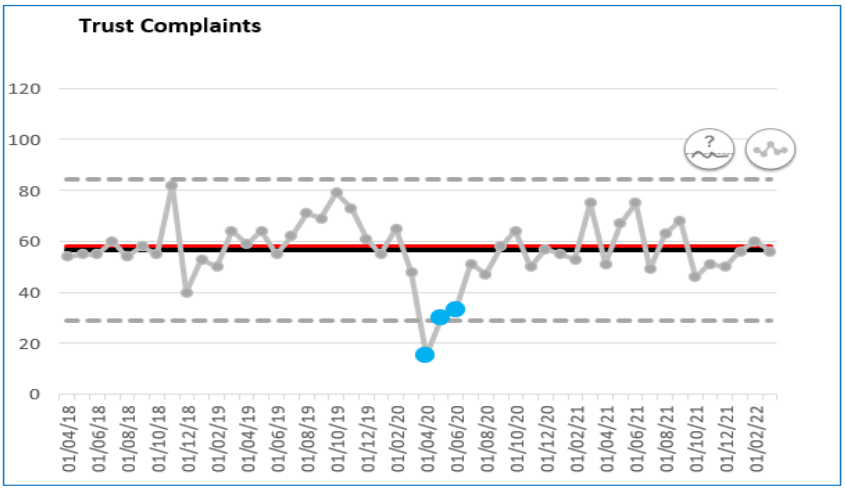


8. Complaints

The Trust endeavours to provide a good patient experience, however when this is not achieved complaints provide valuable feedback and learning which can help drive improvements.

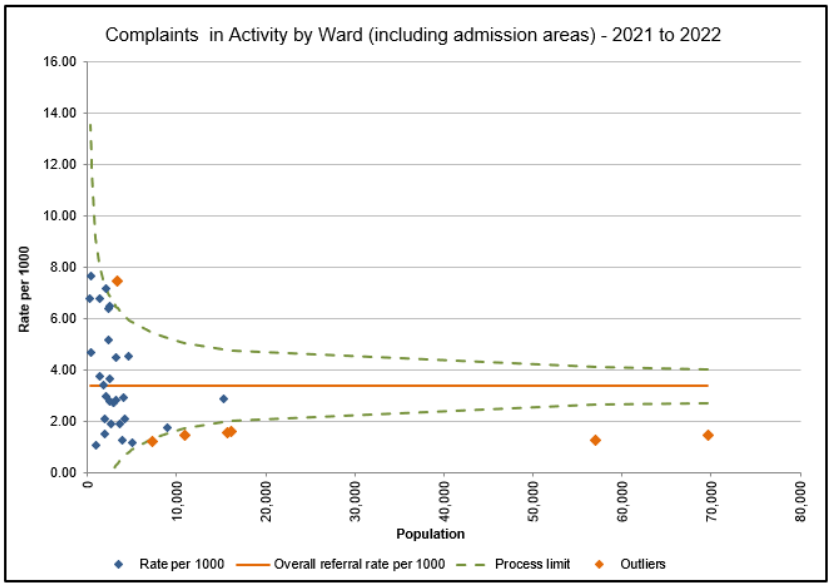
During 2021/2022 the Trust received a total of 688 formal complaints, an increase of 100 in comparison to the previous year. However, this equates to less than one in every 1000 patients complaining (0.72 complaints per 1000 patients) reflecting a slight decrease in comparison to the previous year when compared to activity (0.78 complaints per 1000 patients).

The graph below shows the number of complaints over the last four years which remain within common cause variation through 2021/2022.

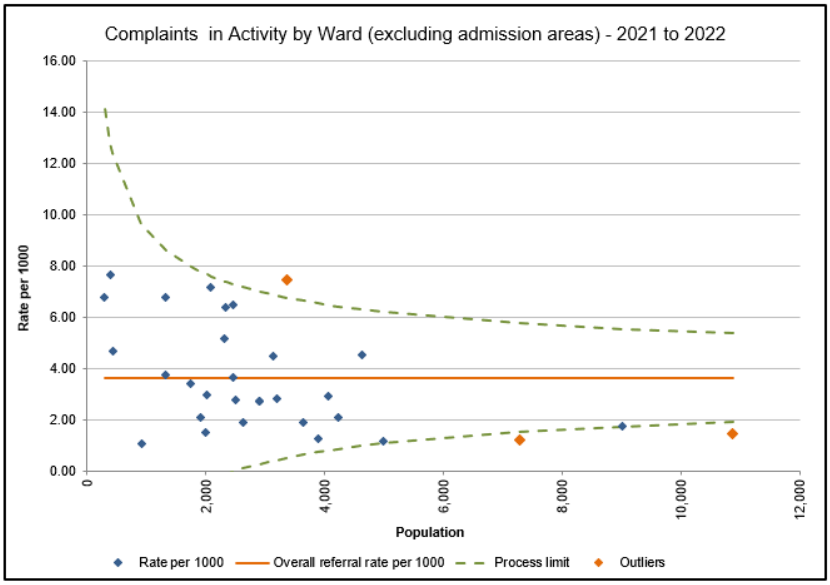


The number of complaints has remained overall in line with average numbers for a Trust this size, with some in-month variation. The breach of the lower control during 2020/2021 corresponded with a decrease in activity, linked with the Covid-19 pandemic.

Of the 740 complaints closed in 2021/2022, 18% (137) were upheld, 66% (487) were partially upheld and 16% (116) were not upheld. A complaint is deemed to partially upheld if any aspect of it is upheld in the response and fully upheld if the main aspects of the complaint are deemed to be upheld.



Reviewing the number of complaints by area in comparison to activity enables comparison per 1000 patients.



Removing admission points from the data set provides greater clarity and transparency to support comparison between wards. Measuring the data in this way identifies three special cause variations (outside of the 99.7% process limits), one variation above the upper process limit and two variations below the lower process limit, identifying two areas with a low number of complaints compared to activity.

Performance

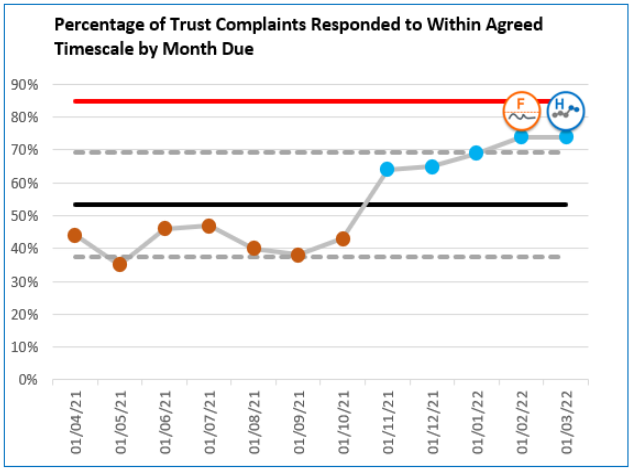
Acknowledgement

The Trust is required to acknowledge all complaints either verbally or in writing within three working days of receipt. This was achieved in 99% of cases in 2021/2022; in those cases where the written acknowledgement was late all patients had had a verbal acknowledgement within three working days. The Complaints Team have set a stretch target of sending a written acknowledgement within two working days, and 92% of complaints were acknowledged within two working days in 2021/2022.

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

Response Times

Each complainant is given a timescale for response, which will vary depending on the complexity of the complaint and the level of investigation required. Where it is not possible to respond within the initial timescale agreed, the complainant is contacted and advised of the delay and given a new timescale. In 2021/2022, 53% of complaints were responded to within the initial agreed timescales, which is a decrease from the previous year by 7%. Delays were due to staff within Divisions not responding to the Complaints Team in time, or further information being required; this was due to a variety of reasons, the main ones being competing clinical priorities, staff availability, and access to patient records.



The table to the left reflects the percentage of complaints due each month that were responded to within the agreed timescale. Work is ongoing to improve response rates, this has been an area of focus during 2021/2022, with response rates in year increasing from 42% in the first quarter, to 71% in the final quarter of the year. Whilst the Trust target of 85% has failed to be achieved, a high special cause improving variation has been demonstrated.

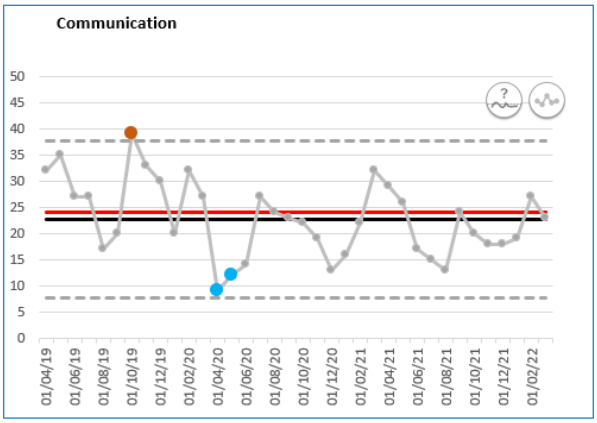
Work is ongoing to sustain and further improve response rates, including training for staff in responding to complaints, weekly meetings with senior managers within the Division, and a more robust sign-off process. There has additionally been a focus on reducing the number of overdue complaints, with the backlog being reduced from 171 to 33 at the end of 2021/2022.

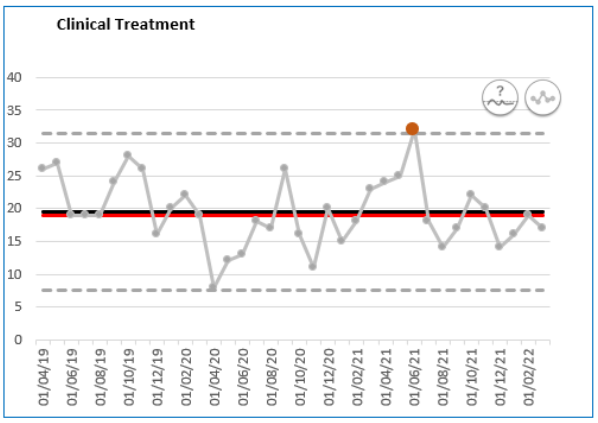
Key Themes of Formal Complaints

Each complaint may be multi-faceted, particularly where the complaint relates to inpatient care that may involve the multidisciplinary team or events over an extended period of time. Each theme identified in the complaint is recorded which means that the total number of issues will exceed the number of formal complaints received. The graphs below show the number of concerns raised by theme across the Trust in 2021/2022.

a) Communication

This category covers all aspects of communication, written and verbal, with the patient, relatives, between staff, with the GP and in relation to test results. During 2021/2022, the Trust received 249 complaints where communication featured. One of the main areas of concern raised continues to be problems with relatives getting updates whilst visiting has been restricted, and areas have continued to work on improving this.





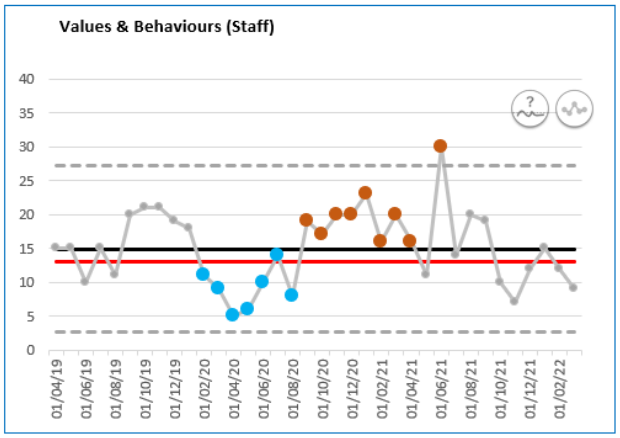
b) Clinical Treatment

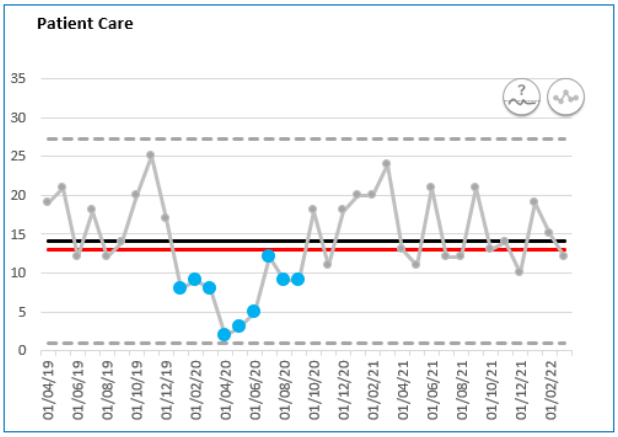
Complaints within this category may involve aspects of the clinical care provided by health professions, as well as complaints about the patient's diagnosis and treatment, any complications,

and pain management. During 2021/2022, there were 238 complaints that fell into this category; there was one breach of the upper warning limit. Most of these complaints related to delays in diagnosis and misdiagnosis (including missed fractures) and delays in treatment.

c) Values and behaviours

This category includes complaints about staff attitude, professional behaviour, and breaches of confidentiality. There were 175 complaints within this category during 2021/2022, with one breach of the upper warning limit. In July 2021, the Trust held a range of activities to raise awareness of the Trust values and behaviours.



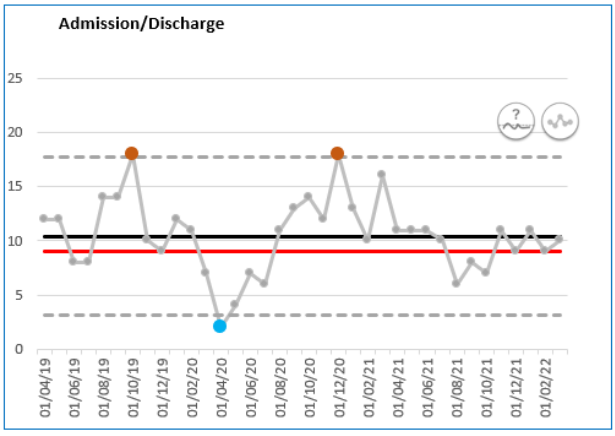


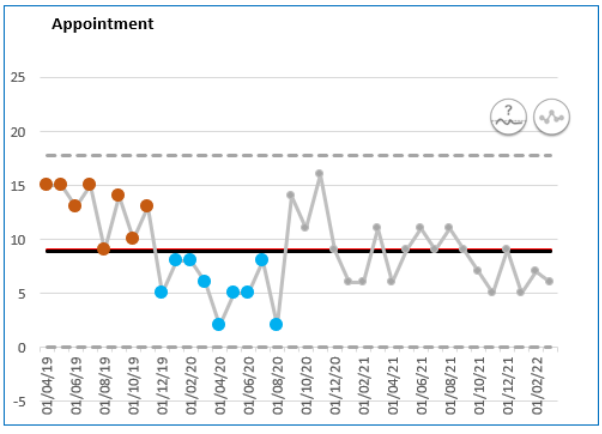
d) Patient care

Complaints within this category include complaints about patient falls, nutrition and hydration, infection control and pressure area care. The Trust received 173 complaints in 2021/2022 about this aspect of care; this has shown an increase from previous years, although numbers remain within expected variation. The majority of these complaints related to patients not having their care needs adequately met.

e) Admission / Discharge Arrangements

Complaints within this category relate to the patient's admission and subsequent discharge, as well as any transfers. During 2021/2022, there were 114 complaints within this category, a slight reduction in comparison to the previous year, and within expected variation.





f) Appointments

Complaints within this category include waiting times to receive an appointment and cancellations of appointments. During 2021/2022, the Trust received 94 complaints; there were no breaches of the upper warning and control limits. Most complaints are linked with waiting times and cancelled appointments.

Patient demographic data is collected for each complaint which enables feedback to be analysed to ensure that there are no groups of patients reporting a worse experience of care when accessing services or treatment within the Trust.

Actions and Learning from Complaints

The Trust is committed to becoming the safest and kindest Trust and as part of that, it is important that each complaint is seen as an opportunity to reflect, learn and make improvements in the areas that matter most to our patients, and the people important to them.

Examples of learning and changes in practice that have arisen in response to complaints are set out below:

- Following several concerns raised about a number of elements of nursing care, including skin care, communication and discharge, the ward used the complaint to make improvements in these areas. They are developing a process for supporting patients who area non-concordant with pressure care and using repositioning clocks for patients at high risk of developing pressure sores. New handover documentation has been developed and educational resources are available for staff on pressure care. The ward has also improved their forward-planning for weekends, to prevent patients being moved inappropriately.
- A patient raised concerns about the new tourniquets in Radiology, which she found were painful and resulting in blood blisters developing. As a result of this complaint, the team have sought advice and support from the Phlebotomy Department in how to fasten the tourniquets without pinching and have introduced additional checks when placing these. All staff have been assessed in fastening the new tourniquets.
- As a result of feedback about the Phlebotomy Department, more signs have been added, inside and outside to remind patients about social distancing when attending for appointments.
- There have been a number of concerns about issues with patient property. There are now specific bags in use for the property of Covid positive patients who have passed away, to help prevent property being lost. In addition, all wards and departments have leaflets on handling property and hand hygiene requirements that are given to relatives when collecting property.
- As a result of a complaint about the way in which a patient's discharge was managed, changes have been made to ensure that discharge bloods are reviewed in a timely manner. Nursing staff also now ensure that they confirm with patients how they are getting home and explore options for transport with them.

