NHS
The Shrewsbury and Telford Hospital
NHS Trust

Quality Account

The Shrewsbury and Telford Hospital NHS Trust

2022/23

Partnering
Ambitious
Caring
Trusted

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

CONTENTS

2.3 Reporting against core Quality Account indicators

Summary: Hospital Level Mortality Indicator
Percentage of patient deaths coded at either diagnosis or speciality level.
Patient Reported Outcome Measures (PROMs)
Patients readmitted to hospital.
Responsiveness to the needs of patients
Percentage of staff who would recommend the Trust to a friend or family needing care.
Patients admitted to hospital who were risk assessed for venous thromboembolism (VTE)
Patient Safety Incidents and the percentage reported that resulted in severe harm or death
Rate of Clostridium Difficile

2.4 Looking forward to our Priorities for Quality Improvement 2023-2024

Priority 1: Integrate learning from both positive and negative incidents
Priority 2: Identify, escalate and timely intervention of deteriorating adults and children
Priority 3: Continuing work on the principles of charting will be a main priority for 2023-24 alongside work to help prevent deconditioning
Priority 4: Ensure improved patient experience in our Emergency Departments, reducing waiting times, timely decision making and intervention
Priority 5: Improve our admission and discharge processes through the Trust, ensuring our patients are receiving the right care, in the right place at the right time
Priority 6: Address and improve care with people with diabetes through close working with system partners
Priority 7: Demonstrating that as a Trust we are learning and improving patient, carer and public experience through complaints, patient surveys, feedback and compliments
Priority 8: Improve the care of patients with a Learning Disability or Autism cared for in the Trust
Priority 9: Continue with delivering the Trusts PEOLC strategy with a focus on improving our care after death through ongoing education, support and monitoring.

Section 3: Other Information Relevant to the Quality of Care

National Patient Safety Alert Compliance
Serious Incidents
Never Events
Friends and Family Test
Learning from Patient Experience
Maternity Improvement
Infection Prevention and Control NHSE Review.

SECTION 1: INTRODUCTION

1.0 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OFFICER

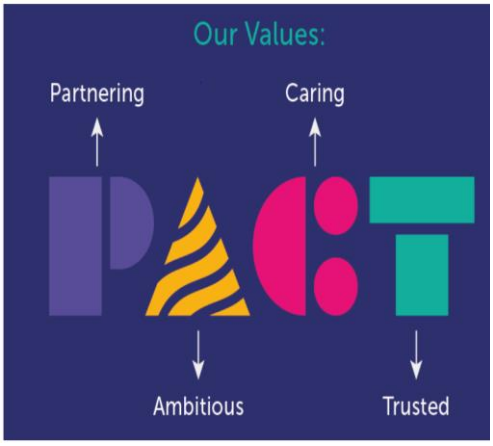
The Shrewsbury and Telford Hospital NHS Trust

The Shrewsbury and Telford Hospital NHS Trust (SATH) is the main provider of hospital services for Shropshire, Telford and Wrekin and mid Wales. It is an acute teaching hospital working across two main sites: The Royal Shrewsbury Hospital (RSH) in Shrewsbury and the Princess Royal Hospital (PRH) 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 RSH. Inpatient paediatrics, gynaecology, and consultant-led obstetrics services are provided at the PRH. Acute Stroke and Stroke rehabilitation services are also provided at the PRH site. The Trust also provides community and outreach services for dialysis, audiology, therapies and maternity services. Our focus is to ensure our patients receive safe and effective care.

Our Vision is to provide excellent care for the communities we serve. We are a values-based organisation, and our vision can only be realised if our values are at the heart of everything that we do. Our values are underpinned by four key values developed in partnership with our patients, families, staff and local communities.

Our values are:



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.

PURPOSE OF THE QUALITY ACCOUNT

All NHS Trusts are required to produce an annual Quality Account that describes and explains the quality and safety of the services provided for patients and their families. Quality Accounts have become an important tool for strengthening accountability for quality within NHS Trusts and for ensuring effective engagement of the Trust's Board of Directors in the quality improvement agenda. By producing a Quality Account, Trusts are able to demonstrate their commitment to continuous evidence-based quality improvement and to explain their progress to patients and their families, the public and those who have an interest in the services that the Trust provides.

The Department of Health and Social Care (DHSC) has confirmed the deadline to publish the 2022/23 Quality Account is by the 30 June 2023. SaTH welcomes the opportunity to provide information about how well we are performing, and the quality of care we provide, that fully considers the views of our service users, carers, colleagues and our local communities.

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OFFICER

Welcome to the Quality Account for the Shrewsbury and Telford Hospital NHS Trust for 2022/2023. This account provides us with an opportunity to look back on the year, highlight some of the main developments to our services and the improvements we have made to our care across the Trust, whilst also reporting on how we have performed against key national clinical standards. Also, this Quality Account sets out our Quality Improvement priorities for 2023/24.

Our vision is to provide excellent care for the communities we serve. The Shrewsbury and Telford Hospital NHS Trust aims to be one of the safest organisations within the NHS. Our valued staff are committed to providing high quality care to patients. The quality of the services we provide is **assessed using a variety of measures, including those relating to** patient safety, the effectiveness of treatments patients receive, and feedback we receive from patients and service users, our commissioners, and our regulators about the care provided. Throughout 2022/2023 we have seen improvements, including a reduction in the number of patient falls resulting in moderate harm or above; improvements in our safeguarding processes and training compliance, in order to improve the care we deliver to patients, and improvements in care in relation to palliative and end of life care.

We have also continued our maternity improvement journey and made significant progress in the delivery of the actions from the Independent Review of Maternity Services at the Trust, chaired by Donna Ockenden. Alongside this, we have seen improvements in our CQC National Maternity Survey results, and achieved full compliance with Year 4 of the Clinical Negligence Scheme for Trust (CNST) against the 10 maternity safety actions. All of these are helping us to improve the quality and reliability of the care we provide.

We continue to strive to provide the best care; however, we do not always get things right. Our teams work hard to learn lessons and improve continually. We recognise that we still have much work to do in relation to improving our care of the deteriorating patient, and embedding the use of the sepsis screening and management tool across all our clinical areas. There is also further work to do to develop our acute care pathways and discharge processes. Much of this work will be undertaken in collaboration with our Integrated Care System colleagues (ICS). The Trust takes the time to understand complaints and issues when they are raised more fully. This is helping us to improve how we respond to complaints, while learning lessons and making changes to the ways we deliver our services, where required. Our Independent Complaints Peer Review Panel supports us with this important work.

We have made significant progress this year despite the many challenges, and this report serves as an open and honest account of the progress we have made, as well as outlining where we still have challenges.

Thank you to all our colleagues, who have continued to work so hard throughout the year to deliver the best possible care to our patients, service users, their families and loved ones. Thank you also to our stakeholders, who work alongside us and help us to improve further, and to everyone who has helped us develop this Quality Account, including Healthwatch and our ICS colleagues.

In 2023/2024, we will see another challenging year for the Trust as we continue to focus on the recovery of our services, delivering the best care possible by achieving positive outcome and access targets, alongside an ever-increasing demand for our services coupled with tighter financial constraints. This Quality Account sets out our priorities for quality improvement for 2023/2024, which are aligned to our Quality Strategy and Operational Plan. The Trust will continue to work with our partners, patients, colleagues, communities, regulators, healthcare providers and as part of the Shropshire, Telford and Wrekin Integrated Care System and we are very grateful for the feedback and support that we continue to receive.

Louise Barnett, Chief Executive Officer

SECTION 2: PRIORITIES FOR IMPROVEMENT & STATEMENT OF ASSURANCE

This section outlines the detail behind each of the quality priorities previously agreed for 2022/2023 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 SaTH performance for core quality indicators. A summary of the priorities identified for 2023/2024 are outlined, why we have chosen these and the actions we will take to achieve these throughout 2023/2024.

2.1 REVIEW OF THE PRIORITIES FOR IMPROVEMENT 2022/2023

As part of the “Getting to Good” Programme the Trust developed a Quality Strategy. The Strategy for 2021-2024 was agreed by the Trust Board in March 2021.

The priorities within the Quality Strategy includes eight key overarching priorities within the three core domains of: ***Safe, Effective and Patient Experience.***

	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

Our Quality Priorities in 2022/23 were based around these eight priorities and included key actions we planned to take to achieve these overarching quality priority improvements. The priority actions for 2022/23 and our achievements against these are shown:

Quality Priority 1: Learning from events and developing a safety culture

Throughout 2022/23 we have continued our work to embed our patient safety culture across the organisation. We have continued to report and investigate incidents that could have or did cause our patients harm in a timely way, and inform patients, their carers, families and our staff when we make mistakes and share any lessons we learn to prevent future harm.

What we said we would do

1. Standardise the process for safety huddles throughout our wards and departments to share best practice to optimise how safety learning and awareness is shared
2. Continue improvements in the percentages of staff responding positively to the relevant safety culture elements included in the staff survey
3. Continue to embed our Quality Governance Framework within the Divisions across the Trust
4. Implementation of the Patient Safety Incident Response Framework (PSIRF) in line with national guidance.