- Following a case in which there was confusion about the impact of self-discharging before all tests could be done, additional information is now included in the regular induction of junior doctors on AMU to ensure that they are familiar with the correct process.

- A woman raised concerns about the lack of support and communication following a miscarriage. A patient information leaflet has been developed and introduced in addition to advice from Tommy's and the Miscarriage Association which are now provided to all women having a miscarriage. A digital patient story has been captured to increase staff awareness and learning from feedback and staff are receiving training in sensitive communication. The area is being visited by the Chaplaincy Team daily to provide additional pastoral support to people experiencing a loss.

- The misinterpretation of a letter from a patient enquiring about their forthcoming appointment led to the appointment being cancelled unnecessarily. This case has been shared with the team, to highlight the need to read correspondence thoroughly before acting. Staff have also been given support in using the different systems to identify patients seen in the community.

- As a result of incorrect information being recorded at pre-operative assessment, a patient's surgery was cancelled. The case was shared with staff so that they were aware of the implication of incorrect information, and the importance of correct documentation. In response to learning, the team have developed an induction form and a leaflet for temporary staff, providing them with the information they need to correctly complete tasks.

- A patient raised concerns that his surgery was cancelled as the correct pre-op arrangements were not in place. As a result of his complaint, the pre-operative assessment and Bookings Teams now work more closely, to identify patients who require additional resources. One of the pre-operative assessment rooms has been adapted to better accommodate patients arriving on stretchers, and the pre-operative template now includes a section to check which Covid-19 pathway the patient is on.

- Concerns were raised about delays in the patient being discharged, and the family not being involved in the discharge planning. Staff have been asked to ensure that they clarify with the patient and their families who the best main contact is for discussions regarding discharge planning. They have also been advised to seek social worker advice and support in terms of discharge planning, particularly when the case is complex or there are conflicting views. Where a concern or resource constraint lies beyond the scope of the Department, staff will provide contact details to help the patient or relative find out the information they need from the appropriate department.

- As a result of a complaint from the family about care and treatment of two patients, and the poor communication with the family, a number of changes have been introduced. There are now clear communication plans in place to ensure that families are updated. The Tissue Viability Team and Falls Specialist Nurse have worked with the ward staff to provide additional training. The importance of the discharge checklist and transfer letter, which

incorporates a body map and telephone handover when discharging to care homes has been reinforced to the clinical teams.

- Concerns about the care and support a patient received led to discussions with staff about personal and individualised care. Staff are aware that personal care includes hair, nails, and shaving for men, and additional training has been given to reinforce this and the importance of supporting patients in maintaining their dignity.

  The Ward Manager has contacted the company that supply continence products and training has taken place with regard to choosing the correct continence product with a focus on the individual. This is ongoing to support staff and the Ward has been identified as a pilot area for trial for continence products and learning.

Parliamentary and Health Services Ombudsman (PHSO)

During 2021/2022, four cases were referred to the PHSO:

- Concerns relating to care of a patient on ITU with Covid-19; during 2022/2023, the Trust has had confirmation that this case was not upheld.
- Concerns relating to care of a patient attending ED with known heart problems; during 2022/2023, the Trust has had confirmation that this case was partially upheld, with recommendations about waiting times in ED, documentation, and referrals to specialty teams.
- Concerns regarding management of infection, and end of life care; this case is still under review.
- Concerns regarding management of a fungal infection; this case is still under investigation.

During 2021/2022, the PHSO concluded four investigations. Three of these were partially upheld:

- Concerns regarding treatment in ED and management of complaint; this case was partially upheld with recommendations about documentation.
- Concerns regarding boarding of a patient, assessments, and communication with families; this case was partially upheld with a recommendation for compensatory payment.
- Concerns regarding management of low potassium levels; this case was not upheld.
- Concerns regarding cardiology care; this case was partially upheld, with a recommendation for a further letter of explanation to be sent to the complainant.

PALS and Complaints Key Achievements

PALS and Complaints key achievements in 2020/2021:

- A reduction in the backlog of overdue complaint cases to 30 at the end of 2021/2022
- Improvement in response rates, achieving 71% in quarter four
- The introduction of a PALS Officer role within the Women and Children's Division, providing a more proactive service to families using services

9. Mixed Sex Accommodation

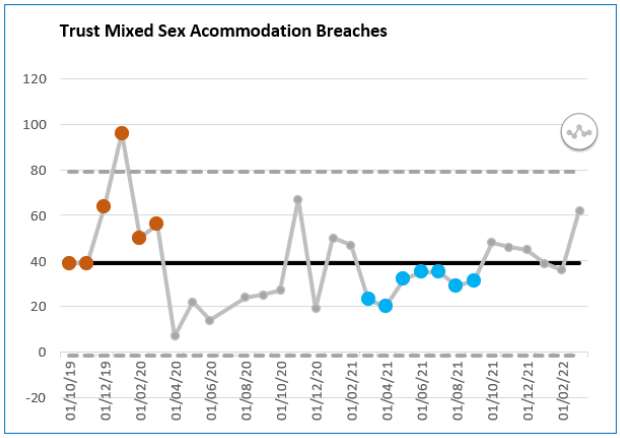
The Trust has a mixed sex accommodation policy in place outlining monitoring and reporting through Datix. Assurance measures are in place to manage breaches in general wards, if every alternative has been explored, proposals to breach are escalated to a Director through the Divisional management team or to the Executive on-call out of hours to gain approval.

Mixed sex accommodation breaches are displayed on local quality dashboards and reported to the Quality and Safety Assurance Committee and the Board of Directors each month in the integrated performance report.

Patient feedback has not identified any concerns or complaints during 2021/2022 which relate to mixed sex accommodation.

Trust Overview of Mixed Sex Accommodation Breaches

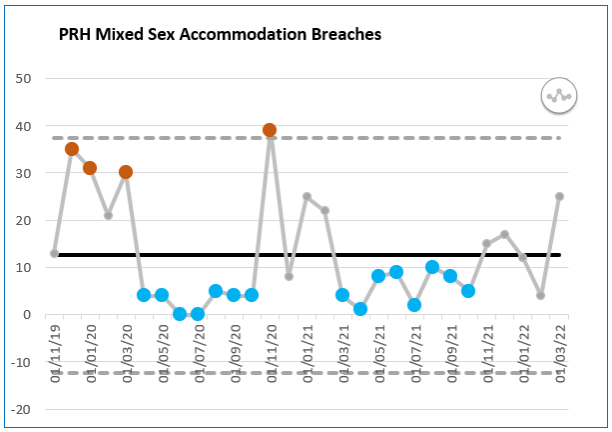
Mixed sex accommodation breaches across the Trust increased in January 2020, reflective of the increase in ITU/HDU reporting. Further increases in reporting were reflected in November 2020, January/February 2021, and February 2022 reflecting an increase in breaches due to Covid-19 measures in place to maintain site safety.

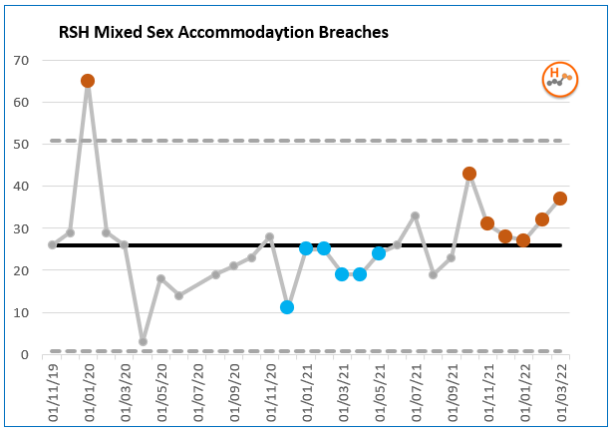


Recent mixed sex breaches reflect an increased demand and the requirement to cohort patients to maintain good infection prevention and control practice creating an additional challenge.

Mixed Sex Accommodation breaches at the Royal Shrewsbury Hospital (RSH) reflect a high special cause concerning variation, this is due to pressure transferring patients out of ITU and cohorting Covid-19 patients.

The number of mixed sex breaches at the Princess Royal Hospital (PRH) declined in April 2020 following a reconfiguration of the Hyper Acute Stroke Unit (HASU).

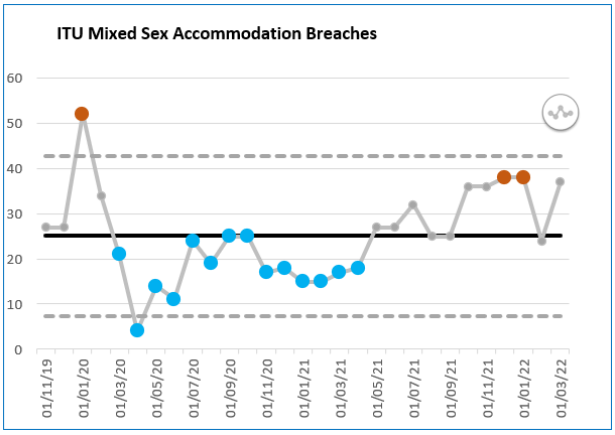


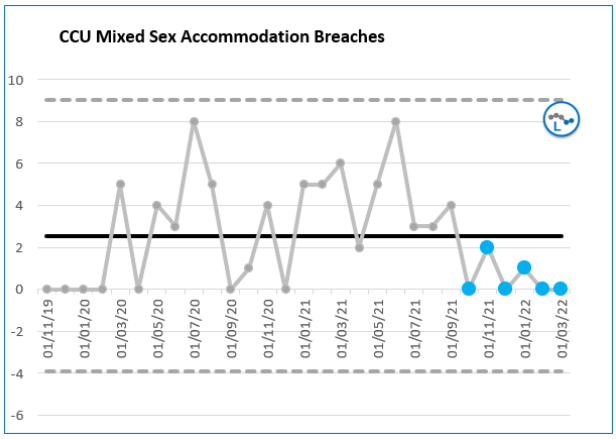


Speciality Mixed Sex Accommodation Breaches

In January 2020, the ITU and HDU mixed sex breach reporting changed to capture all patients who exceeded a 4 hour transfer to a stepdown bed. Prior to this point a local agreement was in place and breaches exceeding 12 hours were captured and reported. The Trust aligned reporting to reflect national guidance and provide greater transparency. The change in reporting is likely to account for the high variation in ITU/HDU reported in January 2020, and subsequent increase in Trust reporting.

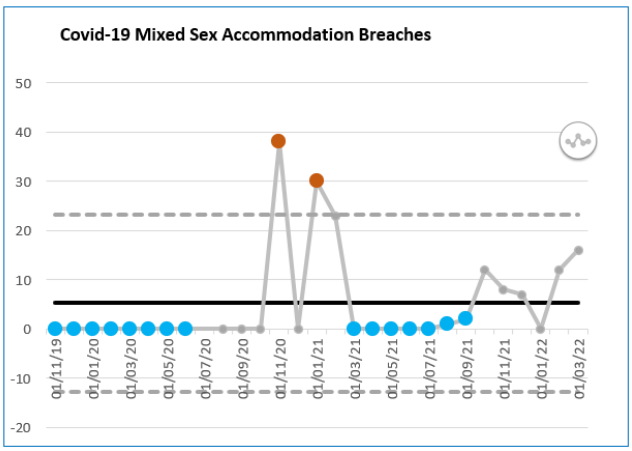
Cardiology moved to PRH in February 2022, since the reconfiguration there have been no mixed sex breaches due to CCU patients being fit to transfer to a stepdown bed.





Covid-19 Mixed Sex Accommodation Breaches

In response to the Covid-19 pandemic, national mixed sex breach data collection paused in April 2020 and resumed for October 2021 data. Whilst national data collection paused, local reporting remained in place to maintain operational intelligence and an understanding of pressure within the system.



To deliver effective infection control patients have been cohorted in accordance with their Covid-19 status, recognising the challenges on mixed sex accommodation to provide a proportionate response to the immediate risk posed by Covid-19. As a measure to reduce risk ready rooms were utilised across the Trust during the pandemic to isolate patients. The use of ready rooms and systems to minimise infection risk do not negate the requirement for single sex accommodation, to provide transparency use has been reported as a mixed sex breach if mixing of sexes occurs.

Covid-19 has had an impact on the number of mixed sex accommodation breaches across the Trust. Whilst breaches within general ward areas have been captured and reported as an impact of Covid-19, the impact is likely to have affected reporting from Level 2 speciality beds due to the pressures placed upon the system.

10. Patient Involvement

When I first volunteered to join the Patient and Carer Experience (PaCE) group back in 2018, I really had no idea of the opportunities that would come my way to be more proactive by getting involved in various projects. At first I was nervous as I thought how I could influence decisions, how could I make a difference, who would listen to me. Afterall, I was working with medical staff who had far more experience.

I soon discovered that I could contribute by making comments on the impact of change from a patient point of view. Meeting staff from SaTH gave me a real understanding and an excellent insight into the work that they were involved in. Also, to appreciate the pressures they were under, but at the same time see individuals drive and determination to make changes to improve the patient experience as well as look to make improvements in their own work areas.

In addition to continuing to attend PaCE meetings, I volunteered to get involved with Quality Walks / inspections on various wards, in food tasting as the contract for a new supplier was going to be awarded. Last year I was invited to help shape the new Public Assurance Forum (an advisory group who ensure that decisions on services and the delivery of care are developed), I joined a group formed from members of the public and healthcare professionals to look at Women's Health, (Screening programmes, Menopause), producing a survey to help us look at what works well, barriers for women coming forward for treatment etc.

I also attended many virtual meetings to comment on proposed service changes within our hospitals, looking particularly on how changes may have an impact on patients but at the same time understand from SaTH's perspective why the change was required.

Another fabulous opportunity was to get involved with the Patient Information Panel, this involves reviewing patient literature and gosh was I surprised at the enormous amount of paperwork / leaflets, instruction booklets etc there was for a patient. The role involves reading the draft material, looking at the language used and ensuring the final product can be easily understood by members of the public.

I have learned so much since volunteering and have enjoyed working with some great people really building up good working relationships.

By Lynn Pickavance

Patient and Carer Experience (PaCE) Panel

The PaCE Panel consists of public and staff representatives who work together in a collaborative approach towards quality improvement and patient experience within the Trust. The panel includes representation from each of the Divisions together with Facilities, Estates, Engagement, PALS, and Complaints. Following a workshop that incorporated PaCE panel members, internal and external stakeholders a new structure for PaCE has been co-developed, the changes include:

- The panel is now chaired by the Director of Nursing.
- A patient representative has been appointed as co-chair to reflect the partnership approach of the PaCE Panel and strengthen the patient voice
- The name of the strategic group will remain as the 'Patient and Carer Experience (PaCE) Panel'.
- Speciality Patient Experience Groups will be established to provide a framework to drive patient experience initiatives at a local level.
- Representatives from Maternity Voices Partnership, Powys Community Health Council and Healthwatch have been invited to join the PaCE Panel, in addition to the Trust's Deputy Director of Education and Improvement, and a Communication Lead.
- The PaCE Panel Terms of Reference have been reviewed to strengthen the duties and ensure that the panel is a decision-making committee with the authority to support the patient experience agenda.
- Terms of Reference for the Speciality Patient Experience Groups have been developed and approved.
- A communication plan has been developed to support recruitment into the PaCE Panel and Speciality Patient Experience Groups. The Panel is seeking to reach patients and carers with recent experience of accessing services within the Trust during 2021/2022.

Involvement of patient and carer representatives provides an opportunity to review processes from a different perspective, providing insight that may not be considered by professionals. Involving patient and carer representatives in this way helps to ensure that the interest and needs of patients are considered at the heart of improvement work.

During 2021/2022 PaCE Panel representatives have supported:

- The Patient Safety Team to review report template paperwork used to investigate serious incidents. Providing feedback to ensure reporting provides clarity and can be easily understood from a patient and carer perspective.
- Patient Discharge Improvement Group.
- Mental Health and Learning Disability Operational Group.
- Patient Information Panel.
- A working group looking at the complaints process.
- Recruitment through participating in stakeholder groups.

In 2014, I was a cancer patient at the Shrewsbury and Telford Hospital (SaTH) Trust. My treatment involved two initial surgical operations, followed by a course of chemotherapy and then a further three operations which were as a consequence of but not related to the cancer. All of this took just four years and at the five year point from initial diagnosis, I was discharged from the care of the hospital. My treatment had been fairly intense at times but every time I was in the hospital I was looked after thoroughly. I did however struggle with life away from the hospital. At that time, support services were very sparse and the closest external support group for me was in Oswestry. I struggled with a wide range of thoughts and emotions which left me with many unanswered questions. My only source of recognised information was from the vast Macmillan library of books and leaflets. I did however manage to regain a fair amount of fitness and individual confidence, slowly, throughout the five years.

In Dec 2018, I answered an advert for people to join a joint venture between SaTH and Macmillan. The programme was titled Living With and Beyond Cancer (LWBC) and was asking for people with real experience of cancer to tell their story during the programme. It was hoped that this would support the theoretical content of the programme by giving a human element. I was selected to join the programme and gave my first presentation in Feb 2019. During the programme I listened to the main presentation and was amazed at how closely the information matched what I had done throughout my recovery. The only difference was that the programme wasn't around when I went through treatment. I could see the relief of some of the patients attending, as they realised that help was available to enable them to help themselves. I had been through recovery by myself but this programme would have such a positive impact on all involved, I was hooked. Nobody should be alone through any illness and being a volunteer on this programme would be really worthwhile. I now help to present on many of the sessions, have been involved with the background of the programme and have started developing support courses for any volunteer who would like to join the programme. I have found the last three years really worthwhile and would recommend the experience to anybody who wants to join us. Since the start, we have helped over 500 people through face to face and online sessions and the feedback has been fantastic.

By Colin Stockton

11. Equality and Diversity

Equality, Diversity and Inclusion (EDI) Advocates Group

The EDI Advocates Group consists of patient representatives, carers and members of the community who volunteer their time to work collaboratively with staff members. With a shared interest and understanding of areas such as: disability, mental health, sexual orientation, sex and gender, pregnancy and maternity, and nationality/ethnicity, the group are able to provide a voice of their lived experiences.

The group is chaired by the Equality, Diversity and inclusion Lead; and includes representation from Patient Experience and Community Engagement Teams. By working collaboratively with staff, the EDI Advocates support and challenge the Trust in identifying existing health inequalities and develop action plans to tackle and eliminate such issues.

During 2021/2022, meetings have taken place virtually, until a recent pause whilst the EDI Lead vacancy was being appointed into. Examples of projects which have taken place include:

- Received updates on Pathway Zero and International Nurse Recruitment
- Received an update on the Chaplaincy Team, work undertaken and future planned objectives.
- Had input into the new Trust Equality Impact Assessment template.
- Explored approaches to expand and promote the group
- Explored how EDI can work closer with organisations across the Integrated Care System (ICS) to establish a system approach.
- The Trust Delivering Same Sex Accommodation Policy was updated during the COVID-19 pandemic and the equality impact assessment has been reviewed by the group to ensure that consideration has been given to the potential impact on patients from a range of demographics.
- The EDI Advocate Group co-chair patient representative has been invited to join the PaCE Panel.

During 2021/2022 the EDI Advocates Group representatives have supported:

- Members took part in a focus group reviewing the Trusts recruitment process to ensure it is accessible for applicants and how best to progress Level 2 of the Disability Confident Scheme
- Mental Health and Learning Disability Operational Group
- Recruitment through participating in stakeholder groups

Equality and Diversity

Cultural Diversity Day (21st May 2021) an event to celebrate diversity was held across the Shropshire, Telford & Wrekin Integrated Care System. The day incorporated a variety of online events, including staff stories, cook-a-long, poetry and Bhangra dancing, as well as presentations from Yvonne Coghill CBE (Director of Excellence in Action) and Dr Michael Brady (National Advisor for LGBT+ Health, NHS England).

Feedback from the event was positive with a number of requests to establish an annual event. The keynote speakers attracted the largest attendance followed by the staff stories which were described as; 'SaTH stories: the international nurses were inspirational', 'true experiences and very touching' and 'it was thought provoking and real and a real privilege to witness the stories that were presented.'

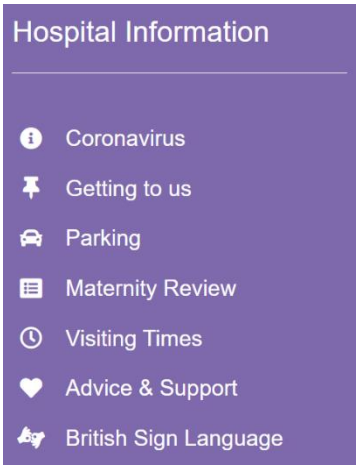
Carers Week (7th to 13th June 2021) is an annual campaign to raise awareness of unpaid carers. Many carers see themselves as husband, wife, parent, child sibling or friend and do not recognise themselves as a carer. Becoming a carer can start gradually through taking on small roles or tasks, however this can often extend and incorporate a wide range of roles such as housework, assistance with washing and dressing, cooking, taking medicines and providing physical and emotional support. The theme of Carers Week this year was 'making carers visible and valued'. This was supported through raising awareness of recording unpaid carers in admission documentation, signposting to the website carers pages for advice, referring carers to the Carers Hospital Link Workers and booking a place on the 'unpaid carers awareness' training sessions.

Learning Disabilities Week (14th to 20th June 2021) the theme of this year's Learning Disability Week was art and creativity. Prior to the Covid-19 pandemic, the Patient Experience Team partnered with Derwen College in Oswestry, to promote the Treat Me Well campaign via Craftivism (craft activism). Treat Me Well is a campaign run by Mencap that seeks to improve the way that the NHS treats patients with a learning disability in hospitals – this includes providing better communication, more time and clearer information.

To raise awareness and support the initiative completion of the Trust learning disability competency workbook was promoted in addition to eLearning and learning disability workshops being held across the Trust. The resources available to support patients were similarly promoted, examples of these include: patient passports, easy read patient information, Acute Liaison Nurses, reasonable adjustments, compassionate visiting, and the Trust intranet page.

Health Screening: In response to feedback additional patient information leaflets have been sourced in a wider range of languages and easy read to provide improved access and points of reference. The information has been made available on the Trust website to support people in the community for whom English is not their first language and for people requiring easy read literature.

A stakeholder group is presently exploring women's health and how information can be made more accessible.



British Sign Language Information: The British Sign Language (BSL) library has been added to, providing further information to members of the community seeking to access services within the Trust.

A link from the Trust Website home page has been introduced to improve ease of accessibility for people using British Sign Language who are accessing the website.

Women's Health: The Gynaecology and Patient Experience Team linked in with the Target Ovarian Cancer charity to helped to raise awareness through Ovarian Cancer Awareness Month during March 2022. An online training toolkit for cervical screening to help practitioners improve the experience for LGBT women developed by the LGBT Foundation has been shared with the Trust Lead Colposcopy Nurse and disseminated throughout the team to increase awareness and enhance support offered to patients.

Interpretation: To help increase awareness of the interpreter service, how this can be accessed to support patients in accessing healthcare and understanding their diagnosis, treatment options and be involved in making choices about their care, posters have been developed and provided to departments to display in waiting areas.

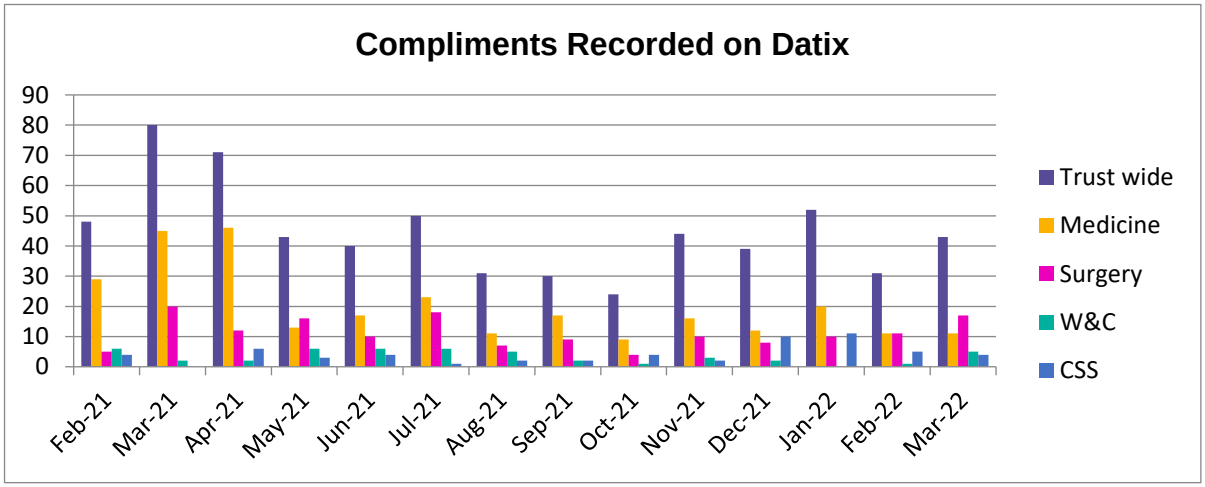
QR codes incorporated into the posters take people to information on interpreting in the main four languages requested through the Trust, in addition to support for patients with a learning disability or autism and support for people who are deaf or hard of hearing.

Access to Information: To help increase accessibility to information for patients and people important to them posters have been developed for all clinical areas. QR codes provide easily access relevant information on the Trust website that includes: patient and visitor information, information for carers, information about the NHS rainbow badge initiative, the feedback hub, the Chaplaincy Service, car parking, PALS and how to raise a concern.

12. Compliments

A system for areas to record positive feedback received from patients, carers and visitors was introduced during quarter four 2020/21. This allows the Trust to measure and report on compliments, in addition to concerns and complaints.

Positive feedback can sometimes be overlooked however it is important to capture positive patient experiences to identify what went well and learn from this. Positive feedback given to a team recognises and appreciates the service they delivered, boosting morale.



A total of 498 compliments were captured and reported on Datix during 2021/2022. The Trust receive substantially more compliments than are presently captured and plan to raise awareness of recording compliments to improve on this figure in 2022/2023.

The main themes mentioned in compliments are around; nursing care (178), support for the patient (162), friendliness of staff (138), meeting the patient's needs (117), clinical care (96), support for family (87), keeping the patient comfortable (81), end of life care (34), emergency care (26), prompt treatment (25), the outcome of treatment (20), the Chaplaincy Team (6) and other themes (55).

The following areas across the Trust recorded the highest number of compliments on Datix during 2021/2022:

1st: ED (RSH)

2nd: Ward 32 (RSH)

3rd Ward 16 (PRH)

A sample of compliments which have been received during 2021/2022 are:

I usually get my injections delivered to my home address, but the company were awaiting a prescription from the hospital. I had no injections as my last injection pen was faulty and I was due to inject within the next few days.
I contacted the pharmacy department at Shrewsbury and spoke to XXXX who dealt with the matter efficiently and professionally. She obtained an emergency script from the IBD team and went above and beyond by offering to meet me to hand over the medication on her way home from work as I lived on her route home. She is a true asset to the pharmacy department and NHS.

(Received via the Trust Feedback Hub)

I had a procedure today and, from the moment I arrived with my husband, we were treated with the level of care the NHS should be proud of, I was made to feel at ease and fully informed all the way through my procedure. I had spent the prior 2 weeks hearing different stories of other people's experiences of the procedure itself, but the staff soon put my mind at ease. It is really nice to see a team so dedicated to their job ♥

The ward itself is very well laid out and all my needs were met from staff that made my time the least stressful as possible.

I would like to thank all staff involved in my care today from a lady with a husband in a wheelchair ♥♥

(Received via Care Opinion)

Our little girl was in for 2 nights, and all the staff were brilliant, so friendly, and helpful. Loved the fact there was a parents' lounge to help yourselves to tea and coffee, no one wants to ask staff for a drink when they are so busy. Special mention to the advanced practitioner, she was fab. She saw our daughter in RSH A&E on Sunday and again on Monday night in PRH. She was brilliant! And great with me as I was understandably distressed and alone. The staff were brilliant and make me grateful to have the NHS! Thank you to everyone that looked after our little girl.

(Received via the Trust Feedback Hub)

I would sincerely like to thank every single member of staff who assisted my elderly neighbour, brought in 26.09.2021 approximately 19.30 hours, we stayed with her to approximately 22.30 hours assisting her sitting/holding, calming her etc. On arrival a kind passing porter offered and found a wheelchair for us to assist the patient to the ward. Another kind member of staff took us onto the AMU ward whilst waiting for the buzzer to be answered. Despite being incredibly busy lots of different members of staff asked if we were being seen to. I was so impressed with the kindness and efficiency of staff from nurses of all grades and doctors. The patient was in immense extreme pain, and she was treated with such kindness and care to quickly get on top of her excruciating pain. I was so impressed with the care and consideration given to her and also to myself and family member assisting with her during this time. I thanked the staff on leaving but really really wanted to express in writing my thanks also. The team was under enormous pressure and so incredibly busy and I was impressed beyond words and hope that they realise that they might just think they are doing their very busy job, but they were absolutely amazing, and I am so grateful for their kindness and expertise. Please pass on my thanks to all the staff, they are so appreciated and wonderful.

(Received via Feedback Hub)

13. Chaplaincy

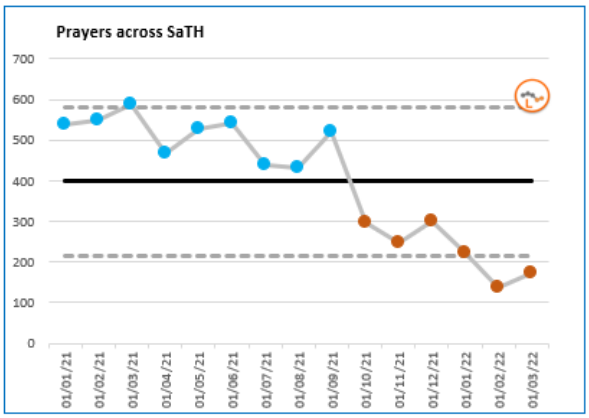
The Chaplaincy Team has been through a period of recruitment to increase the chaplaincy provision and services offered across the Trust. In quarter one the team consisted of a Team Leader and a Chaplain totalling 1.6 whole time equivalent (WTE) chaplaincy staff. The Trust recognises that the growing diversity and different religions, faiths and beliefs need to be taken into account across the healthcare sector in developing and delivering services. Following the posts being advertised openly for applicants of any faith, religion, belief, or none to apply, the Trust recruited an additional 2.5 WTE Chaplaincy staff.

A priority for quarter three and four was to increase visibility of the Chaplaincy Team across the Trust to enhance staff awareness of the support and services they offer, the following examples are actions that have been taken to support this:

Chaplaincy pages have been published on the Trust website, providing information about the Chaplaincy Team, Chapels, and quiet places for reflection across the Trust. The webpages provide information about services the Chaplaincy Team provide, how to contact the team, enables people to leave feedback and highlights pastoral, spiritual and religious events and festivals taking place throughout the year.

Prayer trees have been established by each Chapel entrance, inviting people to write a prayer or message for someone important to them and hang it on the tree. The messages are pruned at the end of each month, leaves gathered, dedicated, and then disposed of in a confidential way. Within the first month of use the prayer trees collected 132 prayers and messages.

Services were held in both Chapels on Armistice Day and Remembrance Sunday, to remember and honour service men and women. Whilst the Chapels remain restricted to 6 people at any one time, in line with the Covid-19 risk assessment, three of the four services were at full capacity with additional staff participating in the corridor to maintain social distancing. In honour of Armistice Day, the Chaplaincy Team asked veterans working within the Trust what the day meant to them. This was shared across the Trust and on the Trust website to raise awareness of veterans and our commitment to the Armed Forces Covenant: [Remembrance Day 2021 - SaTH]

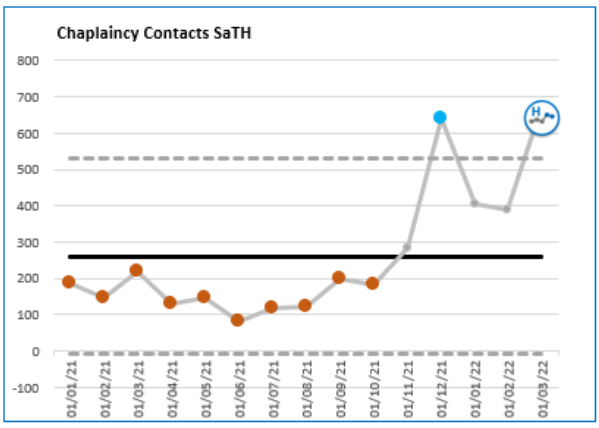


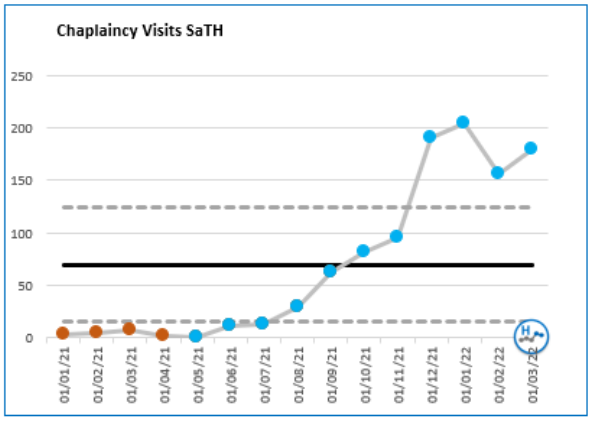
The number of prayers recorded across the Trust include prayer requests, pebble pool requests and messages left on the message / prayer trees. The total recorded has decreased, however, this is due to improvements in processes across the Chaplaincy Team and governance around recording and measuring data.