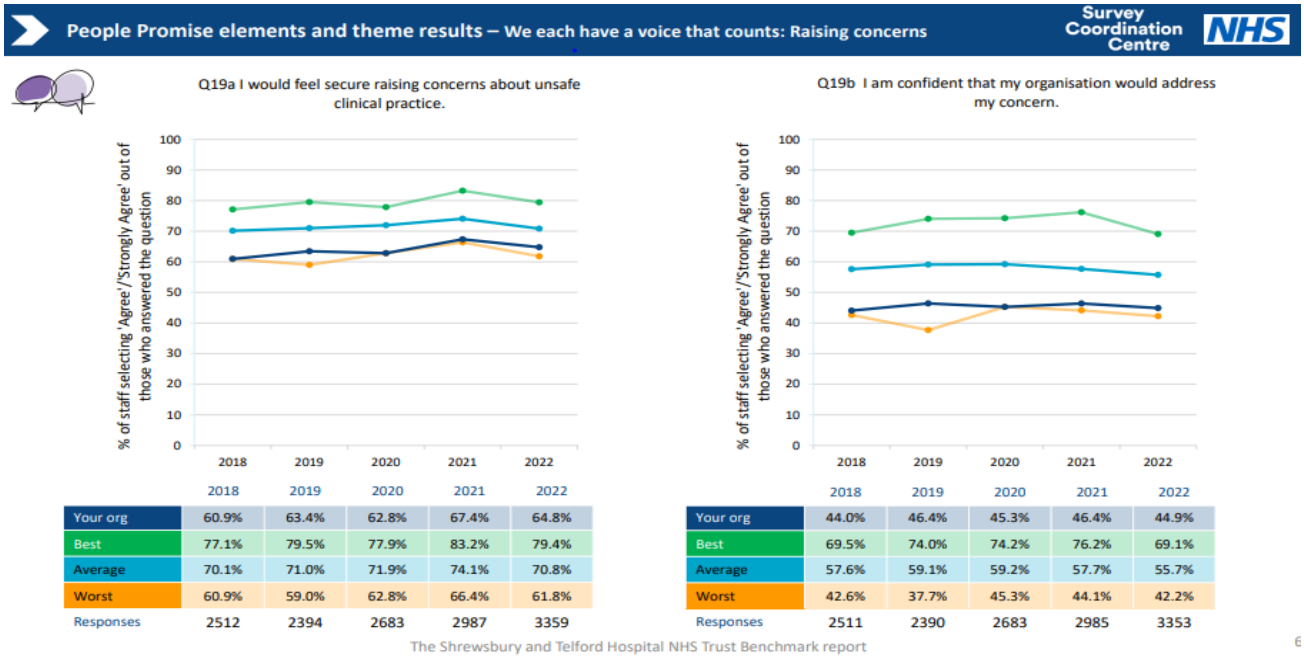
What we have achieved

1. **Standardise the process for safety huddles throughout our wards and departments to share best practice to optimise how safety learning and awareness is shared** — ***Achieved***

Across the medical and surgical wards there are twice daily safety huddles, involving all members of staff on duty. Patients are discussed who have specific care needs to ensure the whole team is fully updated. The time is also spent to raise areas around safety concerns, learning from events and to update staff in relation to quality and safety discussions, which have taken place at Divisional meetings, the weekly Band 7/senior nurse meeting chaired by the Director of Nursing and the Matron meeting.

2. **Continue improvements in the percentages of staff responding positively to the relevant safety culture elements included in the staff survey** — ***Not Achieved***

   Nationally, the performance in relation to the questions about raising a concern deteriorated. Although the Trust saw a decline in the number of staff who would feel secure raising a concern about unsafe practice (↓2.6) and feeling confident that the Trust would address these concerns (↓1.5%), there was a greater decline in relation to the national average for these questions with 3.3% and 2% respectively. There remains significant work to do to ensure our teams feel able to raise safety concerns and that these will be addressed.



3. Continue to embed our Quality Governance Framework within the Divisions across the Trust

Achieved

During 2022/23 the Review, Action and Learning from Incident Group (RALIG) and Nursing Incident Quality Assurance Meeting (NIQAM) has been embedded to enable a multidisciplinary/cross Divisional review and shared learning in the Trust.

The new Quality Governance Framework was implemented across the Trust in November 2021. Throughout 2022/23 we have continued to embed this new framework within the Divisions to reduce the previous variation and to standardise Divisional quality governance processes. In 2022 the previous resources within the Patient Safety Team were realigned with Divisional Quality Governance teams to develop and embed good governance processes.

A new Serious Incident template based on the Health Safety Investigation Branch (HSIB) for undertaking our Serious Incidents across the Trust has also been implemented.

4. Implementation of the Patient Safety Incident Response Framework (PSIRF) in line with national guidance

Achieved

The Patient Safety Incident Response Framework (PSIRF) replaces the existing Serious Incident (SI) Framework and must be implemented by the Trust by September 2023. The new framework outlines a new approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety and has four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approached to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement.

In 2022/23 the initial stages of the implementation have focused on orientation to the guidance, diagnostic and discovery and then in the latter part of the year moved into the governance and quality monitoring stage. The diagnostic and discovery phase has involved answering several key questions relating to "Just Culture", open and transparent reporting, engaging those involved and affected by patient safety incidents, our incident response capacity and training needs, and how we use learning from incidents to inform improvement. This has allowed a gap analysis to be undertaken between the current situation and the PSIRF which will feed the next stage of detailed planning to move to PSIRF. We have also engaged with a number of PSIRF early adopter sites to observe their decision-making processes and review their governance structures to help guide our implementation plans.

To plan the next stage of the project, an implementation group has been established to oversee progress and review findings from the diagnostic phase. Several working groups have also been created based around the four key principles detailed above. These working groups have been assigned specific key considerations to produce recommendations regarding policies, procedures and processes that will be fed back to and agreed at the implementation group, which in turn will report directly to QOC for approval. An initial proposal on the governance framework required for PSIRF oversight will be brought to QOC in May 2023 and will include an overview of potential changes to the current meeting structures and information flows and implications for capacity across teams.

Quality Priority 2: The deteriorating patient

Recognising a patient who is deteriorating at the earliest opportunity and identifying the most appropriate course of treatment for them to give them the best possible outcome is our key priority.

What we said we would do

1. 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

2. Revise deteriorating patient training to include soft signs of sepsis, deterioration competency assessments for all relevant clinical staff, develop and deliver an e-learning programme
3. 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
4. Ensure all identified patients receive full antimicrobial review at 72 hours following prescribing of antibiotics
5. Strengthen the Deteriorating Patient Membership and attendance to include all aspects of the deteriorating patient and engage key staff in the improvements and reporting

6. Work with the Clinical Lead to improve the processes, pathways, and training for AKI and DKA.

What we have achieved

1. Develop a Sepsis and Deteriorating Patient Dashboard to triangulate all key performance indicators and use this to track and drive improvements

Achieved

A draft dashboard has been developed which will be used to triangulate the key performance indicators from April 2023. The aim is that this dashboard will be used by the Divisions as the basis of their reports for the Deteriorating Patient Group and will inform future improvement works.

2. Revise deteriorating patient training to include soft signs of sepsis, deterioration competency assessments for all relevant clinical staff, develop and deliver an e-learning programme

Partially Achieved

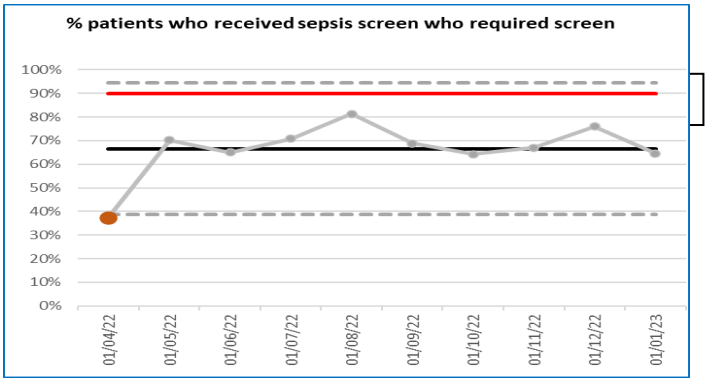
In 2022/23 work commenced on supporting the implementation of a “train the trainer” programme for the delivery of basic life support skills which will mean that the Divisions have the ability to also deliver this training in-house which will provide more flexibility in ensuring our staff receive this important mandatory training. Alongside this, scoping work has taken place in relation to implementing an Acute Illness Management programme training; this is to be implemented in 2023/24. This training will enhance the knowledge, confidence and performance of our ward teams in dealing with acutely ill patients and promote a multi-disciplinary approach to patient care.

3. Further embed the use of the sepsis screening tool and Sepsis Six bundle and pathway arrangements across the Trust to achieve 90% compliance in the inpatient areas

Not Achieved

The roll out of the sepsis module within Vitals 4.2 across the Trust helped to improve the compliance of patients being screened for sepsis appropriately. A key priority in 2023/24 is to ensure that Vitals is implemented across our paediatric services.

Compliance is improving, however, more work is required to embed this and achieve the 90% target for all inpatients. Ongoing training in relation to sepsis has continued in 2022/23. Deteriorating Patient Specialist Nurses are spending more time visible on the wards/clinical areas, achieving good engagement with the teams and this provides greater opportunity to teach best practice whilst working clinically.