In 2021/2022 there were a total of 4304 prayer requests, 4,765 pebble pool requests and 380 messages on the prayer/ message trees over the five months following introduction.

The Chaplaincy Team have continued to visit clinical areas throughout the Covid-19 pandemic, providing pastoral, spiritual and religious support to patients, people important to them and staff. During 2021/2022 the Chaplains recorded 1246 visits, which can range between minutes to hours dependent upon need.

Chaplaincy visits and contacts demonstrate increases in activity in September and December 2021 and March 2022, directly comparable with dates when new members joined the Chaplaincy Team.





Further examples of activities and work undertaken are:

- The Chaplaincy Team have been building relationships with staff across the Trust, visiting Wards and Departments
- Attending the End of Life Steering Group
- Attending the Race, Equality & Inclusion staff network
- Visiting Chaplaincy Teams within the Region to share practice
- Established a Pastoral, Spiritual and Religious Care Group with members of the local community
- In November 2021, the Chapels were lit up to celebrate Diwali, also known as the festival of lights
- Developed relationships with Play Leaders and Teachers in Paediatrics, to work together to recognise festivals and events throughout the year
- The Chaplaincy Team are involved in the new Health Care Academy training programme across the Integrated Care System, highlighting the pastoral support offered by the team to support patients, people important to them, volunteers and staff.
- A local Chaplaincy network has been established by the SaTH Chaplaincy Team, the meeting was well received by chaplaincy colleagues across the system and wider, presenting an opportunity to network and share best practice. Quarterly meetings are planned throughout 2022/2023, to build upon the initial work.
- The Chaplaincy Team seek to recognise and celebrate events and festivals, for a range of faiths and beliefs. In February 2022 the team recognised Parinirvana, a Buddhist festival of remembrance, and staff were invited to add a heart with the name of a family member or friend who has passed away, in order to remember them. A total of 48 messages of remembrance were shared.

14. Next Steps

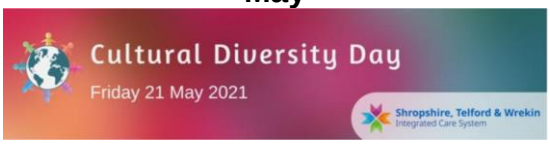
The Trust recognises that to create a patient-centred organisation there needs to be meaningful engagement and involvement with patients, carers, the community, and stakeholders. The importance of obtaining feedback using a range of methods is critical and can provide information which can be used to influence change and improve services.

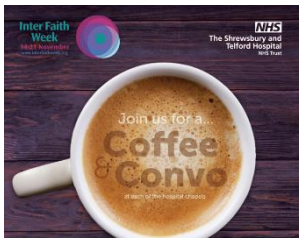
The Trust aims to provide patients and their carers with the best possible experience whilst accessing services within the hospital. There are a range of positive improvements which have been introduced over the last year, however it is recognised that there is still work to do and the Trust is on a journey of improvement. Over the next year the Trust will continue to make further improvements which include:

- Investment into the Complaints Team to incorporate development opportunities for staff within the departments, providing succession planning to develop talent and potential future leaders to fill business-critical roles.
- Focused work to further improve complaint response rates to provide an improved experience to people accessing the service.
- Development of improved governance and monitoring of actions arising from complaints to track improvements.
- Prior to Covid-19 a small number of volunteers supported the patient experience team through gathering patient experience surveys and feedback. This work stopped during the pandemic, however, as volunteers are resuming their roles within the Trust, re-establishing a volunteer team to support and enhance the work previously undertaken will be a priority.
- Maximising use of the 'you said – we did' functionality in Gather, will provide greater visibility of actions being taken in response to feedback. Displaying improvements will encourage patients, and people important to them to share feedback as they will have assurance that the Trust is actively listening and responding.
- The Chaplaincy Team were unable to provide baby remembrance services due to restrictions in place throughout Covid-19. In 2022/2023 the Chaplaincy Team and Bereavement Specialist Midwives plan to relaunch biannual remembrance services within the local community, working with local faith and belief leaders to support families that have experienced a bereavement.
- The Chaplaincy Team will develop wider links with faith and belief leaders across the community, seeking to recruit a diverse team of volunteers and honorary Chaplains.
- Develop a new patient experience strategy, through engagement and involvement of patient and carer representatives
- Recruit patient and carer representatives to become active members of the Speciality Patient Experience Groups and Patient and Carer Experience Panel.
- Establish an Independent Complaint Review Group to review and improve the quality of complaint responses, providing greater assurance to stakeholders and regulators.
- A customer care and complaints training programme will be made available to staff, to develop knowledge and skills to ensure that they are better equipped to communicate effectively to support early resolution of concerns.

Appendix

Patient Experience 2021/2022

	2021
April 	**Experience of Care Week** The Trust celebrated experience of care week, reflecting upon work undertaken across health and social care to keep improving the experiences of our patients, families, and carers.
May 	**Cultural Diversity Day** A cultural diversity event was held in partnership with the Integrated Care System to celebrate diversity within the workforce and across the local community.
June PACT Partnering · Ambitious Caring · Trusted	**Corporate Welcome Launch** Corporate welcome sessions launch, providing all new staff joining the Trust an oversight on a range of corporate functions. A session on patient experience is now delivered to all starters.
July THE TRUST ANNUAL AWARDS 2021	**Behaviours and Values Month** The Trust held a range of activities to raise awareness of the Trust values and behaviours, activities included: drop in sessions, capturing staff stories, identifying what the values mean to staff and celebrating staff nominated as demonstrating the Trust values in the Trust awards.
August 	**Swan Room** A new SWAN Room opened on Ward 35, to provide privacy and dignity for patients and the people important to them. Helping to provide a calm and peaceful environment at the end of life. There are now over 20 Swan Rooms across the Trust.
September 	**PENNA Award** The Trust won the Integration and Continuity of Care Award in the Patient Experience Network National Awards 2020-2021 for the support and resources provided for people affected by cancer.

October	**Living with Dementia** Mandatory Dementia training updates become mandatory for consultants to reinforce best practice and improve the experience for people living with dementia receiving treatment in the Trust.
November 	**Inter Faith Week** To celebrate Inter Faith Week the Chaplaincy Team hosted 'Coffee and Convo' sessions in the Chapels, inviting staff to join them for a coffee, biscuit, and chat about how the service is developing to meet the needs of the diverse community served by the Trust.
December 	**Chaplaincy Team** Throughout advent the Chaplaincy Team engaged in a Trust wide campaign to market the service and promote staff engagement, highlighting the range of services offered by the Chaplaincy Team.
	2022
January 	**UNICEF Accreditation** The Neonatal Team received UNICEF Baby Friendly stage one accreditation for putting parents' voices at the heart of care, minimising separation, and empowering parents to participate in delivering their baby's care.
February 	**LGBT+ History Month** The Trust librarian team promoted an LGBT+ game to raise awareness of the barriers people experience to support a more inclusive culture.
March 	**Supporting people in A&E** The Serenity Suite has been created at the Princess Royal Hospital to provide a calm and sensory stimulating space within the A&E, providing a dedicated space for people living with dementia, a learning disability or autism.

NHS
The Shrewsbury and Telford Hospital
NHS Trust

This report can be made available in a range of languages and formats such as large print, audio, BSL film and Braille through contacting the Patient Experience Team:

Address: Patient Experience Team
Flat 1, Stretton House
Royal Shrewsbury Hospital
Mytton Oak Road
Shrewsbury
SY3 8XQ

Email: sath.patientexperience@nhs.net
Telephone: 01743 261000 extension 3032

Partnering
Ambitious
Caring
Trusted

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

Appendix 1

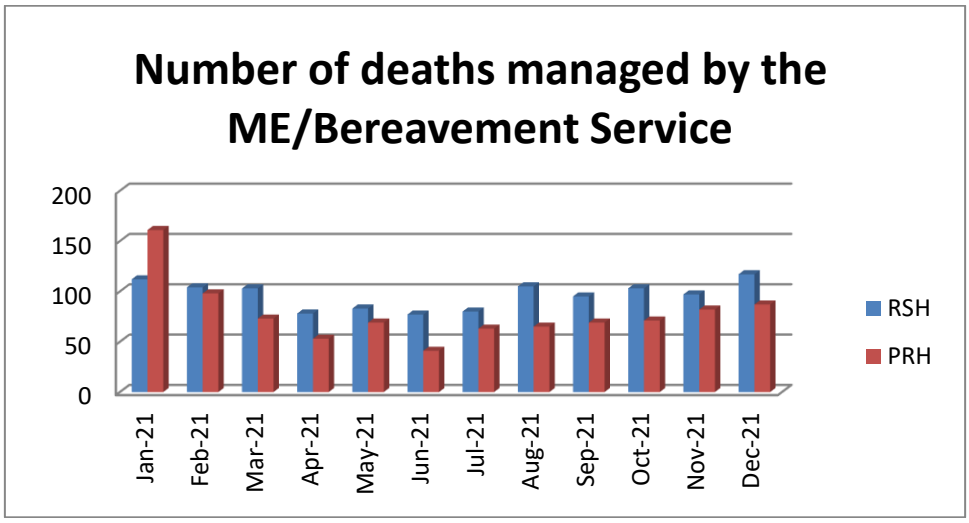
MEDICAL EXAMINER & BEREAVEMENT SERVICE REPORT QUARTER 3 – OCTOBER – DECEMBER 2021

1. Introduction

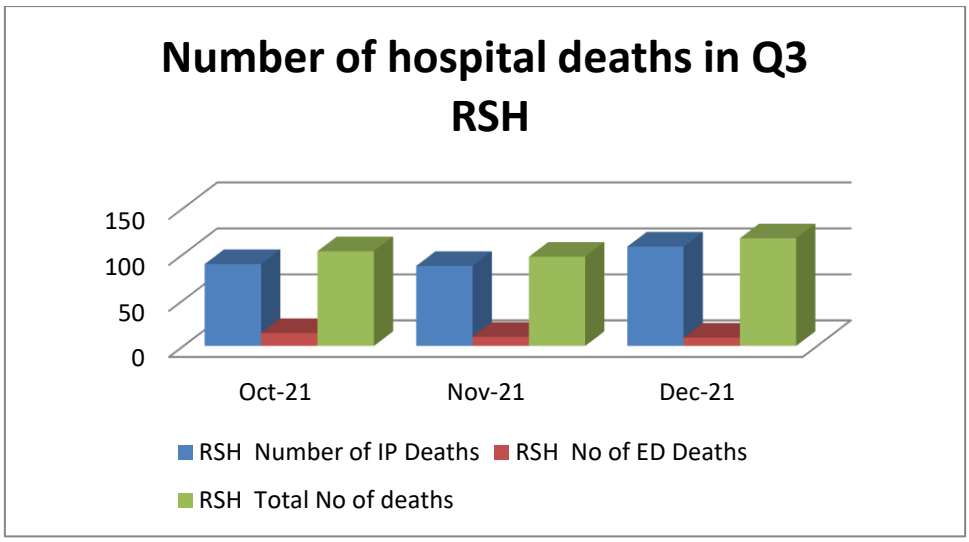
The purpose of this report is to provide the Trust Board with an overview of the hospital deaths managed by the Medical Examiner & Bereavement Service during quarter three (Oct-Dec 2021).

2. Hospital Deaths

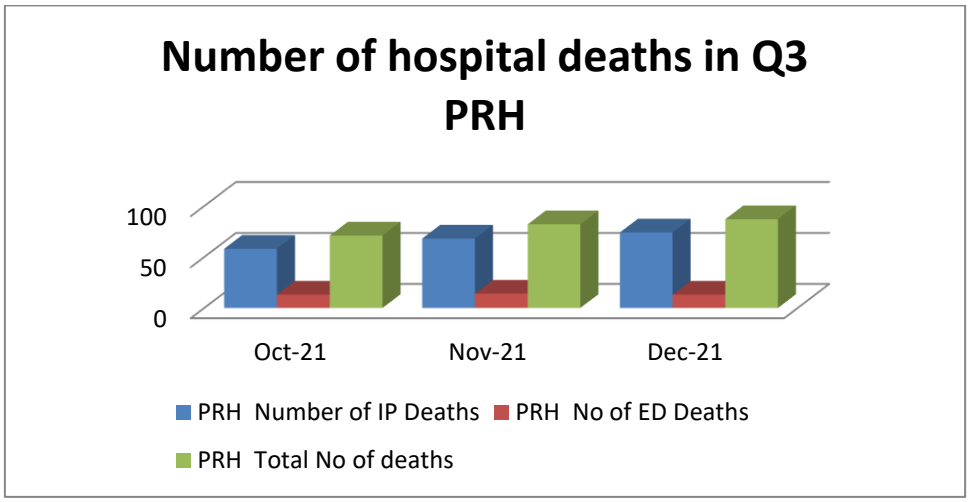
During quarter three, there were 557 deaths across both of our hospitals, which is an increase of 80 deaths from quarter two of 2021/2022 and an increase of 13 deaths for the same quarter of 2020.



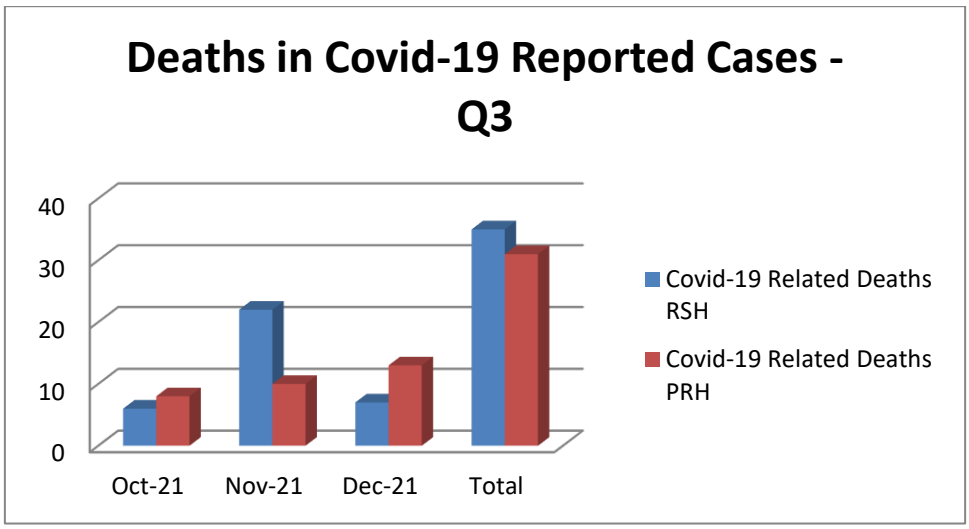
At RSH there were 284 inpatient deaths and 33 deaths in our Emergency Department.



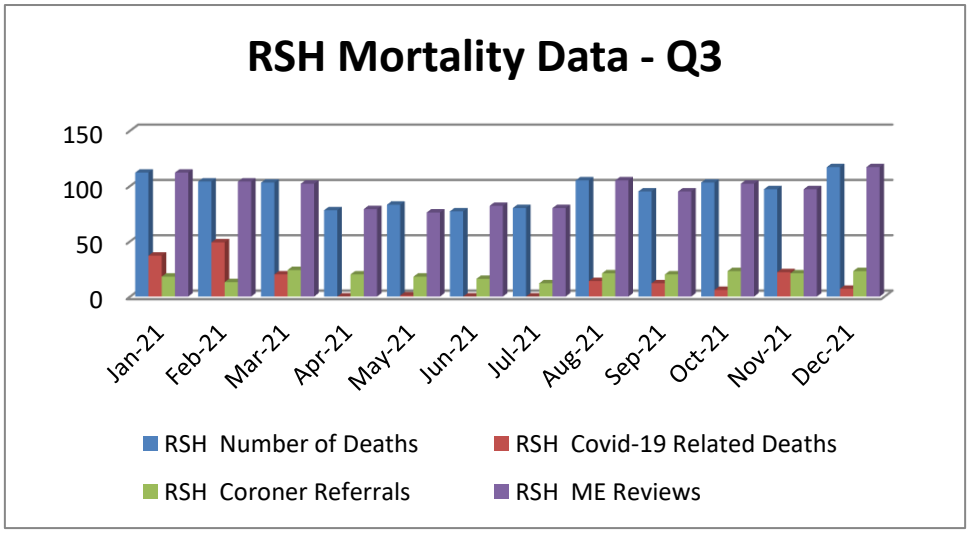
At PRH there were 200 inpatient deaths and 40 deaths in our Emergency Department.

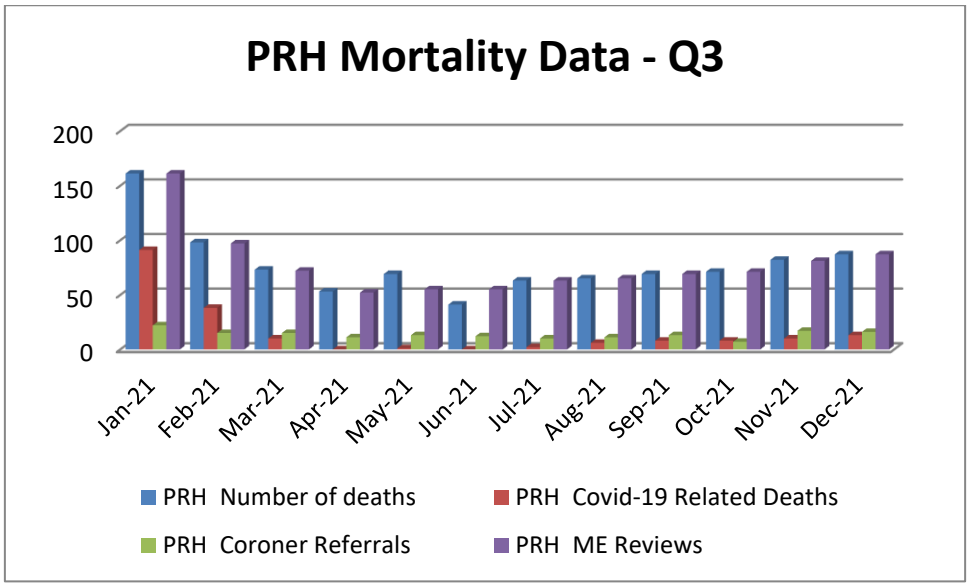


Maintaining review of the impact of the Covid-19 pandemic over the last 20 months, we can see the mortality data for each hospital below for patients who died with a positive PCR result for Covid-19 and whose deaths were reported to NHS England. We note the marked increase in covid-19 related deaths on each site in quarter three of this financial year with 66 Covid-19 related deaths reported which was an increase of 24 cases from what was reported in quarter two but a significant decrease from the same quarter of the previous year, when 125 Covid-19 related deaths were reported.



The graphs below demonstrate the overall mortality data in terms of the total number of deaths for each site and of that how many referrals were made to the Coroner, the activity of the Medical Examiner Service and deaths in patients with a positive Covid-19 PCR.

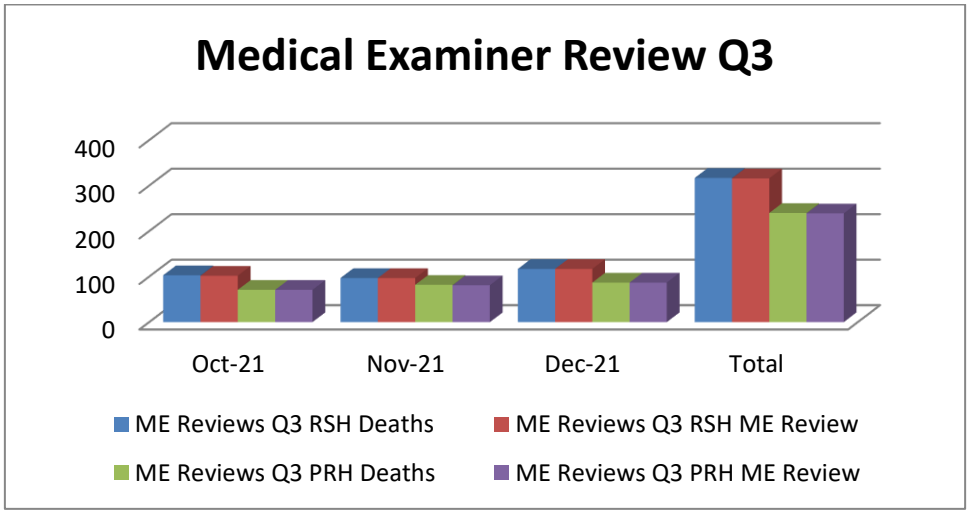




Medical Examiner Review.

Of the 557 deaths that occurred in quarter three, the Medical Examiner (ME) service reviewed 555 deaths, making referrals to the Coroner service, where appropriate and necessary, and liaised with and supported the families, taking the time to explain the cause of death or reason for coroner referral, and answering any questions the family members had regarding the care and treatment their relative received.

The two cases that were not reviewed by the Medical Examiner were patients who were brought into our ED, verified, and then treated as non-acute deaths, and so there was no treatment to scrutinise.

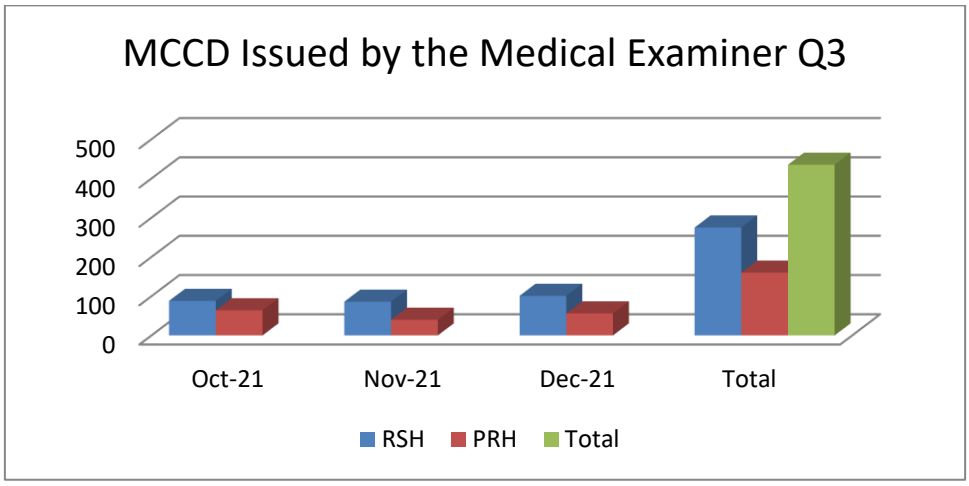


Medical Certificates of Cause of Death

In quarter three the Medical Examiner service continued to work under the emergency Covid legislation which allows any medical healthcare professional to complete the MCCD providing they have spoken with a qualified attending physician (QAP) who had seen and treated the patient in the preceding 28 days. We have been working in this way since April 2020 to relieve the operational pressures of the clinical teams and so they can maintain their presence on the ward and with clinical duties.

However, anticipating the Coronavirus Act easements coming into place in the following months, the ME service took the approach that where there was capacity for the treating clinician to write the MCCD, they would be asked to do so, and so in quarter three there were some MCCDs written by the treating clinician.

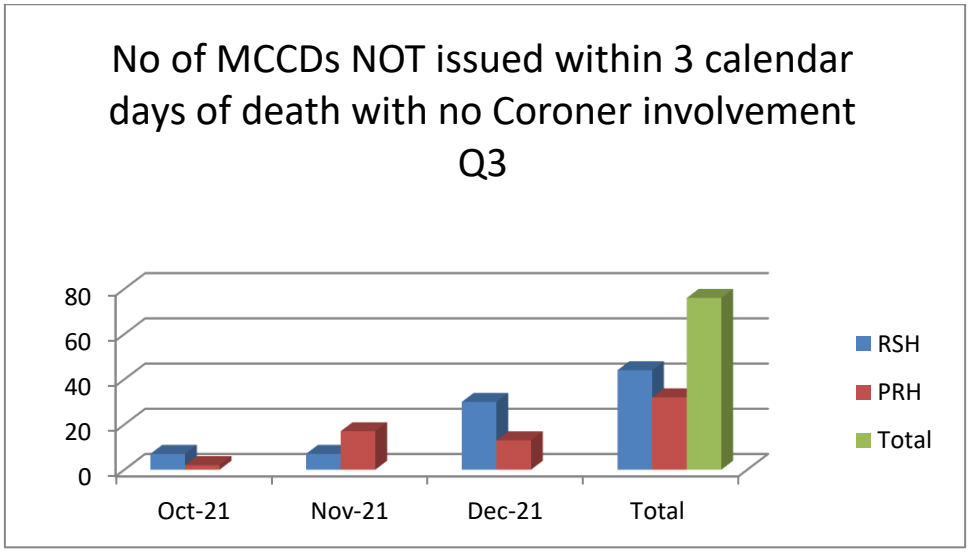
In quarter three 435 certificates were written and issued by the Medical Examiner with the cause of death being explained to the bereaved during the discussion the Medical Examiner has with the relatives.



A further 73 MCCDs were written by the treating clinicians, however all families were contacted by the ME service to have the cause of death explained to them and an opportunity to raise any questions regarding the cause of death or raise concerns about the care their relative received.

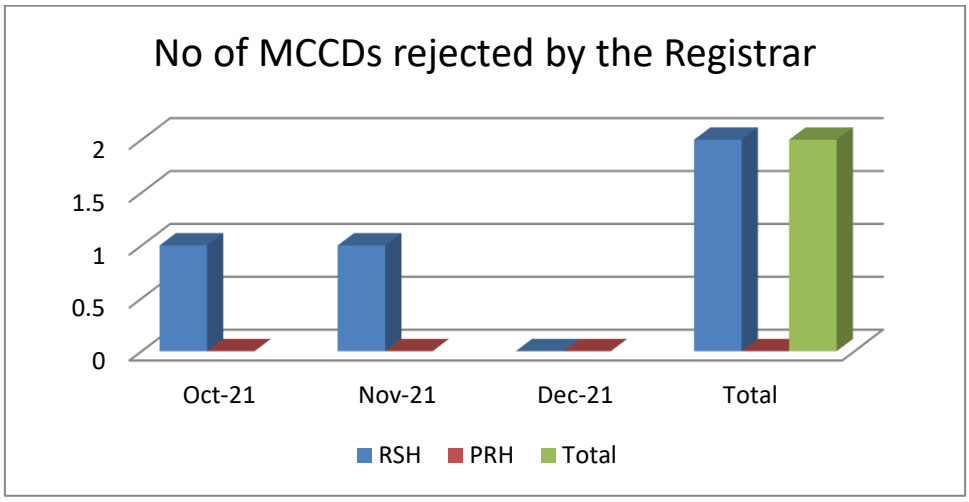
The Bereavement Service remains unable to invite bereaved relatives in to collect the Medical Certificate of Cause of Death (MCCD). The Registrar of Births Marriages and Deaths also remains off site with the main facility for registration of death being telephone registration. In partnership with Shropshire and Telford & Wrekin Registrar Services, the Bereavement Service processed the 508 MCCDs by sending these electronically to the Registrar Services so that telephone registration could be facilitated for the bereaved.

With the use of the Covid emergency legislation, it has enabled MCCDs to be written and released much sooner than in previous times, prior to the pandemic. Whilst our performance with ensuring the 5 day registration target has always been good, we are always assessing this and are mindful to ensure our work does not impact on this target. The National Medical Examiner requires our service to submit quarterly data on the number of MCCDs not issued within 3 calendar days. You will see our performance in the graph below. Out of the 508 MCCDs issued, 76 of them were over 3 calendar days, which is an increase on the previous quarter and attributed to the Christmas period.



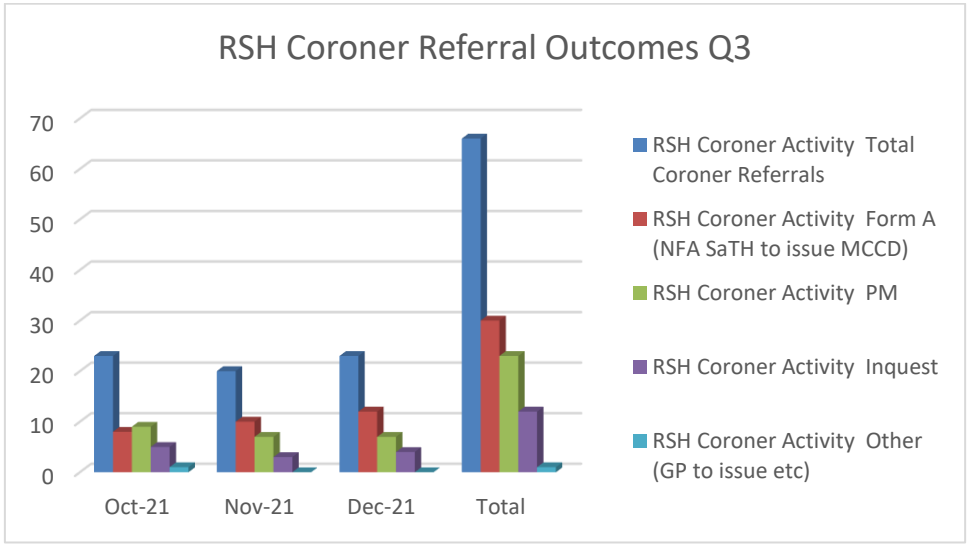
Although all adult deaths are reviewed by the Medical Examiner, and a sign off from this review is provided to the Registrar when the MCCD is sent over to confirm this has taken place, there can still be occasions where they see it necessary to reject an MCCD we have provided. In these cases the Registrar will either contact the Bereavement Service to discuss the cause of death, or

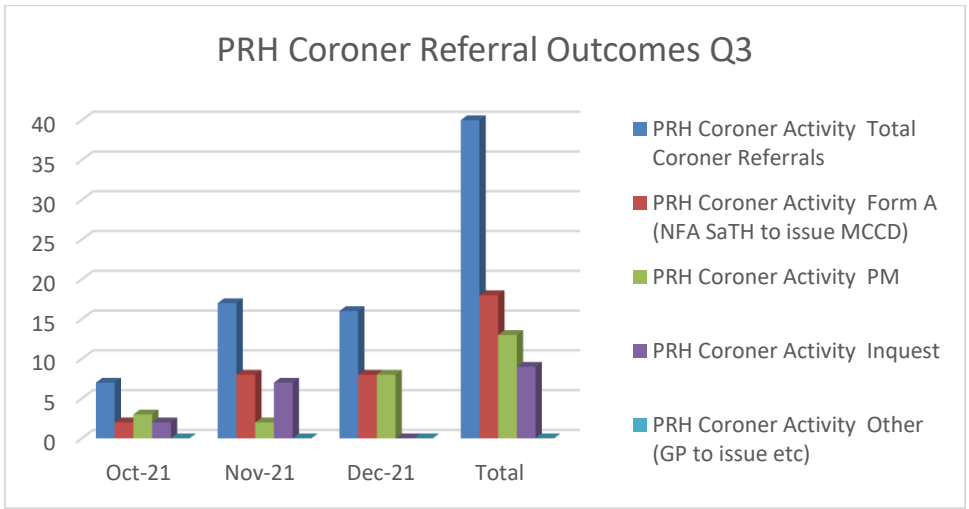
they will refer the death directly to the Coroner. Out of 508 MCCDs issued, 2 were rejected in quarter three.



Coroner Referrals

All referrals to the Coroner are managed by the Medical Examiner Service and are made following ME review. In quarter three the service across both sites referred 106 deaths to the Coroner which is an increase of 20 referrals from quarter two. The outcome of referring to the Coroner can vary between no further action being taken (Form A), to an inquest and requesting a post mortem. A breakdown of the outcomes from these referrals for each hospital is below.