4. Ensure all identified patients receive full antimicrobial review at 72 hours following prescribing of antibiotics

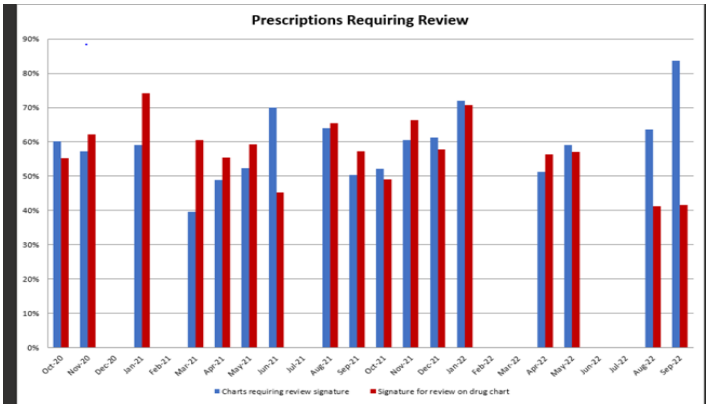
All patients who are commenced on antibiotics should have these reviewed within the first 72 hours. Our anti-microbial pharmacist undertakes audits of the drug charts for patients who are on antibiotics. This is to ascertain if a review was completed within the first 72 hours by ensuring that there is documented evidence via

a signature from the medical team to show a review has taken place. There is variation in compliance month by month with a range between 40-75%.

Whilst the audits show that often it is documented “continue” this doesn’t necessarily indicate that an active review has taken place and that all the elements of review have been considered.

Further work is being undertaken by the antimicrobial team who are presenting at the Medical Director’s Grand Round sessions to reinforce expectations and focus on 72-hour reviews taking place, as well as intravenous to oral switching of antibiotics.

5. **Strengthen the Deteriorating Patient Membership and attendance to include all aspects of the Deteriorating patient and engage key staff in the improvements and reporting**



The Deteriorating Patient Group reviewed its meeting “Terms of Reference” in 2022. The chair of the meeting is the Lead Consultant for the deteriorating patient. There has been better representation at the meetings from various disciplines. A deteriorating patient action plan was also developed to help structure the priorities for the Group in the forthcoming year.

6. **Work with the Clinical Lead to improve the processes, pathways, and training for AKI and DKA**

Not Achieved

This work did not commence in 2022 but will be a focus in the next year.

QUALITY PRIORITY 3: 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.

What we said we would do

1. 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. This team will have 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.
2. Ensure other key members of our multi-disciplinary teams involved in the care of patients who are at risk of falls have received falls training including doctors, physiotherapists, occupational therapists, and pharmacists
3. 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.

What we have achieved

Throughout 2022/23 we have continued with our improvements to reduce the number of falls and patients who sustain harm following a fall in our care.

1. **Establish an Enhanced Patient Supervision Team in 2022/23 and work undertaken to reduce de-conditioning for our patients**

Achieved

In September 2022 funding was agreed to establish an Enhanced Patient Supervision (EPS) team. Recruitment to this team has been ongoing and 14 staff have now been recruited and received training to ensure they have the right skills to undertake this role. The EPS Policy and Risk Assessment have been revised and further work will continue in 2023/24 in relation to fully recruiting to the team and establishing robust processes for allocating these staff to those vulnerable patients most in need of this care. We know that nationally that 50% of patients admitted to hospital experience functional decline between admission and discharge which can lead to increased risk of pressure damage, falls, malnutrition, loss of confidence and loss of dignity. In 2022 the Trust signed up to the national "Recondition the Nation" which promotes "reconditioning" approaches with the aim to help our patients, particularly those older patients stay active and mobile.

In November 2022, the Trust launched its re-conditioning programme across the adult inpatient wards. Work undertaken included:

- Local launch of reconditioning games included a week programme of events (taster sessions)
- Promotion of the games to encourage activeness and cognitive interaction, activities included bingo, balloon tennis
- Upskilling and supporting staff
- Shared learning with and from Care Homes
- Linking key people together – keeping patients moving workbook
- NHSEI podcast streamed on social media.

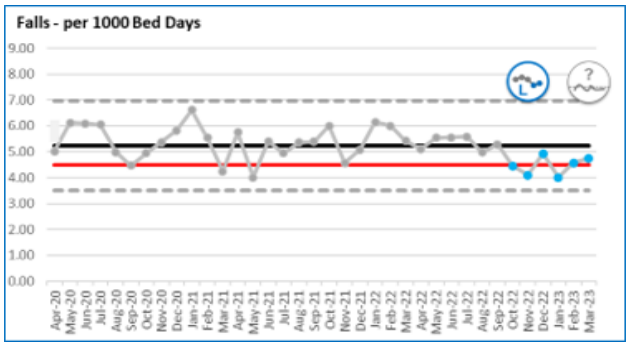
The Trust currently sits third on the national league table and first on regional table for its initiative in relation to the "re-conditioning programme.

2. **Ensure other key members of our multi-disciplinary teams involved in the care of patients who are at risk of falls have received falls training including doctors, physiotherapists, occupational therapists and pharmacists**

Falls training has continued to be delivered to staff across the Trust in 2022/23.

- At the Royal Shrewsbury Hospital 70% of Physiotherapists have completed training and at the Princess Royal Hospital 69% have completed this training

- Occupational therapists have received training with 36% having completed at the Princess Royal Hospital and 80% at the Royal Shrewsbury Hospital
- The Falls Practitioner is currently working with our Medical Falls Leads to identify what falls training should be mandated for our medical teams moving forward.



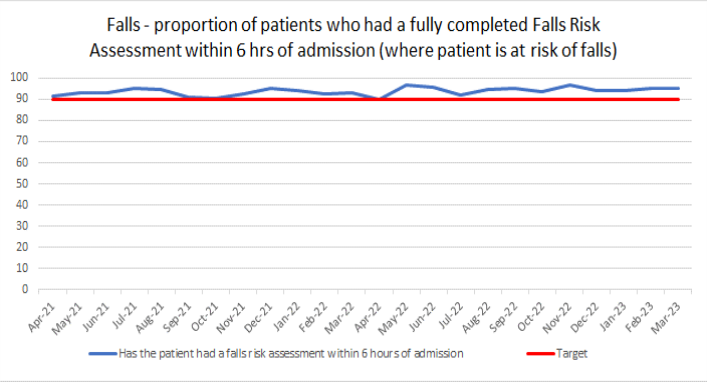
3. Ensure all patients have a falls risk assessment completed on admission, a care plan and care after a fall adheres to our falls procedure and best practice

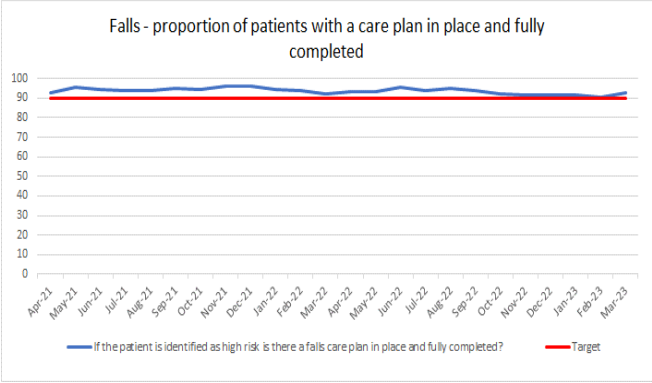
Achieved

Throughout 2022/2023 we have continued to review monthly the number of patients who had a falls risk assessment completed on admission has been >90% and above 90% for those patients assessed a s being at risk having a falls care plan in place to guide the care they require.

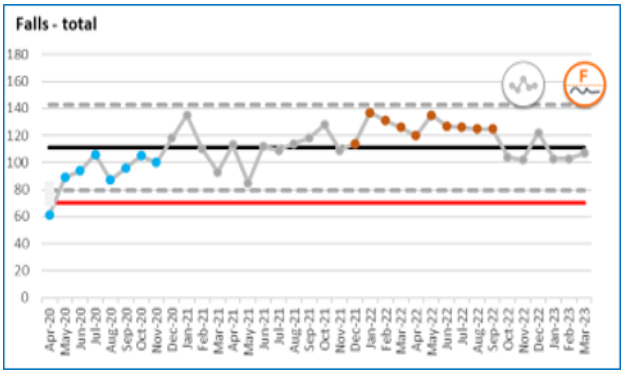
Impact of the achievements made in 2022/2023

Positive results in relation to our outcome measures for falls have been seen in 2022/23:





Although our number of falls were high at the start of the year, we have seen these reduce throughout the year and particularly from October 2022 to March 2023.



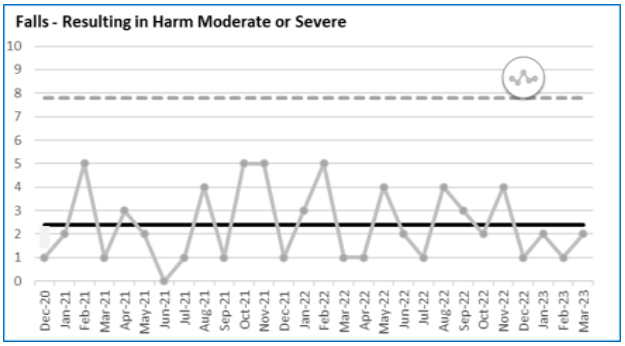
The ratio of falls per 1,000 bed days is another important indication of whether our falls interventions are having a positive impact. The ratio of falls per 1,000 bed days is important as it reflects the business of the Trust and the number of

patients we are caring for. The ratio of falls per 1,000 bed days has reduced throughout Quarter 3 and Q4.

There has been a reduction in the number of falls resulting in moderate or severe harm, with 27 cases reported in 2022/23 compared to 31 in the previous year (↓13%). Of these 18 were reported as Serious Incidents, 10 cases less than in 2021/22 (↓35%). Our aim remains for no patient to sustain a fall resulting in serious harm whilst in our care.

Priority 4: Best clinical outcomes

Ensuring we do the right things in the right way, by the use of innovation and ensuring our teams base their practice on the best recommendations, clinical outcome monitoring, audit, and NICE compliance has remained a key priority throughput 2022/23.



What we said we would do

1. Further development of clinical standards for each speciality
2. 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
3. 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
4. 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
5. Aim to ensure maximum use of this NICE guidance by:
    - 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.

What we have achieved

1. Further development of clinical standards for each speciality — *Partially Achieved*

Throughout 2022/23 the Senior Clinical Lead for the Levelling Up Clinical Standards Project has continued to support the specialties to develop clinical standards and to refresh internal professional

standards A number of these have been drafted including the Ear, Nose and Throat Team (ENT), Frailty, Neurology, Acute Medicine and the Emergency Department. The standards include quality, safety and performance metrics and also incorporate national and best practice measures.

2. Consistently review and monitor clinical standards and identify areas for improvement through the development of speciality level Clinical Standards Dashboards

Progress has been made with draft dashboards for Acute Medicine and the Emergency Department clinical standards. Once agreed, these will be added to the agenda for review and discussion at specialty governance meetings, divisional performance review meetings and will be used to identify areas for improvement. This will be further rolled out to include all specialties with support from the Performance and Business Intelligence Team

3. 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

Not Achieved

Clinical Policies and Standard Operating Procedures are agreed and approved at the Quality Operational Committee chaired by our Medical Director. Work has commenced to establish a new governance process for the approval and sign-off of these documents in 2023/24.

4. Use our Clinical Audit Programme as a force for sustained performance and improvement

Achieved

The Clinical Audit programme has been developed using national guidance and includes national audits highlighted by the National Clinical Audit and Patient Outcomes Programme (NCAPOP) as a priority for Trusts to participate in and local audits against national guidance including NICE guidance.

During 2022-23 audit clerks working on some of the ongoing national audit programmes have been brought into the central clinical audit team. This has helped to ensure that findings from these important national audits are presented and acted on to improve patient care. Work during the year to strengthen our processes for reviewing and implementing NICE guidance within the Trust has made it easier to carry out case-note audits of this important national guidance to provide assurance this guidance is being followed when caring for our patients. All our clinical audits are carried out against standards and as our own key clinical standards are being developed, we are able to monitor performance against them through our audit programme in a constant process of review and improvement.

5. Aim to ensure maximum use of Nice Guidance. Aim to achieve a target of 100% completion of templates within target timescales

Partially achieved

During 2022-23, our performance against NICE guidance within target timescales was achieved for 92% of NICE guidance overall. This was a slight decline on performance in 2021/2022 and reflects the increased complexity of some of the new guidance published, requiring input from multiple clinical teams and still represents a significant improvement on compliance achieved during 2020-21. This has been achieved through delivery of training to clinical audit staff to enable them to better support clinical teams in reviewing and implementing NICE guidance, and further consolidation of work with specialist nurses to ensure compliance.

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	Percentage of guidance published during the year completed within target timescale 2022/2023
Clinical guidelines (NG)	93% (28/30)	92% (11/12)	80% (12/15)
Quality Standards (QS)	62.5% (5/8)	100% (3/3)	100% (1/1)
Interventional Procedural Guidelines (IPG)	67% (12/18)	100% (26/26)	97% (32/33)
Total	**80% (45/56)**	**98% (40/41)**	**92% (45/49)**

Focused work in this area has resulted in sustained maintenance in the overall percentage of all published guidance completed during 2022-23, which increased from 99% in 2020-21 to 99.9% in 2021-22 and remaining at 99.9% 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	Percentage of all published guidance completed 2022-23
Clinical guidelines (NG)	97% (283/291)	99.6% (289/290)	99.7% (297/298)
Quality Standards (QS)	99% (195/197)	100% (197/197)	100% (198/198)
Interventional Procedural	99% (543/544)	100% (552/552)	99.9% (576/577)
Total	**99% (1021/1032)**	**99.9% (1038/1039)**	**99.9% (1071/1073)**

During 2023-24 the Trust aims to achieve over 98% of guidance reviewed within target timescales and maintain overall completion of guidance at 99.9%. To succeed in achieving these targets dedicated members of Clinical Audit support staff will be assigned to monitoring NICE guidance, training will be delivered to both support staff and clinical staff, and systems for ensuring local guidelines incorporate NICE guidance will be refined.

Further strengthening links with specialist nurses to facilitate completion of benchmark assessment templates

Achieved

There are now two members of the clinical audit team with dedicated responsibility for monitoring our NICE guidance tracker and ensuring guidance is disseminated, monitored, and benchmarked and that associated actions are followed up on. This continuity has helped to ensure strong links with Specialist Nurses and Consultants, making it easier for local guidance to be updated, and helping staff caring for patients to have easy access to recommendations from NICE guidance.

All members of the clinical audit team have been trained in extracting auditable standards from NICE guidance and in completing benchmark assessment templates. This ensures that more members of the clinical audit team have the skills to meet clinical staff on a one-to-one basis to provide support ensuring templates are completed within target timescales to a standardised format. This is important in making sure we are following NICE recommendations.

Further expansion of case-note audits of NICE guidance to provide assurance that guidance is being implemented as expected

Achieved

A full programme of NICE case-note audits across all specialties is now incorporated into the clinical audit forward plan. A system has been implemented to ensure that newly published or updated NICE guidance is added to the plan to be audited the following year, allowing for updated local guidelines to become embedded prior to audits being carried out. This has increased the volume of NICE case-note audits being carried out, and to support this process all clinical audit staff have been trained in extracting auditable standards from NICE guidance.
During 2023-24 clinical audit staff will receive further training on working with clinical staff to support the audits, continuing to provide assurance that our care meets these standards.

Review and strengthening of the process for incorporating new and updated NICE guidance into local guidelines

Achieved

The process for dissemination of NICE guidance within the Trust has been further refined and strengthened during 2022-23. To ensure that relevant local clinical guideline/s are reviewed, when new NICE guidance is published or existing guidance updated, the clinical audit team identify relevant local clinical guidelines and work with clinical staff to support the review process. To ensure this guidance is easily accessible to staff working in clinical areas, local guidelines have been made more accessible through development of an Application (App) which is available on the Trust intranet. This helps us to ensure that the recommendations are used in the care of our patients.

Review and refinement of the process for tracking, reviewing, and updating action plans arising from NICE guidance

Achieved

To complement the existing Trust database of NICE guidance, a tracker has been developed during 2022-23 which highlights outstanding actions in red. There are now two dedicated trained members of the clinical audit team who are responsible for monitoring this tracker and ensuring actions from NICE guidance are implemented as planned.

Priority 5: Right care, right place

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

What we said we would do

1. Further reviews and development of the IDT to streamline planning processes and to develop the Discharge to Assess model in 2022/23
2. Re-establish the Discharge Improvement Group chaired by the Chief Operating Officer, 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
3. 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 twice across wards during their stay in hospital unless clinical indicated
4. Improve the provision of capacity within the Discharge Lounges including chair and beds, on both hospital sites to enable timely discharge of patients
5. Further develop weekend working to improve discharges including the establishment of Criteria Led Discharge.

What we have achieved

1. Further reviews and development of the IDT to streamline planning processes and to develop the Discharge to Assess model in 2022/23

Partially Achieved

A review of the Integrated Discharge Team (IDT) was undertaken in 2022/23. Following this a decision was made that moving forward the IDT team would be led and managed by Shropshire Community Health NHS Trust. A new “transfer of care” document was rolled out across the adult wards in the Trust in 2022 to streamline processes and information. Social workers are also now onsite in the Trust to support earlier conversations and assessments.

2. Re-establish the Discharge Improvement Group to ensure improvements enable patients to be discharged safely and efficiently and all appropriate treatments, medication and clinical discharge information are in place before discharge

Achieved

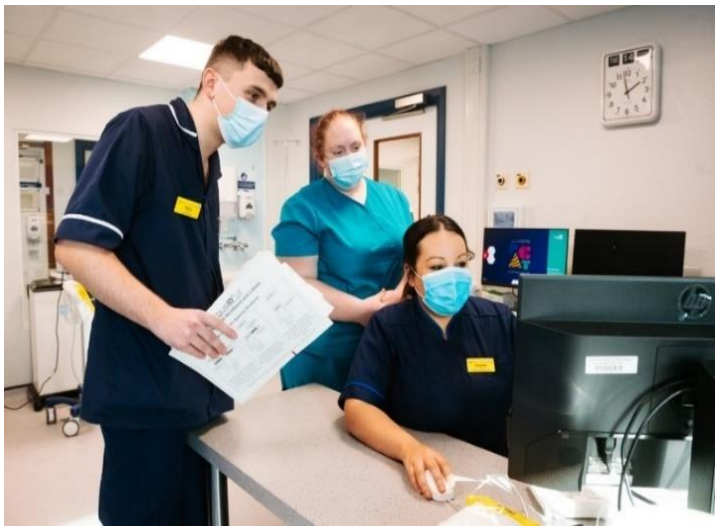
During 2022/23 an Urgent and Emergency Care Improvement Group was established that incorporates discharge improvement activities. Ward processes improvement work progressed across all medical wards and discharge lounge utilisation improved from September and has been sustained. There remains further work to do via this Group in 2023/24 to ensure safe and timely discharges for patients across the two hospitals.