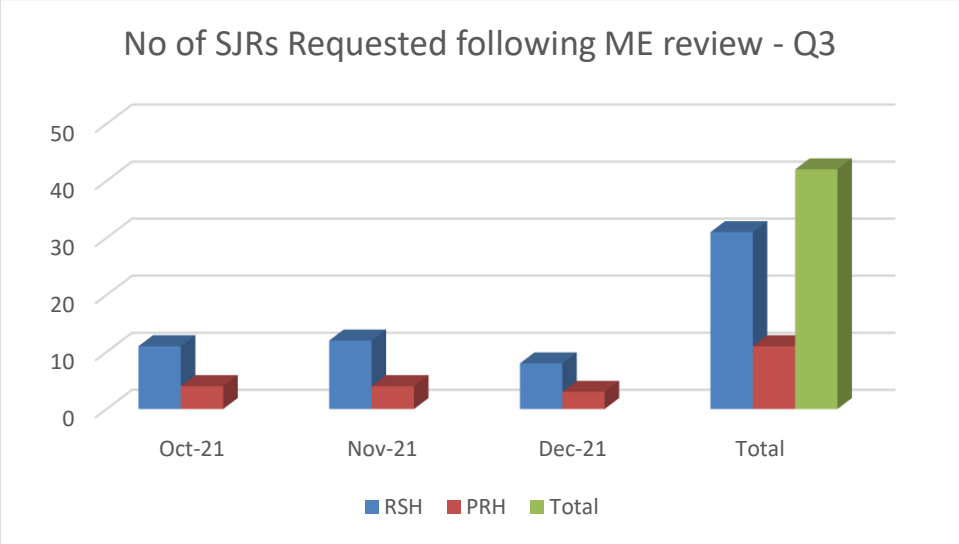


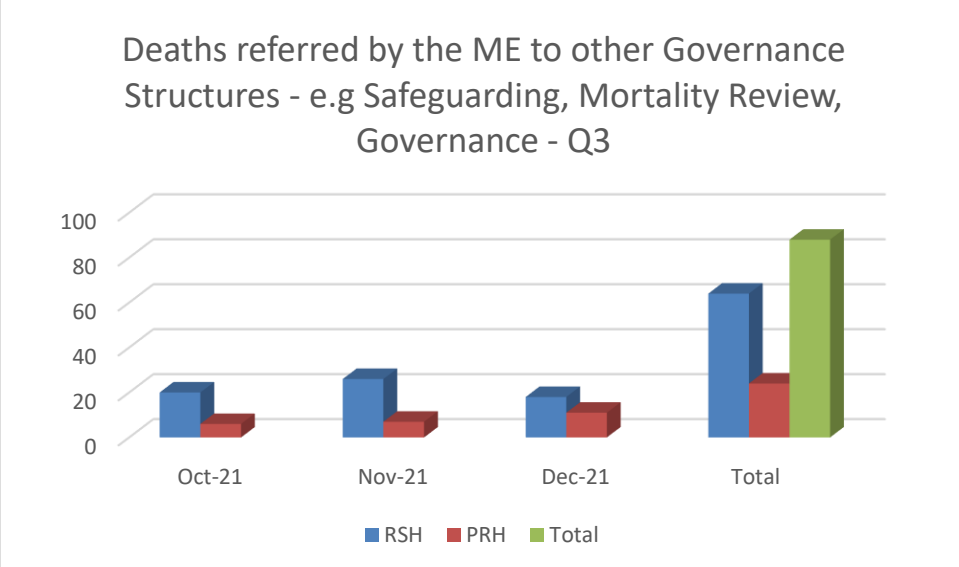
Of the 106 referrals made to the Coroner, he took no further action in 49 cases and took 57 for investigation by proceeding with PM and or Inquest.

The National Medical Examiner wishes to know the number of cases we manage in respect of urgent body release. There were no requests for urgent body release during quarter three.

Part of the role of the medical examiner is to ensure any concerns or potential learning that has been identified as part of the review and discussion with the bereaved, is detected and then escalated. Work between the ME service and the Mortality Lead continues in how to ensure a robust process for escalating learning and potential SJRs takes place.

In quarter three the ME service requested 42 SJRs which was an increase of 7 from the previous quarter. Completed ME reviews also identified potential learning in 88 cases, which were then referred on to the speciality for action and awareness. This data is also shared in the quarterly submission to the National Medical Examiner.





14 Medical Examiner and Bereavement Services Review

The ME and Bereavement Service continues supporting bereaved relatives, whilst not in person, but by maintaining contact with them over the phone and ensuring they know what action we are taking in respect of their relatives death. Families continue to receive our swan bereavement folders via the post to help provide ongoing support and we are still open to receive enquiries from bereaved relatives and provide ongoing support to them. Medical Examiners are continuing with their reviews of all deaths and an important part of this is the support they offer to the bereaved.

In quarter one the National Medical Examiner set out his expectation that all acute trusts with an established ME service, will move to expand the service to include reviews of community deaths. It is the expectation that all community deaths will be reviewed by the end of March 2022. It has been escalated to the Midlands Regional Medical Examiner, by the Medical Examiner Service Manager that review of all community deaths in our health economy is not going to be achievable by the end of the financial year. Taking on the review of the community deaths will increase our numbers to over 5,000 deaths. This requires expansion of our service to include additional Medical Examiners and Medical Examiner Officers. Operational planning is taking place and is being led by the Medical Examiner Service Manager who is liaising closely with community partners to achieve this expectation, but in an incremental and proportionate way. The Regional Medical Examiner is aware and supportive of the plans the ME Service at SaTH has, whereby initially we will work with Robert Jones Agnes Hunt NHS Trust, the Severn Hospice and a GP practice as pilot sites for this roll out. The ME Service Manager will continue to keep the committee updated of progress with this initiative.

Appendix One

Examples of Feedback from Bereaved Relatives received in Q3
RSH

Ward 22

"*** had heart attack on 30th July, was not expected to survive. However, he pulled around and was eating and drinking as normal. Because he fought so hard he was taken off palliative care and back on meds. He had a fall in toilet and I was informed he bruised his back and when I looked he did not have an at risk bracelet for falls, however, one was placed on after photo evidence. Ward 21 then referred him to Ward 28. I was even shaving him myself, otherwise he was left. His breathing deteriorated over 3 days – he struggled to breathe – staff was informed but did not seem to be interested. *** is then moved to Ward 22. There was nothing mentioned about palliative care. *** had a drain put in and over 4 days had several x-rays. He was on antibiotics which he got thrush in the mouth. On the Thursday was told there was a lot more they could to do to help him. I shaved him and wiped him down. After death they told me his bowel had stopped working which was a lie. I called for a bed pan twice and was ignored. *** deteriorated at 4.30 in morning on 28th August. I was not informed. Was told of his death by phone at 11.50"

"There was no real explanation as to why my mum had kidney failure. We knew about the lung and liver cancer but nothing was mentioned about the kidneys until less than 24 hours of her death. Also, I advised that my mum hadn't been drinking much fluids prior to her visit, yet she was only put on a drip a day or two before death – (NO OPPORTUNITY TO ASK QUESTIONS AT A LATER DATE). I appreciate you are extremely busy and am grateful for the care, but just one or two unanswered questions which would help me."

"The staff on Ward 22 could not have been more kind, sympathetic or understanding to either me or my family. I will always be grateful to them."

Ward 22 T&O

"If I had a complaint it would be that after I informed a member of staff that my mother had passed away, the lights were snapped on and someone packed up all her belongings within 15 minutes. It seemed a little harsh, but I had only informed them when I was ready – and maybe the practical, unemotional approach is best? It didn't bother me unduly, but for different people in different circumstances it may not be a very sensitive approach"

Ward 23

"When my mum was on Ward 23 every single member of staff was amazing with both my mum and us as a family. They all went above and beyond their duties and we can't thank them enough for how they cared for my mum in her final hours."

ED & AMU

"Huge 'thank you' to all staff in A&E and AMU for their care of my dad and of his family at a very difficult time. I honestly cannot think of any way in which improvements could be made. Especially thanks to the lady who brought us tea, breakfast and a caring smile – and to ***, who brought a

reclining chair in case we were still there at night, Glen Miller CDs for dad to listen to and a chocolate flavoured mouth swab!"

Ward 25
"I feel my sister was ignored and interaction was not evident due to her learning disability, dignity and respect was not evident. Personal care was poor, my sister was left with vomit all down her gown and staff were happy to leave her like that until they next washed her, this did not happen and she remained unwashed. The room my sister was placed in for end of life was shocking, no curtains or blinds, decoration was poor, no place to end your life. Relatives and visitors were treated poorly, no staff checked if we were okay or provided us with any information or support. Contact with hospital when my sister died was poor and did not know what was to happen, promises to contact me were broken."

Ward 28
"My mother was on the acute medical ward 28. We have no complaint with either ward, medically or staff-wise but it would have been good to have been in a side ward for privacy in mum's last few days. We do appreciate this may not have been possible in the current situation."

Examples of Feedback from Bereaved Relatives received in Q3
PRH

Wards 9, 36 & 11
"In this case, in spite of persistent requests, we were not given ANY indication of my brother's deterioration. Discharged on 13th Aug from (??). Due to the lack of appropriate care by *** Home Care he was admitted as an emergency to PR, Ward 9. At this stage he was still capable of using his own phone and speaking on the ward phone (when it was answered)! He was sent to Ward 36 (Discharge ward)!!! They thought a care package was in place, but a safeguarding issue raised by QCC meaning *** company could no longer be involved had not been put on the computer by the social worker. On Ward 36 we could not speak to him AT ALL. He could no longer use his own phone. He constantly said he just wanted to come home. He was moved to Ward 11. It proved almost impossible to contact him. His son (who lives abroad) and d. in law (London) relied on me to transmit information about his condition and future so they could make plans to visit. He had a horror of dying (one, without family present, as his eldest son had died alone in February). I promised him he wouldn't, that I would be there. I broke my promise!"

Ward 6
"Everyone was excellent – thank you all very much for helping with my dad's end of life needs."

Ward 7
"The bereavement care team were lovely so no complaints here BUT we arrived to see my mum; she was struggling to breathe. Nurse gave her paracetamol whereby she choked and then we were taken to the staff office and told she would die. It was pointed out it was the staff office so couldn't stay long. Staff did walk in. We went to see my mum and she died very quickly. When asked if she was dead, no answer to confirm. She was left looking uncomfortable (not dignified). When we left no-one was there and no information give".

Ward 17
"When our brother passed, we, as his family, felt we had let him down; he died alone and was probably very frightened. Due to the severity of the tumour on his tongue – he lost his speech, he was also disabled. A junior registrar stood by the side of my brother's bed assuring him there would be no more drips, needles etc., only morphine if needed. If he started to deteriorate he would be transferred to a side ward and his family would be contacted to be with him. His sister rang at 8am to be told he had just passed away whilst being washed. I found that extremely hard to accept. We arrived at the ward at 11am to see him; there was no-one at all to speak to, we waited a while until we could find someone to take us to our brother. We were taken to his cubicle by a nurse who promptly left. I don't think she liked me showing how upset we were that he was left in the bed, as he died with his mouth wide open – shocking! No condolences offered; poor, poor man, heart-breaking. It is too late to talk to anyone now. We desperately wanted to see someone on the day

our brother passed but everyone seemed to have disappeared. Can I add there were some very nice staff in attendance to my brother – others not so and lacking in compassion."

Ward 11
"Having been told on the Friday by a doctor that I should be prepared for my husband not to last the weekend, I asked if I could visit him as I hadn't even been able to speak to him since he was admitted to hospital the previous Sunday following a fall in the nursing home. He said he would check but I heard nothing back. On the Saturday I was finally able to get through to Ward 11 on the phone (I had tried all week but either it was busy or no-one answered). The nurse I spoke to took the phone to him and we had what was to be our last contact. I was phoned by a nurse on the Sunday morning around 9.30 and told that I should come but by the time I arrived at the hospital around 10.20 he was already dead!"

Ward 17
"I was asked to attend the hospital twice. The first time I spoke to a doctor who explained the situation. However, I was then told I couldn't see her. The second time I was asked to attend I was told I could see her. However, at this point she was unconscious. I feel I lost any chance to see or have any communication with my mother one last time."

Ward 4
"When my sister and I met with Dr *** in the afternoon before my mother died, I understood that the plan was to move my mother to a side bay and give her medication via a syringe driver to make her comfortable. I was led to believe that there was no reason for delaying that treatment. However, there was no syringe driver in place when we returned later that evening or at any time while we were there. My wife and I arrived the same evening between 22.45 and 23.00 approximately. My mother was in a side room and appeared somewhat distressed and agitated. I went to find a member of staff to try to find out about the plan for medication. I spoke to staff nurse ***. Shortly after this conversation my mother was given midazolam. It took a while for her to settle and we were frequently having to replace her mask as she kept removing it. Eventually she was calmer and once she had been calm for a reasonable period of time (I would estimate over an hour) we decided to leave. As a result of what we saw when we arrived, our planned visit of 10 or 20 minutes became about 5 hours. My questions are: Why had the treatment discussed with Dr *** not been started when we arrived or indeed by the time we left at just before 04.00 am? How often was my mother checked up on after we left? Did she have any further medication?"

The Shrewsbury and Telford Hospital NHS Trust

	Developing Workforce Safeguards Gap analysis action plan			
Executive Sponsors	Hayley Flavell - Director of Nursing			
Responsible Officers	Tracie Black - Lead Nurse for workforce			
Corporate Nursing Review	30.06.2022			
Report signed by (Executive Lead)	Hayley Flavell - Director of Nursing			

Developing Workforce Safeguards Action Plan

ID	Recommendation	Site	Compliance	Actions required	Deadline	Status
	Recommendations 1 & 2 1. Trusts must formally ensure NQB's 2016 guidance is embedded in their safer staffing governance. 2. Trusts must ensure the 3 components are used in their safer staffing processes (evidence based tools, professional judgement and patient outcomes).	Trust	**Fully compliant. ↔**	SOP under development to confirm process and annual calendar for training, data collection and inter-rater reliability checks being organised for completeness in regards to the bi-annual staffing process.	31.07.2022	In Progress
				Training on acuity and dependency ratings to be agreed with National Team. All band 7 Ward Managers and above to be trained plus at 2 other seniors for each ward area.	30.06.2022	Delivered and ongoing monitoring
				Ensure yearly renewal of safer Nursing Care Tool licence	31/10/2021	Delivered
	Recommendations 3, 4 & 5 Trusts will be required to confirm their staffing governance processes are safe and sustainable, based on national assessment on the annual governance statement.	Trust	**Fully compliant. ↔**	Director of Governance and Communications to add statement to future annual governance statement	31/01/2022	Delivered
				Biannual staffing reviews will have a statement from the Medical Director and Director of Nursing regarding assurances in relation to safer staffing.	31/07/2021	Delivered and ongoing monitoring
				Additional training with senior staff on acuity and dependency.	31/03.2022	Delivered and ongoing monitoring
				A further full biannual staffing review to take place in June and July 2021.	31/07/2021	Delivered

ID	Recommendation	Site	Compliance	Actions required	Deadline	Status
	Recommendation 6 As part of the safe staffing review, the Director of Nursing and Medical Director must confirm in a statement that to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable.	Trust	**Partially compliant. ↔**	A nursing 5 year workforce plan to be fully completed and agreed.	31.07.2022	Delivered ongoing monitoring
				A full organisational wide process for vacancy oversight from Ward level upwards	31.07.2022	Delivered and ongoing monitoring
				Development of a local Safer Staffing Policy which includes establishment setting and will note the requirement to have QIAs for all changes to staffing establishments – signed off by the Director of Nursing.	01.07.2022	In progress
				Matrons to receive an inter-rater reliability assessment as part of their induction	30/03/2022	Delivered and ongoing monitoring
				Review monthly staffing paper once dashboard on Gather system to ensure greater triangulation and explicit reference to Care Hours Per Patient Day (CHPPD)	30/11/2021	Delivered
				Commence an inaugural Safer Nursing Care Tool assessment on the Emergency Departments once the new tool is released and licence obtained.	31/03/2022	Delivered and ongoing monitoring

The Shrewsbury and Telford Hospital NHS Trust

Appendix 1

Maternity red flag events, NICE (2015)

A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing. If a midwifery red flag event occurs, the midwife in charge of the service should be notified. The midwife in charge should determine whether midwifery staffing is the cause, and the action that is needed.

- Delayed or cancelled time critical activity.
- Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing).
- Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication).
- Delay of more than 30 minutes in providing pain relief.
- Delay of 30 minutes or more between presentation and triage.
- Full clinical examination not carried out when presenting in labour.
- Delay of 2 hours or more between admission for induction and beginning of process.
- Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output).
- Any occasion when 1 midwife is not able to provide continuous one-to-one care and support to a woman during established labour.

Other midwifery red flags may be agreed locally.

The Shrewsbury and Telford Hospital NHS Trust

Appendix 2

SBAR & QIA

SBAR to inform QIA for suspension of Midwifery Continuity of Carer

Main Paper

Situation

The Ockenden review into Maternity Services at Shrewsbury and Telford Hospital (SaTH) (2022), includes a specific immediate and essential action (IEA) on continuity of carer: 'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (IEA 2, Safe Staffing page 164)

All NHS Trusts have been asked to submit their MCoC plans by 15 June 2022 in line with the maternity transformation programme. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Following publication of the Ockenden review, NHS England has requested that Trusts should immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.