3. Implementation of the Acute Floor, a Trauma Assessment Unit and Oncology Assessment Unit

Achieved

During 2022 the Trust reviewed the model of acute care provision across the Trust. A new Acute Floor was created at RSH which has meant that patients that are referred from the GP to see an acute

physician can go directly to the Acute Medical Assessment Area rather than waiting in the Emergency Department (ED).
The acute floor consists of 26 short stay beds, 20 beds in the acute medical unit and 14 trollies, three assessment rooms and a seating area for up to 15 patients in the Acute Medical Assessment area. A further expansion is planned in 2023 to utilise nine enhanced care beds once staff have been recruited and fully trained.



The new Acute Floor at RSH opened in December 2022 and has seen some initial successes in relation to improving access and timely patient care.

Since opening the new acute floor:

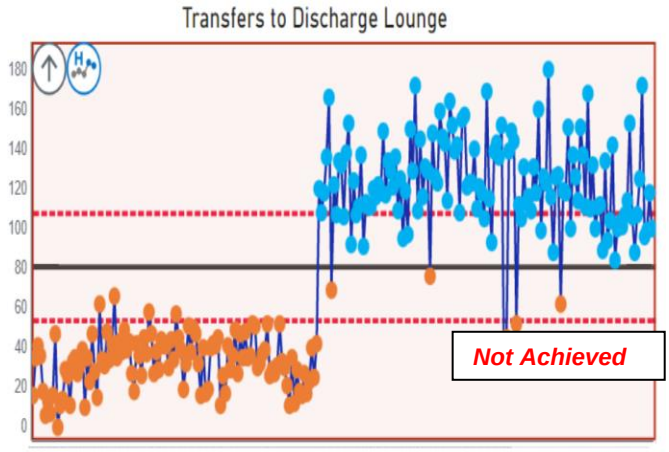
- 1,778 patients have been treated in the space (between 21 December 2022 and 31 March 2023);
- 1,244 patients (70%) have arrived directly without going through A&E
- Of these patients, 25% have been discharged home directly from the acute floor
- Added benefits include direct ambulance referrals to AMA by-passing the Emergency department.

The Oncology Assessment Unit opened in March 2023. This is really important in relation to the care of our oncology patients as it enables patients to avoid attending and waiting in the Emergency department.

A trial of using four beds on the Trauma and Orthopaedic ward as an Assessment Unit has commenced, there are ongoing plans to open a Trauma Assessment Unit as part of the acute re-modelling in 2023/24.

4. Improve the provision of capacity within the Discharge Lounges including chair and beds, on both hospital sites — *Achieved*

Throughout the year the Trust has worked to ensure that we are making better utilisation of the Discharge Lounge for patients on the day of their discharge with an emphasis on early morning moves and increasing the capacity through the discharge lounge at each site. This has enabled our beds to be freed up early for patients requiring admission. In addition, we have secured funding from NHSE to increase the Discharge Lounge space at the Princess Royal Hospital to further support this work.



5. Further develop weekend working to improve discharges including the establishment of Criteria Led Discharge

Criteria Led Discharge (CLD) is the use of agreed clinical criteria and their related clinical parameters, agreed by a senior decision maker and guides clinical decisions regarding a patient's discharge from hospital. It enables a range of registered health care professionals as part of the MDT to lead on patient discharge.

At our Trust, we started to relaunch CLD in March 2023 within the medical division, this commenced on Ward 24 at the Royal Shrewsbury Hospital and Ward 17 at the Princess Royal Hospital. Moving forward in 2023/24 this will be expanded to additional wards across the hospital. The aim is to increase our simple and timely weekend discharges across the organisation to improve patient experience and quality whilst supporting effective flow.

Priority 6: Learning from experience

We aim to create a positive experience for both our patients and service users, those closest to them, and staff who deliver the care and use their feedback to continuously improve and be able to address concerns at the earliest opportunity, making sure those using our services to be heard.

What we said we would do

1. Develop and implement a Patient Engagement Strategy, creating more ways for patients to share their experiences
2. 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.
3. 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

4. Develop and implement improvement plans in response to patient surveys and feedback (See National Survey Section)
5. Increase the prominence of patient stories at key committees or training opportunities across the organisation.

What have we achieved

1. Develop and implement a Patient Engagement Strategy, creating more ways for patients to share their experience

Partially Achieved

A Public Participation Plan (2021-2026) has been developed by the Public Participation Team in partnership with members of the community, identifying six priorities for areas of focus; inclusion, responsive, decision-making, get involved, communication and our staff.

A Patient Experience Strategy is to be developed in 2023, with planning underway to engage with patients to gain insight into what matters to them when accessing services across the Trust. The approach has been co-developed with patient partners from the Patient and Carer Experience Panel who will be involved in the engagement work and strategy development.

2. Establish a Complaints Peer Review Panel

Achieved

A Complaints Peer Review Panel has been established to provide independent oversight and analysis of a random selection of closed complaints each quarter. The panel is chaired by a patient partner, providing greater governance and assurance.

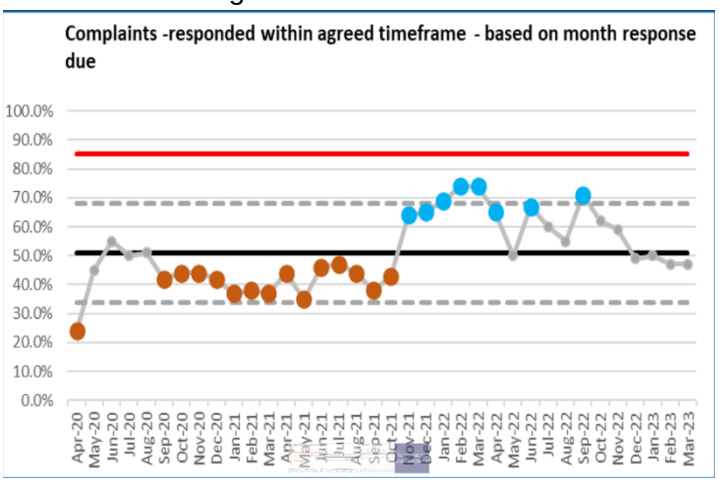
3. Patient Complaints Processes

Not Achieved

During 2022/23 the Trust aimed to improve the timeliness of responses with close working with Divisions to support timely investigations. Response rates have improved from an average of 53% in 2021/22 to an average of 59% in 2022/23.

Ongoing work is required to further improve, this is being supported through regular meetings with the Divisions and streamlining of processes to assist them in providing timelier responses. Work has commenced in 2022/23 to adopt a similar framework for complaints as that used for 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.

There have been improvements in how the information from complaints is used by managers to improve the quality of learning arising from complaints. However, this work with our patients and their family's needs to continue in 2023/24 to ensure that we use every opportunity to learn from the feedback and experiences of our patients.



4. Develop and implement improvement plans in response to

patient surveys and feedback. (Also included in National Survey Section)

The Trust has developed Speciality Patient Experience Groups to support improvement work at a local level. Seven groups have been established and are meeting to review feedback received from a range of sources, including Friends and Family Test, local surveys, national surveys, digital stories, compliments, concerns and complaints. The Speciality Patient Experience Groups feed into the overarching Patient and Carer Experience Panel, to provide oversight and share good practice and learning across specialities.

Learning taken from PALS contacts and complaints are discussed within Divisional Committees and Governance Meetings, to examine and share learning.

5. Increase the prominence of patient stories at key committees or training opportunities across the organisation

Achieved

The value of incorporating the voice of people with lived experience in compassionate learning is recognised by the Trust. During 2022/23 the use of digital stories has been expanded across the Trust, introducing a patient voice in a range of training environments such as the Health Care Support Worker Academy, Corporate Welcome, mandatory training and a range of workshops.

The Human Library have provided additional insight into learning from people with lived experience with a range of diverse lived experiences. Challenging stereotypes, breaking down barriers, and having an opportunity to engage in open and respectful conversations in a safe environment can change people's attitudes and understanding of excluded or marginalised groups.

The Trust has introduced ways in which the workforce can learn from people with lived experience, creating values led learning environments through storytelling to underpin education and a culture of inclusion. An example of feedback shared through a digital story and actions taken are outlined in the following example:

You Said:

The storyteller outlined that her husband was diagnosed with leukaemia and subsequently received palliative chemotherapy seven days each month, with blood transfusions every two weeks. Combined with inpatient admissions for treatment.
when needed, both the storyteller and her husband, gained a range of experience in accessing services within the Trust. Whilst both the storyteller and her husband were happy with the interactions they received from staff, when he became pyrexial and urgent treatment was required there could be difficulty in identifying an appropriate area in which to wait, and subsequently delays in accessing treatment. The storyteller highlighted that, whilst the care they have received has been excellent, something needs to be done to improve the system.