2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.

3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Additionally, further guidance was published by NHSE/I on 6 May 2022 outlining that for Trusts which identify staffing challenges, before suspension they should:

- Use the NHSE/I national modelling tool to determine what impact suspension of teams will have across clinical settings. This will mitigate the risk of unintended consequences for particular clinical settings.
- In relation to Newly Qualified Midwives: A national working group is being convened to guide implementation of the IEAs and will be considering the IEA on placement of this staffing group. Services should therefore await national guidance before redeploying Newly Qualified Midwives currently in MCoC teams, that are following trust safe staffing governance processes.
- Consider the clinical risk of suspension on safety for vulnerable women. Under the Equality Act 2010, the NHS has a duty to give 'regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.'

Background

Following the publication of Better Births in 2016, there has been a National drive to implement full scale MCoC so it is the default model for all women; and this was recently updated to include that 75% of women of

Black, Asian and Mixed ethnicity and from the most deprived neighbourhoods are placed on MCoC pathways by March 2024.

Two MCoC teams were launched in September 2019, Rose team based in the Wrekin MLU and another team who were based in Shrewsbury. The Rose team faced significant workforce challenges due to staff leaving, and re-integrated into the traditional community team in early 2022.

SaTH now has just one operational MCoC team, known as the Violet team, who care for a geographically based mixed risk caseload comprising of all pregnant patients from five GP practices in the Shrewsbury area. A total of 7 midwives, working 6.0 WTE hours are currently providing antenatal care for 127 women and postnatal care for 27 women and their babies. They also contribute to a 24-hour standby rota for when any of the caseload require intrapartum care.

In March 2022, the Violet team provided intrapartum care for 8 women out of a possible 25 women who gave birth from the MCoC caseload. They were unable to attend due to community activity (including no midwife on call) for 8 women and were not called to attend 5 women in labour for reasons unknown. The remaining 4 women birthed rapidly therefore the midwives did not have time to attend.

Very recently, a request has been made by two of the team to move back to a traditional team due to changes in their personal circumstances meaning that the team would reduce to 4.4wte and therefore could not function effectively without additional staffing.

Assessment of current position

Safety:

The attached Quality Impact Assessment (QIA) highlights that suspension of the Violet team would carry the following risks to women booked to receive that model of care:

- 7 x more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby
- 19% less likely to lose their baby before 24 weeks
- 15% less likely to have regional analgesia
- 24% less likely to experience pre-term birth
- 16% less likely to have an episiotomy

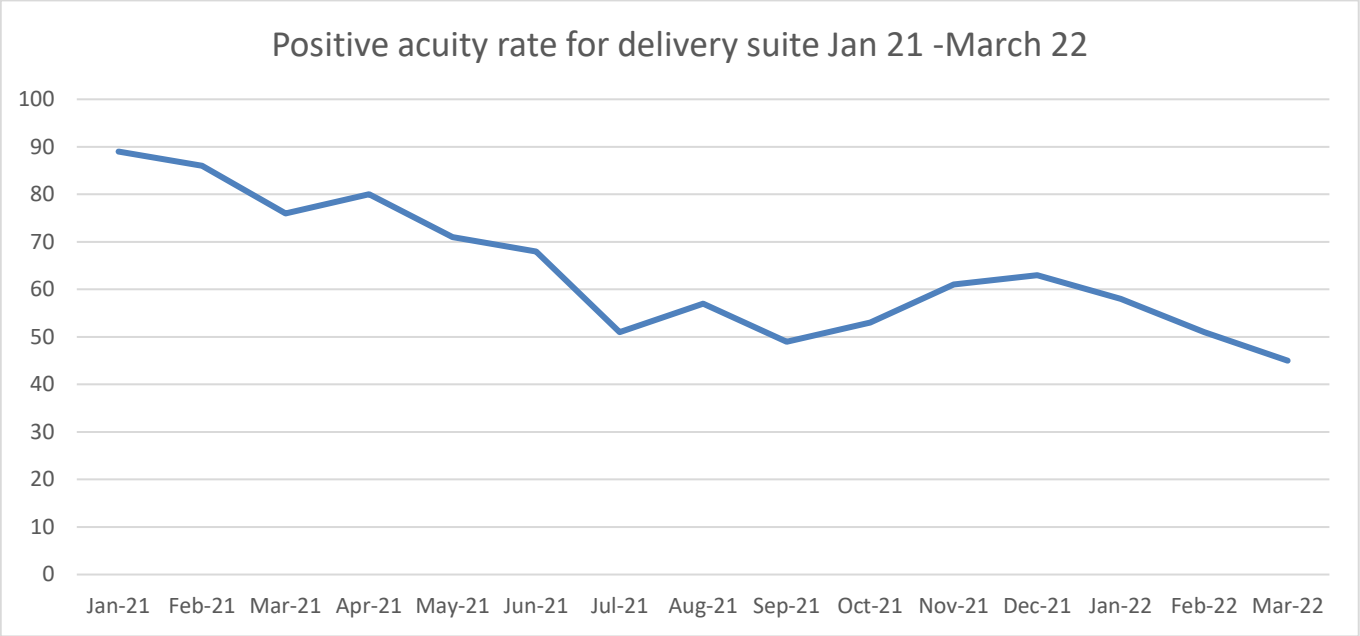
However, it could be argued that the current provision brings with it a postcode lottery style of care which disadvantages others, and this is in-keeping with the findings from other regions that has led to an all or nothing rollout in those areas.

The current team undertake a standby on-call whereby they are paid for a nightshift irrespective of whether they are called out for a Violet woman in labour. The on-call is generally protected to support the ethos of the MCoC model, and the team are rarely used for escalation, except for exceptional circumstances (i.e., to prevent closure of the unit).

Staffing:

When the teams were initially launched back in 2020, the service was able to maintain safe staffing levels to support this model of care (consistently above 85%). The graph below however demonstrates the decline in safe staffing over the last 14 months.

Table 1:



For the month of March 2022, the safe staffing rate was 45%, however the rolling 13-week figure is 50%. This is largely due to the following:

Table 2

	Establishment*	In post
Midwives Bands 5-7	180.55	176.01
MSW's Band 3**	20.05	11.6
Specialist Midwives Bands 6-8***	22.06	30.22
To reopen Wrekin MLU****	4.84	0
Total	227.5	216.83

** Based upon an establishment which is exclusive of MCoC*

*** 90/10 split not yet fully implemented as some of the workforce are yet to complete the competency framework, with a further 6wte currently on the apprenticeship programme which is due to complete in September 2022*

**** All specialist midwives (including managers) in Bands 6-8 have an element of clinical to their role, using either a 50:50, 60:40 or 80:20 split*

***** Our Wrekin MLU is currently closed; to reopen we require an additional 4.84wte as prescribed within BR+ assessment*

Table 3

Maternity leave	14.92wte
Long term sickness absence	14.5wte
Total	29.42wte

Current position

Cessation of the Violet team would enable the remaining 4.4wte to be mobilised into the inpatient midwifery team, supporting the reopening of the Wrekin MLU which has faced staffing challenges of late that have affected choice for women. This would have a positive impact on birth options for service users, reduce acuity on Delivery Suite and potentially reduce the risk of birth interventions associated with place of birth.

The two Violet team members who have requested to move back into a traditional community model will remain the named midwives for those booked on the pathway as they will remain within the same locality area, delivering a model that supports a 1:96 caseload.

Recommendation

As can be seen in the above tables, the maternity service is facing some significant staffing challenges and safe staffing levels for all shifts is not currently being met. The original ask was for '***All trusts must review and suspend if necessary, the existing provision and further roll out of MCoC unless they can demonstrate staffing meets safe minimum requirements on all shifts***.' (IEA 2, Safe Staffing page 164).

It is therefore the recommendation of the Director of Midwifery that the existing provision and further roll out of MCoC is suspended at SaTH until safe staffing on all shifts is met as standard.

An innovative recruitment strategy is ongoing to increase the clinical workforce, alongside a review of the clinical component of the specialist midwives' hours alongside their non-clinical role to ensure a workforce that is fit for purpose that can respond to the changing landscape that is maternity staffing. Early indicators are positive for the service to be in a better position in the Autumn based on the number of staff recruited to but not yet in post.

Appendix 3
Ockenden Final Report Letter

Official
Publication approval reference: B1523

To:

- NHS Trust and Foundation Trust: Skipton House ○ Chief Executives 80 London Road ○ Chairs London ○ Chief Nurses SE1 6LH ○ Chief Midwives ○ Medical Directors
- ICS leads and Chairs 1 April 2022
- LMNS/LMS leads
- CCG Accountable Officers CC:
- Regional chief nurses
- Regional chief midwives
- Regional medical directors
- Regional obstetricians

Dear colleagues

OCKENDEN – Final report

The Ockenden – Final report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March.

Donna Ockenden and her team have set out the terrible failings suffered by families at what should have been the most special time of their lives. We are deeply sorry for the loss and the heartbreak they have had to endure.

This report must act as an immediate call to action for all commissioners and providers of maternity and neonatal services who need to ensure lessons are rapidly learned and service improvements for women, babies, and their families are driven forward as quickly as possible.

NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate & Essential Actions (IEAs) and every trust, ICS and LMS/LMNS Board must consider and then act on the report's findings.

We have announced significant investment to kick-start transformation of maternity services with investment of £127 million over the next two years, on top of the £95 million annual increase that was started last year. This will fund further workforce expansion, leadership development, capital to increase neonatal cot capacity, additional support to LMS/LMNS and retention support. We will set out further information in the coming weeks.

Your Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening at your organisation / within your local system. The Ockenden report should be taken to your next public Board meeting and be shared with all relevant staff – we strongly recommend everyone reads it, regardless of their role. After reviewing the report, you should take action to mitigate any risks identified and develop robust plans against areas where your services need to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months. We will soon publish a revised national policy and guidance on speaking up.

Staff in maternity services may need additional health and wellbeing support. Please signpost colleagues to local support services or national support for our people.

The report highlights the importance of listening to women and their families. Action needs to be taken locally to ensure women have the necessary information and support to make informed, personalised and safe decisions about their care.

It includes a specific action on continuity of carer: *'All trusts must review and suspend if necessary, the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts.' (*IEA 2, Safe Staffing page 164)

In line with the maternity transformation programme, trusts have already been asked to submit their MCoC plans by 15 June 2022. In doing so, they must take into account this IEA in ensuring that safe midwifery staffing plans are in place. Trusts should therefore immediately assess their staffing position and make one of the following decisions for their maternity service:

1. Trusts that can demonstrate staffing meets safe minimum requirements can continue existing MCoC provision and continue to roll out, subject to ongoing minimum staffing requirements being met for any expansion of MCoC provision.
2. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC, but can meet the safe minimum staffing requirements for existing MCoC provision, should cease further roll out and continue to support at the current level of provision or only provide services to existing women on MCoC pathways and suspend new women being booked into MCoC provision.
3. Trusts that cannot meet safe minimum staffing requirements for further roll out of MCoC and for existing MCoC provision, should immediately suspend existing MCoC provision and ensure women are safely transferred to

alternative maternity pathways of care, taking into consideration their individual needs; and any midwives in MCoC teams should be safely supported into other areas of maternity provision.

Boards must also assure themselves that any recent reviews of maternity and neonatal services have been fully considered, actions taken, and necessary assurance of implementation is in place.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway. We are committed to consolidating actions to ensure a coherent national delivery plan.

However, there can be no delay in implementing local action that can save lives and improve the care women and their families are receiving now.

In the 25 January 2022 letter we asked you to set out at a Public Board your organisation's progress against the seven IEAs in the interim Ockenden report before the end of March 2022. Your position should be discussed with your LMS and ICS and reported to regional teams by 15 April 2022. We will be publishing a detailed breakdown of these returns and compliance by Trust with the first Ockenden IEAs at NHSE/I public Board in May. Your trust also needs to provide reliable data to the regular provider workforce return, with executive level oversight.

For organisations without maternity and neonatal services, this report must still be considered, and the valuable lessons digested.

We know you will be as determined as we are to ensure the NHS now makes the changes that will prevent other families suffering such devastating pain and loss.

Yours sincerely

Amanda Pritchard

NHS Chief Executive

Ruth May

Chief Nursing Officer

Professor Stephen Powis

National Medical Director

Appendix 2

Identification of the Current Population of potential maternity service users

12. Ethnicity

12.1 The most recently published data available for ethnicity in the county of Shropshire is still from the 2011 National Census.

	Shropshire Unitary Authority		Telford and Wrekin Unitary Authority	
	No.	%	No.	%
All categories	306,129	-	166,641	-
White: English/Welsh/Scottish/ Northern Irish/British	292,047	95.4	149,096	89.5
White: Irish	1,410	0.5	729	0.4
White: Gypsy or Irish Traveller	312	0.1	166	0.1
White: Other White	6,105	2.0	4,424	2.7
Mixed/multiple ethnic group: White and Black Caribbean	765	0.2	1,423	0.9
Mixed/multiple ethnic group: White and Black African	231	0.1	278	0.2
Mixed/multiple ethnic group: White and Asian	669	0.2	799	0.5
Mixed/multiple ethnic group: Other Mixed	503	0.2	483	0.3
Asian/Asian British: Indian	752	0.2	3,076	1.8
Asian/Asian British: Pakistani	216	0.1	2,243	1.3
Asian/Asian British: Bangladeshi	208	0.1	162	0.1
Asian/Asian British: Chinese	1,020	0.3	647	0.4
Asian/Asian British: Other Asian	893	0.3	863	0.5
Black/African/Caribbean/ Black British: African	302	0.1	1,023	0.6
Black/African/Caribbean/ Black British: Caribbean	164	0.1	607	0.4
Black/African/Caribbean/ Black British: Other Black	114	0.0	149	0.1
Other ethnic group: Arab	179	0.1	86	0.1
Other ethnic group: Other	239	0.1	387	0.2

12.2 Information obtained from the Maternity Information System gives a breakdown of the ethnicity of service users who booked under the care of SaTH in 2021/22

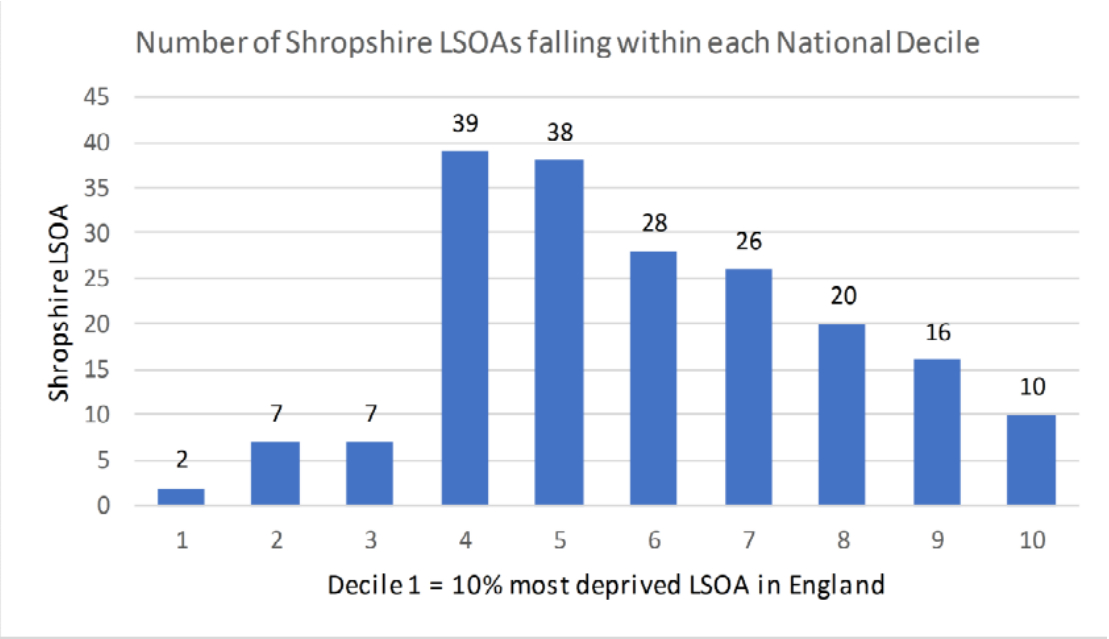
Ethnic Category	Number of Bookers
African	22
Any other Asian background	8
Any other Black background	3
Any other ethnic group	45
Any other mixed background	17
Any other White background	87
Asian-Other	19
Bangladeshi	5
Black African	31
Black Caribbean	4
Black-Other	10
British	3782
Caribbean	4
Chinese	4
Indian	68
Irish	12
Mixed-Other	15
Not stated	794
Pakistani	50
White and Asian	9
White and Black African	6
White and Black Caribbean	23
White-Other	174

12.3 Due to the limitations of the previous Maternity Information system at SaTH, it is not possible to accurately obtain further information about the locations of ethnicity of people accessing maternity services in 2021/22. Recent and accurate ethnicity data of people accessing maternity care at SaTH will be available twelve months following the introduction of the BadgerNet maternity information system (Q3 2022).