We Did:

Following the patient story being captured the subsequent actions have been taken:
A new Oncology Assessment Unit opened on Ward 23 in March 2023. The Oncology Assessment Unit enables patients to avoid attending and waiting in the Emergency department.

Priority 7: Vulnerable Patients

In 2022/23 we have worked hard 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 and ensure we have arrangements in place to safeguard and promote the welfare of adults and children in line with national policy and guidance.

What we said we would do

1. 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.
2. Improve compliance with Dementia screening to ensure all patients over 75 are screened on admission
3. Develop a Learning Disabilities Charter
4. Deliver the Trust's Dementia Strategy and the Dementia Friendly Hospital Charter
5. 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
6. 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.

What we have achieved

1. **Ongoing work to achieve our safeguarding training compliance across all disciplines**

Partially Achieved

A key priority for the Trust over the last two years has been achieving our training compliance for safeguarding adults and children for all our staff so we are assured that our staff have the knowledge and skills to keep our most vulnerable patients safe. We have seen significant improvements in our training compliance and by the end of 2022/23 had achieved compliance across all our safeguarding training with the exception of MCA/DoIs training which is just below the 90% compliance and the safeguarding Level 3 training. This training was impacted by some changes in ward configurations that meant that some staff on wards which weren't previously designated for the care of 16–17-year-old patient had to complete this training.

We now have multiple ways of delivering our training with both face-to-face and e-learning packages and specific training for our medical teams to ensure they have also undertaken this very important training.

Category of Safeguarding Training	Q1	Q2	Q3	Q4
Safeguarding Level 1 Adults and Children	93%	95%	98%	97%
Safeguarding Level 2 Adults	83%	87%	88%	94%
Safeguarding Level 2 Children	85%	90%	89%	93%
Safeguarding Level 3 Children	78%	79%	81%	83%

Safeguarding Level 4 Training	100%	100%	100%	100%
Safeguarding Level 3 Adults	61%	75%	84%	90%
Safeguarding Level 4 Adults	100%	100%	100%	100%
MCA/DOLS	77%	80%	82%	88%
Prevent – WRAP	81%	87%	89%	92%

2. Improve compliance with dementia screening to ensure all patients over 75 are screened on admission

Not Achieved

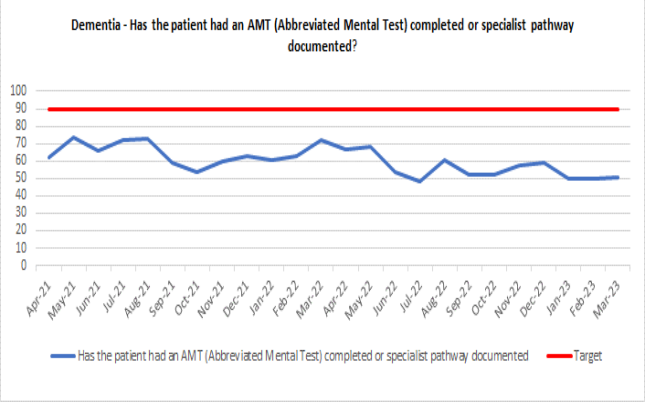
Throughout 2022/23 the Trust has continued to monitor dementia screening on admission for patients who are over the age of 75.

Audits have been completed as part of the Nursing Quality Audits and the results have been highlighted via Divisional meeting level and at our Trust quality meetings.

In 2023/24, with the appointment of a new Clinical Director Care of the Older Adults there will be a review of the screening documentation and process to ensure our screening tool is based on best practice and our compliance improves.

3. Develop a Learning Disability (LD) Charter

Achieved



A draft Learning Disabilities Charter was developed in 2022/23. The Charter was developed with the involvement of our patients with a learning disability, their carers/families and staff.

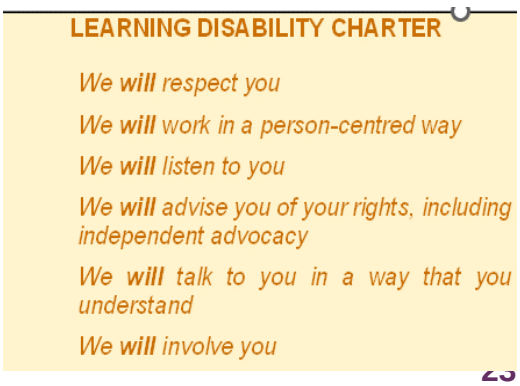
In 2023/24 the Learning Disability Charter will be agreed and endorsed by our Trust Board and launched across the Trust to drive the improvements in care for our patients with LD. This is an important step in our ambition to ensure all patient with LD are treated with respect and dignity and will be a priority next year alongside ensuring we meet the needs of our patients with LD and autism and deliver comprehensive training for both LD and autism (including the Oliver McGowan training).

4. Deliver the Trust's Dementia Strategy and the Dementia Friendly Hospital Charter

Partially Achieved

The Dementia Care Team continues to work to deliver the Dementia Strategy through:

- **Personalised support Plan -** An "All about me" plan is completed on admission to hospital with the person living with dementia, family /Carer. This is displayed on the locker, a copy is stored



in the medical notes and saved to our patient electronic data system. These are updated on each admission. Over the last 12 months we have completed 71% of these within 24 hrs of admission.

- **Activity Boxes -** Our activity boxes continue to be stocked in all clinical areas each week with the support of volunteers. We are working with our community engagement team to train and support wards with activity volunteers.
- **Training** - Ongoing training has continued throughout 2022/23, with Tier 1 Dementia Training sitting at 87% and Tier 2 face- to-face training introduced in 2022 sitting at 72% at the end of the year.

In 2022/23 improvement work has commenced in relation to dementia and delirium. We have set up a delirium steering group and developed a delirium information page on the intranet for all teams to access for further advice help and guidance.

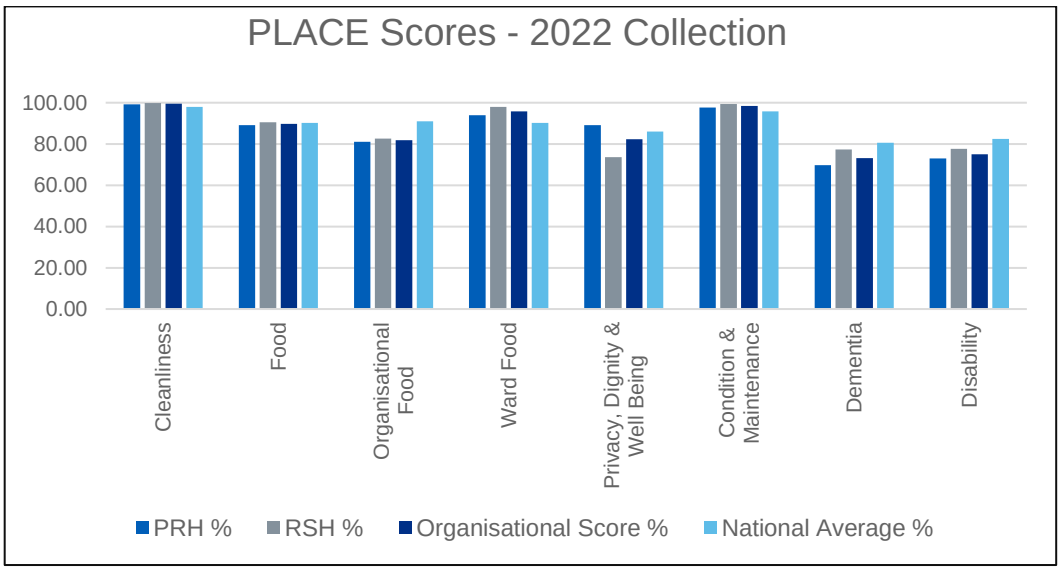
5. Recommence Patient-led assessments of environment (PLACE) and improve scores relating to Dementia-friendly environments

Achieved

Patient Led Assessment of Care Environment (PLACE) reviews are assessments of the non-clinical aspects of NHS healthcare settings, undertaken by teams made up of staff and members of the public (known as Patient Assessors). The teams look at the environment's cleanliness, maintenance and condition, food and hydration provision, the extent to which the provision of care with privacy and dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or disabilities.

PLACE was re-launched in 2022 and took place in October and November, the results were issued in March 2023.

A summary of the Trust's results is shown:



The Trust achieved good scores in the cleanliness, food tasting, ward food service and condition and maintenance. Domains that scored lower were organisational food, privacy dignity and wellbeing, dementia and disability.

The issues in these domains are mostly the longer term, as they are difficult to address with the current challenges with the Estate. The longer-term actions are being discussed at a PLACE Task and Finish group which is a multi-disciplinary team including the Patient Assessors who took part in the assessments.

6. 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 with learning disabilities and dementia to ensure patients receive safe, dignified, person centred care

Partially Achieved

Throughout 2022/23 we have continued to monitor and review the quality of care provided to our patients with mental health, LD and dementia.

Working with our mental health service partners we have continued to audit monthly our compliance in relation to the Mental Health Act (1983) to ensure we are following the legal framework to ensure the needs of our patients with mental health are met. These audits have demonstrated positive result.

All patients in our care who have required a restrictive intervention have been discussed as part of our weekly review meeting of incidents to ensure the care provided was appropriate, that our policies and risk assessment were completed and that any learning is shared. Quarterly audits have continued to be undertaken; this ongoing improvement work has been supported by our Mental Health team.

Priority 8: Palliative and End of Life Care (PEoLC)

Ensuring that patients in the last year and days of life are treated in line with their wishes and with the utmost dignity and respect, seeking to ensure that an individualised approach is afforded to our patients and those closest to them is paramount.

What we said we would do

1. 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
2. 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.
3. Improve the percentage of patients who are in the last days of life and are cared for on the end-of-life care plan
4. Reduce the number of complaints relating to end of life care
5. Continue to use bereavement feedback data to inform our improvement actions
6. Continue to deliver and improve compliance with PEOLC training for all staff including revising the medical statutory PEOLC training
7. 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.

What we have achieved

1. Continue to refine the PEoLC Dashboard to enable monitoring of key performance indicators

Achieved

The PEOLC Dashboard was initially implemented in July 2022. Since then, the team has continued to review key performance metrics that they want to include and monitor within this dashboard. An example of some of these indicators is shown:

Palliative and End of Life Care Dashboard

Metric	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Average/ Total	Target
Nursing Quality Assurance									
Palliative/End of Life Care - Nursing Quality Audit	95	97	98	97	98	94	98	97	80-90
ReSPECT and DNACPR	95	93	93	92	93	94	93	93	80-90
Training									
End of Life Care 3 Yearly	-	-	80.27	82.84	84.83	81.63	86.86	83.23	90-80
T34 Pump Training 2 Yearly	-	-	83.89	84.3	83.91	82.61	89.7	84.8	90-80
Complaints, Compliments & Datix									
Total PEoLC Complaints	4	3	5	7	7	2	5	33	
Total PEoLC Compliments	3	6	6	10	8	3	8	44	
Datix Incidents	13	4	5	4	2	4	4	36	
Ask 5									
Ask 5 - %'s				93	100	98		94	
Referrals, PPOC and diagnosis									
Referrals to PEoLC team	109	125	106	115	131	104	123	813	
PPOC Discussion - total number	94	103	90	89	101	80	104	661	
PPOC Achieved - total number	79	91	87	81	88	77	89	592	
PPOC Achieved %	84.04	88.35	96.67	91.01	87.13	96.25	85.58	89.56	90-80
Triage times									
PEoLC <4 hr achieved rate	100	100	96	97.22	92.86	90.63	95.45	96.25	90-80
PEoLC 4-24 hr achieved rate	90	91.04	95.31	93.44	100	93.65	96.15	94.65	90-80
PEoLC 24-48 hr achieved rate	100	90.91	100	80	77.78	83.33	100	90.24	90-80
% Pts seen within 24 hours	84	88	90	94	92	97	94.3	91.33	70-90

The PEOLC Dashboard is discussed monthly at the PEOLC Steering Group and included in the Quarterly PEOLC Update Report for our Quality Operational Committee. It is used to monitor, provide assurance, and to influence developments. Development examples include data feeding into therapies business case for a dedicated PEOLC "Fast Track" Occupational Therapy role and data to confirm accuracy of coding for specialist palliative care involvement (code Z515). In 2023/24 the dashboard will also include medical compliance in EOLC training and number of specialist palliative care Structured Judgement Reviews (SJR) undertaken as part of our Learning from deaths Process. (See Learning from Deaths Section).

2. Audit the new EOLC plan for the last days of life to provide assurance in relation to clear conversations have taken place with

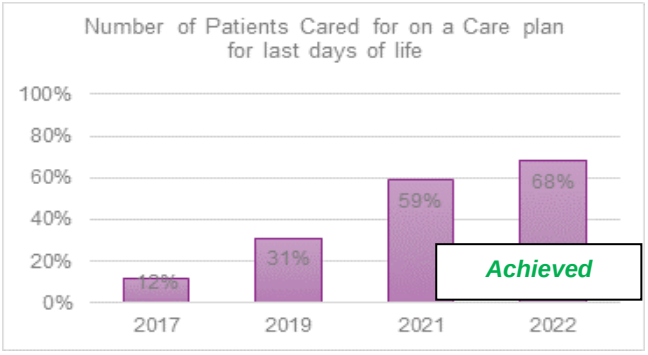
Achieved

the patient and documentation of preferred place of care

Information in relation to conversations about Preferred Place of Care and the documentation of this are now captured monthly in the PEOLC Dashboard. In 2022/23 Year to Date 80% of patients referred to the PEOLC team had a discussion about Preferred Place of Care/Death and an average 89.6% achieved their Preferred Place of Care.

In the National Audit of Care at the End of Life (NACEL) the summary score for communication with a dying person for the Trust is 7.9 against the National benchmark average of 8.0.

This is a combined score for conversations such as recognition that an individual is dying, involvement in planning individual care, discussing medications, nutrition and hydration or documentation in the notes regarding why a discussion with the patient was not possible such as they were unconscious.



3. Improve the percentage of patients who are in the last days of life and are cared for on the end-of-life care plan

The number of patients who are anticipated to be dying that are cared for on a care plan for last days of life has increased year on year since 2017.

In 2022/23 68% of patients who were anticipated to be dying were cared for on an EOL care plan.

(Data taken from local audit and National Audit of Care at the End of Life (NACEL)

4. Reduce the number of complaints relating to end of life care

Not Achieved

The number of complaints has increased, reflecting an overall increase in the number of complaints received by the Trust and in the Trust's increased activity.

The Complaints Team is working with the Palliative and End of Life Care Team to monitor themes arising from complaints, to ensure that these are being addressed. Complaints are discussed at the PEOLC Steering Group, where there is Divisional senior nursing representation to identify key actions to address the themes around PEOLC.

4. Use data from our bereavement surveys to inform our improvement actions

Achieved

Bereavement survey feedback is now included on the PEOLC Dashboard and reviewed quarterly at the PEOLC Steering Group. This data has been used to drive some of our improvements in 2022/23.

Examples of improvements made as a result of feedback from bereavement families/loved ones are:

- Rollout of care after death training
- Initiatives to ensure that patients do not move wards in the last days/hours of life

- The PEOLC Intensive Support Programme for our adult inpatient wards, with the PEOLC team providing wrap around support and education to a ward for a specified time period to enhance the skills, knowledge and confidence of our staff in relation to care and management for PEOLC patients.

Care after death and ward moves in last days of life would be examples of bereavement feedback that has influenced improvement work in 2022/23.

5. Continue to deliver and improve compliance with PEOLC training for all staff including revising the medical statutory PEOLC training

Partially Achieved

Throughout 2022/23 ensuring our staff have undertaken PEOLC training has been a key priority. This has been monitored at our monthly Nursing Metric Meetings and at the PEOLC Steering Group.

As of March 2023, compliance with EOLC training was 87.9% for e-learning for clinical staff. Syringe driver training compliance was 89% overall for the Trust but 93.09% for the inpatient adult wards, with training delivered at ward level by the Quality Team when wards were unable to release staff.

In October 2022 new training for Care after Death was introduced, currently 77.4% of staff have completed training.

A medical statutory and mandatory (SSU) PEOLC training review was completed during 2022; a decision was made to continue this training face to face rather than switch to e-learning. Medical staff training compliance will be added and monitored through the PEOLC dashboard in 2023/24.

Training %	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Target
End of Life Care	76.6	69.6	75.7	76.4	78.1	80.3	82.8	84.8	81.6	86.9	86.7	87.9	>90%
T34 Syringe Pump	69.0	63.7	74.9	73.0	77.2	83.9	84.3	83.9	82.6	89.7	88.2	89	>90%
Care After Death (new training Oct 22)							15.6	42.7	49.1	65.1	71.6	77.4	>90%

6. Improve internal processes in relation to the Fast Track EOLC and contribute to the System Fast Track Improvement work

Partially Achieved

For an individual who is approaching the end of their life the “Fast Track” continuing care assessment allows an appropriate care and support package to be put in place as soon as possible at the end of their lives.

In 2022/23, members of the Trust Palliative and End of Life Care Team have attended the process mapping events undertaken across the Integrated Care System (ICS). These events aimed to look at System improvements required to ensure we had a robust and responsive “Fast Track” process in place. Following this our own internal process mapping event was held with support of the Improvement team in Sept 2022. This identified three workstreams, work in relation to these workstreams commenced in Quarter 4 of 2022/23 and will continue in next year:

- Consider our Trust-wide education offer on fast track and complex discharge
- A business case for a dedicated PEOLC fast track Occupational Therapy
- Review of our own internal processes and documentation.

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 2022/2023 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.

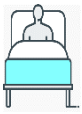
RELEVANT HEALTH SERVICES AND INCOME

During 2022/23 SaTH 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 £472.2m. In activity terms, the following activity was delivered in 2022/23:

ACTIVITY 2022/23

66,272 elective/day cases 

565,394 outpatient attendances 

55,012 non-elective cases 

150,262 emergency attendances 

4,163 Births 

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.

STATEMENT FROM THE CARE QUALITY COMMISSION (CQC) & OUR CQC IMPROVEMENT PLAN

SaTH is registered with the CQC. The Trust was last inspected by the Care Quality Commission in July to August 2021. Although this inspection demonstrated tangible 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 continues to be rated overall as "Inadequate".