12.4 Lower Super Output Areas (LSOAs) are used as the geography for publishing the national Indices of Multiple Deprivation (IMD). Shropshire has 9 out of 193 LSOAs ranked within the 20% most deprived areas in England, (JSNA 2019).
The most deprived areas in Shrophshire and the associated current community midwifery team are:

- 1st decile: Harlescott (Shrewsbury) and Ludlow East (Ludlow)

- 2nd decile: Monkmoor (Shrewsbury), Oswestry South (Oswestry), Meole (Shrewsbury), Castlefields and Ditherington (Shrewsbury), Market Drayton East (Market Drayton), Sundorne (Shrewsbury), Oswestry West (Oswestry).



12.5 It is estimated that a quarter of the Borough's population (26%), some 53,800 people are living in areas in the 20% most deprived nationally with 27,300 (16%) in areas in the 10% most deprived.

12.6 The most deprived LSOA in the Borough (Brookside) is ranked 346 nationally (where 1 is most deprived) placing it in the top 2% most deprived of areas nationally. The areas in Decile 1 and 2 are listed in the table on the following page (JSNA 2019).

Ward	2019		
	IMD score	IMD rank	IMD decile
Brookside	68.039	346	1
Madeley & Sutton Hill	66.907	409	1
Woodside	64.743	541	1
Brookside	62.013	747	1
Woodside	60.976	832	1
Malinslee & Dawley Bank	59.531	951	1
Malinslee & Dawley Bank	59.266	980	1
Woodside	58.541	1,058	1
Woodside	55.723	1,385	1
Hadley & Leegomery	54.864	1,480	1
Dawley & Aqueduct	50.273	2,137	1
College	49.811	2,211	1
Madeley & Sutton Hill	47.465	2,582	1
Madeley & Sutton Hill	47.276	2,610	1
Malinslee & Dawley Bank	47.002	2,658	1
Dawley & Aqueduct	46.506	2,750	1
Madeley & Sutton Hill	46.45	2,767	1
Donnington	44.291	3,209	1
St Georges	41.862	3,765	2
Donnington	40.951	3,989	2
Haygate	39.672	4,360	2
The Nedge	39.445	4,441	2
Wrockwardine Wood & Trench	38.104	4,839	2
Woodside	37.023	5,203	2
The Nedge	36.055	5,510	2
Oakengates & Ketley Bank	35.59	5,680	2
Arleston	33.82	6,330	2
Hadley & Leegomery	33.569	6,436	2

Appendix 3

Proposed MCoC Planning Detail

13.1 Maternity services and LMS (or LMNS) have been asked to prepare a plan to reach a position where midwifery Continuity of Carer is the default position model of care available to all birthing people by March 2023 where safe staffing allows and building blocks are in place for the Maternity Incentive Scheme (Year 4).

13.2 The plan for the implementation of MCoC teams is to prioritise those that are more likely to experience poorer outcomes, focusing on birthing families from ethnic minority backgrounds and also those from the most deprived areas as identified by the JSNA (Joint Strategic Needs Assessment) 2019.

13.3 The model will commence with 7.0 WTE midwives per team, with a band 7 supporting a maximum of 4 teams. The band 7 requirement will by identified as part of the overarching skill mix review to be completed.

13.4 MCoC caseloads will be mixed health and social risk, within the team geographical area, with the following annual caseload ratios

- 1.0 WTE = 1:36 caseload
- 0.8 WTE = 1.30 caseload
- 0.6 WTE = 1:24 caseload

13.5 The MCoC midwife will make contact directly with the birthing person to offer the option of MCoC and arrange a booking appointment.

13.6 If the SaTH board opt to suspend the current MCoC provision, the current Violet MCoC midwives can be utilised to provide support and be part of wave one for the relaunch of MCoC in Shropshire. This will ensure that there is a geographically based model supporting vulnerable birthing families from across the whole of Shropshire. This is recognised as a more sustainable work pattern to prevent burnout of midwives.

13.7 The current Standard Operating Procedure v2 valid from 19/04/21 will be updated and presented for agreement at maternity governance to reflect the antenatal selection for MCoC by geographical area instead of GP practice.

13.8 In the most recent Birthrate Plus® (BR+) workforce report (February 2021), it was noted that there were 336 women (attrition cases) who do not complete pregnancy or move out of the area.

13.9 There were 250 women who birthed under the care of SaTH, but were from out of area so received community care from neighbouring Trusts. (BR+ 2021)

13.10 There were 379 women who birthed in neighbouring units and received community care from SaTH community midwifery teams. 51% of these were in Oswestry and 23% in Ludlow. (BR+ 2021)

13.11 BR+ is a framework for workforce planning and strategic decision-making. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. A new BR+ assessment has been requested, but for the purposes of the MCoC planning spreadsheet, staffing levels and birth statistics report 2019 figures have been used, but will be recalculated when the new BR+ report is available.

13.12 The BR+ figures provided are based on a total number of 4745 bookings which has now increased to 5192 bookings in 2021-22, according to data from the Maternity Information system.

Linked Obstetrician

13.13 Each team will have a linked named Consultant Obstetrician who is an integral member of the team in providing a clear well-defined route for obstetric or other specialist referral. The obstetrician may be linked to more than one team, and they will attend the regular MCoC team meetings to discuss any concerns. The midwives and the linked obstetrician will agree their method of communication and working eg communication via secure email.

13.14 Women with clear medical/obstetric risk factors that are set out in their referral (either by themselves or their GP) are referred from the outset to the maternity service obstetrician with a specific interest/specialisation in their condition.

Equipment and Estates

13.15 Each Team will require their own clinical equipment, laptops, and mobile telephones. Each team will need estate to be identified from which they will work. Health Centres, Children's Centres, GP Surgeries and Local Council facilities will be included in the scoping of suitable venues.

Training

13.16 A completion of training needs analysis for the service will be undertaken (see section 1.7)

Communication and Engagement

- Confirm the suggested locations for the teams based on the most recent public health data
- Group discussions led by the current MCoC team in order to learn and identify development and training requirements of the staff
- Seek expressions of interest to join the teams and have an external recruitment drive to support MCoC
- Explore MCoC in partnership with the wider maternity service

- Establish and agree care and referral pathways
- Celebrate the successes of the project through the MVP, audit meetings and staff communication channels.
- Run staff engagement events, to promote CofC in a positive manner supported by RCM (Royal College of Midwives) representative to promote, answer questions and empower staff. Work with MVP to assist with these. Inviting service users who have recently experienced care delivered by CofC midwives to support.
- Work with Communication team to develop CofC updates sharing good news stories from service users and positive impact on existing CofC team midwives of working in this model.
- Continue to engage and liaise with National Continuity of care lead to ensure we are in a strong position with reporting Continuity of care data regionally and nationally.
- Continue to attend regional continuity of care meetings to remain informed and share learning wider.

Appendix 4

Staffing Planning

- An innovative recruitment strategy is ongoing to increase the clinical workforce, alongside a review of the clinical component of the specialist midwives' hours alongside their non-clinical role to ensure a workforce that is fit for purpose that can respond to the changing landscape that is maternity staffing. Early indicators are positive for the service to be in a better position in the Autumn based on the number of staff recruited to but not yet in post

- Once workforce stabilised – plan for roll out of 1 team per quarter to ensure sustainable delivery model. Teams to be rolled out in areas where postcodes have been identified to have greatest impact within areas of deprivation.

Challenges:

- Band 5/6 midwives working part-time under 0.61wte and flexible working contracts impacting on the ability to deliver requirement of the national definition of midwifery continuity teams
- Maternity staff needing to continue with current pattern of long days/nights as part of work-life balance
- The unpopularity of on-call integral to the provision of the model
- The maintenance of the protected 1:36 case loading ratios when there are periods of sickness absence within the teams
- Escalation data demonstrates that currently only 50% of shifts have safe staffing levels, based on the workforce needed for 51% rollout of MCoC.

The Continuity of Carer Workforce Modelling tool and associated staffing plan were used to predict midwife recruitment required for each wave of the rollout (see page 20). Divisional agreement is required for the safe staffing levels for delivery suite as the rollout occurs, therefore for the purpose of this paper, the current minimal safe staffing levels for inpatients have been used.

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Uplift= 24%	Birth rate plus	funded:		C of C	All women		deliveries:			
Percentage and local calc	Midwife to woman ratio:1:23.4				attrition rate: 6.7%					
	total b3-8: = 222.61 sp/managers= 22.06 clinical mw: = 181.5 MSW (b3): = 20.05	total b5-8 = 218.23	deployment (=BR+4l)	C of C pathway	All care given=4280 AN/PN only=379 attrition= 336	% of women delivered	in area:4030 OOA:250		time scale	recruitment plan using the Continuity of Carer Workforce Modelling Tool
care location	Total b5-8 midwives: 203.56 + 22.06WTE additional roles	178.01	27 per IP shift		4995	0.00%	4280	ratio 1:27.6		
C of C team	0	5.8	2						current	
DS	56.21	52.48	10				4280			Workforce establishment required to provide care for all women is 206.71 Midwives
DAU & ANC	10.86	6.86	4							
AN ward&triage	26.41	21.32	6							
PN ward	37.87	29.87	5							
community&MLU	50.15	61.68	1 to 61.68							
specialists	12.06	26.22	1 to 26.22							
managers 7	7	7	7							
managers 8a & up	3	7	7							
TOTAL	226.16	218.23								218.23
Wave 1	7 WTE	1 team		6.70%		5.89%				0
C of C team		7		294		252				No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision is 204.14 Midwives
DS		52.48	10				4028			Workforce establishment required to provide care for all women is 210.86 Midwives
DAU & ANC		6.86	4							
AN ward & triage		21.32	6							
PN ward		29.87	5							
community&MLU		54.68	1 to 54.68		4701					BR+ recommended ratio of 1:94 for community, 7 x CMW used for Coc
specialists		26.22								
managers 7		7								
managers 8a & up		7								
TOTAL		212.43								212.43
Wave 2	14 WTE	2 teams		13.4%		11.78%				215.69 - 211.63 = 4.06 needed
C of C team		14		588		504				No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision is 201.14
DS		52.48	10				3776			Workforce establishment required to provide care for all women is 215.69
DAU & ANC		6.86	4							
AN ward & triage		21.32	6							
PN ward		29.87	5							
community&MLU		46.88	1 to 46.88		4407					BR+ recommended ratio of 1:94 for community
specialists		26.22								
managers 7		7								
managers 8a & up		7								
Total		211.63								211.63
Wave 3	21 WTE	3 teams		20.10%		17.66%				220.53 - 215.69 = 4.48 needed
C of C team		21		882		756				No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision is 198.14
DS		52.48	10				3524			Workforce establishment required to provide care for all women is 220.53
DAU & ANC		6.86	4							
AN ward & triage		21.32	6							
PN ward		29.87	5							
community&MLU		43.76	1 to 43.76		4113					BR+ recommended ratio of 1:94 for community
specialists		26.22								
managers 7		7								
managers 8a & up		7								
Total		215.51								215.51
Wave 4	28 WTE	4 teams		26.80%		23.55%				224.67 - 220.53 = 4.14 needed
C of C		28		1176		1008				No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision is 195.57
DS		52.48	10				3272			Workforce establishment required to provide care for all women is 224.67
DAU & ANC		6.86	4							
AN ward & triage		21.32	6							
PN ward		29.87	5							
community & MLU		40.63	1 to 40.63		3819					BR+ recommended ratio of 1:94 for community
specialists		26.22								
managers 7		7								
managers 8a & up		7								
Total		219.38								219.38

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wave 5	35 WTE	5 teams		33.50%		29.44%				229.51 - 224.67 = 4.84 needed
C of C team		35		1470		1260				No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision is 192.57
DS		52.48	10				3020			Workforce establishment required to provide care for all women is 229.51
DAU & ANC		6.86	4							
AN ward& triage		21.32	6							
PN ward		29.87	5							
community&MLU		37.5	1 to 37.5		3525					BR+ recommended ratio of 1:94 for community
specialists		26.22								
managers 7		7								
managers 8a & up		7								
Total		**223.25**								223.25

wave 6	42 WTE	6 teams		40.20%		35.33%				234.34 - 229.51 = 4.83 needed
C of C team		42		1764		1512				No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision is 189.57
DS		52.48	10				2768			Workforce establishment required to provide care for all women is 234.34
DAU & ANC		6.86	4							
AN ward& triage		21.32	6							
PN ward		29.87	5							
community&MLU		34.37	1 to 34.37		3231					BR+ recommended ratio of 1:94 for community
specialists		26.22								
managers 7		7								
managers 8a & up		7								
Total		**227.12**								227.12

wave 7	49 WTE	7 teams		46.90%		41.21%				238.49 - 234.34 = 4.15 needed
C of C team		49		2058		1764				No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision is 186.99
DS		52.48					2516			Workforce establishment required to provide care for all women is 238.49
DAU & ANC		6.86	4							
AN ward& triage		21.32	6							
PN ward		29.87	5							
community&MLU		31.24	1 to 31.24		2937					BR+ recommended ratio of 1:94 for community
specialists		26.22								
managers 7		7								
managers 8a & up		7								
Total		**230.99**								230.99

wave 8	56 WTE	8 teams		53.60%		47.10%				243.32 - 238.49 = 4.83 needed
C of C team		56		2352		2016				No. of MWs required to provide care for Women Not on C of C pathway and core staffing provision is 183.99
DS		52.48	10				2264			Workforce establishment required to provide care for all women is 243.32
DAU & ANC		6.86	4							
AN ward& triage		21.32	6							
PN ward		29.87	5							
community&MLU		28.12	1 to 28.12		2643					BR+ recommended ratio of 1:94 for community
specialists		26.22								
managers 7		7								
managers 8a & up		7								
Total		**234.87**								234.87

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Appendix 5

Building Blocks in readiness to implement and Sustain MCofC assessment Framework. 2021 Guidance NHSEI. Appendix 3

Building block	Detail/notes	RAG
	The plan needs to be developed and presented to the board. It then needs to be rolled out according to the trust's specific needs. Work already underway should continue unless there is an urgent reason not to.	
Safe staffing	• Agreed safe staffing level for traditional model, proceeding only when safe to do so – using the NHS England and NHS Improvement tool to support planning • How many midwives required • How many in post • Recruitment plan with timeframes	
Planning spreadsheet	Demonstrates safety from a staffing perspective: • How many women can receive MCoC – reviewing in and out of area and cross-boundary movement • Where women are cared for at any given time, now and in MCoC models (see NHS England and NHS Improvement toolkit https://continuityofcarer-tools.nhs.uk/tools for an example of this) • Midwifery deployment plan for MCoC, including timescales and recruitment plan for a phased scale up to default position	
Communication and engagement	• Provides evidence of staff engagement and logs responses/ counter responses • Gives opportunity to share vision	
Skill mix	• Review of skill mix, within whole service. This includes: – Number of Band 5 midwives placed in MCoC team. Likewise, number of Band 5 midwives working in the core – In both settings ensure there is appropriate support for these newly qualified members of staff, via the preceptor framework – Band 5 midwives (usually one per team) report being very well supported while undertaking preceptor programme • Appropriate and planned use of MSW, particularly in teams working in areas of greatest need.	

Building block	Detail/notes	RAG
	• Ensure preparedness of Band 7 delivery suite coordinators to support programme of change	
Training	Each midwife who will work in the team has a personal training needs analysis (TNA); existing TNAs can be used and the toolkit also gives examples.	
Team building	Time allocated for team building and softer midwifery development as midwives move to a new way of working.	
Linked obstetrician	Has there been obstetric involvement and are linked obstetricians identified? Is the referral to obstetrician process clearly set out in the SOP as well as other clinical guidance?	
Standard operating policy (SOP)	Each trust needs a SOP (an example can be found in the toolkit) that outlines roles and responsibilities to support delivery of MCoC. As with other guidance documents, it should pass through the maternity service governance processes.	
Pay	No midwife should be financially disadvantaged for working in this way. Each trust needs to review and manage this; the toolkit provides helpful information.	
Estate and equipment	Place for midwives to see women. Equipment with which to provide care. Any problems should be escalated at trust board quarterly review and to the ICS.	
Evaluation	Is there a system for local, regional, and national evaluation and reporting to take place smoothly?	
Review process	Date for initial plan to be reviewed by the trust board. Quarterly review dates set. Dates set for LMS and regional and national review.	