The overall ratings for the Trust are shown:

Ratings	
Overall trust quality rating	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive?	Inadequate
Are services well-led?	Requires Improvement

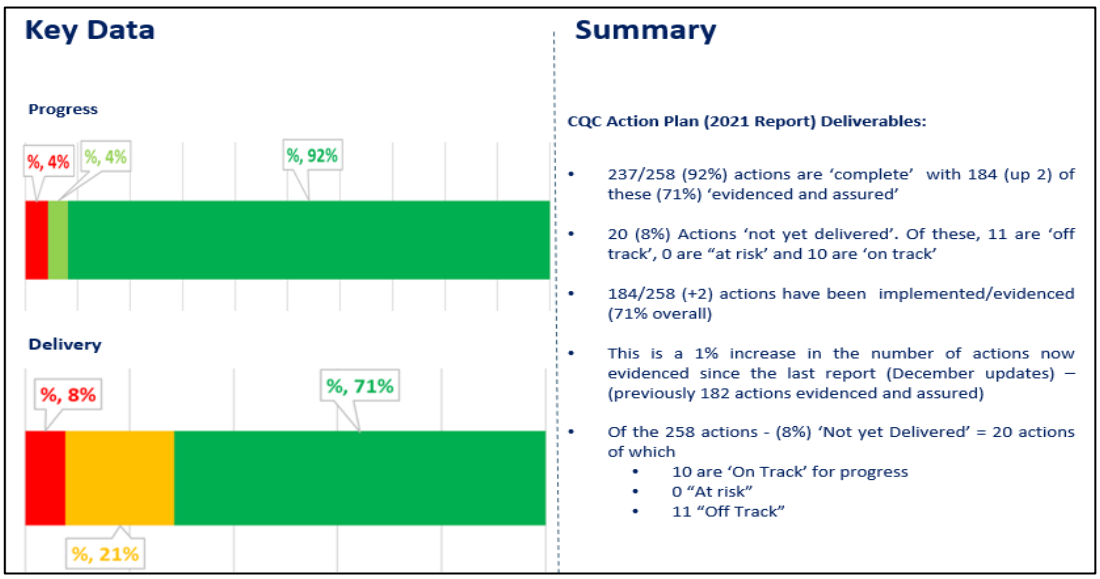
Five conditions remain in place in relation to the Trust which are applied against both the Princess Royal Hospital and the Royal Shrewsbury Hospital. Ongoing improvement work has continued in 2022/23 to progress the improvements required to enable these conditions to be removed moving forward.

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

Overall CQC Improvement Plan Progress.

Following the publication of the CQC Inspection report in November 2021 the Trust developed an overarching improvement plan. The improvement actions included in the plan are monitored with monthly meetings with the core services and Divisions. Achievements in relation to the improvement plan are reported monthly through the Trust governance processes including the Steering Groups, such as the Deteriorating Patient Group, Safeguarding Operational Groups, and Palliative and End of Life Steering Group. They are reported through to the Quality Operational Committee and Quality and Safety Assurance Committee and the Trust "Getting to Good" Programme.

To date 92% of the improvement actions are completed, with 71% of these evidenced and assured meaning we can evidence that these are embedded in the clinical areas.



PARTICIPATION IN CLINICAL AUDIT 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 2022/23 60 national clinical audits and six national confidential enquiries were prioritised by the HQIP (Healthcare Quality Improvement Partnership) commissioned National Clinical Audit and Patient Outcomes Programme (NCAPOP) for Trust's to participate in (where applicable). During that period, SaTH participated in **97%** (58/60) of the national clinical audits and 100**%** *(5/5)* 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. Some examples of actions taken following participation in national audits are listed in table 3.

Table 1: National Clinical Audits 2022/2023

Table 1 – national clinical audits 2022/23				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
*Breast and Cosmetic Implant Registry		x	x	
[1]Blood samples for transfusion		✓	✓	All eligible cases
*Case Mix Programme (CMP) – ICNARC		✓	✓	All eligible cases
*Child Health Clinical outcome Review Programme	Testicular Torsion (NCEPOD)	✓	✓	Currently in progress
*Cleft Registry and Audit Network (CRANE)		×	×	Referred to specialist centre
*Elective surgery (National Proms Programme)		✓	✓	All eligible cases
Emergency Medicine QIPS (RCEM)	*Assessing Cognitive Impairment in Older People	✓	N/A	Delayed, due to start April 2023
	*Consultant Sign-Off PRH 2021	✓	✓	All eligible cases
	*Mental Health	✓	✓	Currently in progress
	**Infection Control	✓	✓	Currently in progress
	*Pain in Children	✓	✓	All eligible cases

Table 1 – national clinical audits 2022/23				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
Falls and Fragility Fractures Audit programme (FFFAP)	*Fracture Liaison Service Database	✓	✓	Currently in progress
	*Inpatient Falls	✓	✓	All eligible cases
	*National Hip Fracture Database (NHFD)	✓	✓	All eligible cases
*Inflammatory bowel disease Audit		✓	✓	All eligible cases
*LeDeR - Learning Disabilities Mortality Review		✓	✓	All eligible cases
*Maternal, new-born and infant clinical outcome programme (MBRACE)	Maternal mortality surveillance and confidential enquiry	✓	✓	All eligible cases
	Perinatal confidential enquiries	✓	✓	All eligible cases
	Perinatal mortality surveillance	✓	✓	All eligible cases
*Medical and Surgical Clinical outcome Review Programme	Community Acquired Pneumonia - NCEPOD	✓	✓	Currently in progress
	Crohn's study (NCEPOD)	✓	✓	84%
	[1]Out of hospital cardiac arrest (OHCA)	✓	✓	6/7 questionnaires returned
*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
	Suicide by people in contact with substance misuse services	×	×	Not applicable
*Muscle Invasive Bladder cancer audit		✓	✓	All eligible cases

Table 1 – national clinical audits 2022/23				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
National Asthma & COPD Audit Programme (NACAP)	*Adult Asthma Secondary Care	✓	×	Due to staffing issues
	*Paediatric - Children and young people asthma secondary care	✓	✓	399 cases submitted (2022)
	*Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	✓	×	Due to staffing issues
	*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		×	×	Not applicable, primary care
*National Audit of Care at the End of Life (NACEL)		✓	✓	All applicable
*National Audit of Dementia		✓	✓	All applicable
*National audit of Pulmonary Hypertension		×	×	Not applicable
*National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)		✓	✓	All applicable
*National Bariatric Surgery Registry		✓	✓	All applicable
*National Cardiac Arrest Audit (NCAA)		✓	✓	All applicable
National Cardiac Audit Programme (NCAP) - NICOR	*National Audit of Cardiac Rhythm Management (CRM)	✓	✓	All applicable
	*Congenital Heart Disease (CHD)	×	×	Not applicable
	*Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	No cases submitted April to September 2022, re-commenced October to December 2022. All eligible cases submitted for Oct to Dec '22
	*Heart Failure Audit	✓	✓	All eligible cases

Table 1 – national clinical audits 2022/23				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
	*National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	×	×	Not applicable
	*National Adult Cardiac Surgery Audit	×	×	Not applicable
*National child mortality database		✓	✓	All applicable
*National Clinical Audit of Psychosis (NCAP)		×	×	Not applicable
National Comparative Audit of Blood Transfusion programme	** Audit of NICE Quality Standard QS138	✓	✓	All applicable
	**Re-audit of the medical use of blood	✓	✓	38/38 (100%)
	[1]Acute Upper Gastrointestinal Bleeding: clinical management and the use of blood	✓	✓	All applicable
*National Diabetes Audit - Adult	*National Diabetes Inpatient Safety Audit	✓	✓	All applicable
	*National Diabetes in Pregnancy Audit (NPID)	✓	✓	All applicable
	*Core Diabetes Audit	×	×	Not applicable, primary care audit
	*Foot Care Audit	✓	✓	All applicable
*National Early Inflammatory Arthritis Audit (NEIAA)		×	×	Not applicable
*National Emergency Laparotomy audit (NELA)		✓	✓	232 cases submitted (2022)
Gastro-Intestinal Cancer Programme	*Oesophago-gastric Cancer (NAOGC)	✓	✓	All eligible cases
	*National Bowel Cancer (NBOCA)	✓	✓	All eligible cases
*National Joint Registry (NJR)		✓	✓	108 (21/22 report)
*National Lung Cancer Audit (NLCA)		✓	✓	All applicable
*National Maternity and Perinatal Audit (NMPA)		✓	✓	All applicable
*National Obesity Audit		×	×	Not applicable
*National Ophthalmology Database audit		✓	✓	All eligible cases

Table 1 – national clinical audits 2022/23				
Title		***Eligible***	***Participating***	***Submission rate (%) / Comment***
*National Paediatric Diabetes Audit (NPDA)		✓	✓	282 patients for 2020-21
*National Perinatal Mortality Review Tool (MBRRACE)		✓	✓	26 cases submitted (2022)
*National Vascular Registry		✓	✓	All applicable
*Neonatal intensive and special care (NNAP)		✓	✓	All applicable
*Neurosurgical National Audit Programme		×	×	Not applicable
*Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry		×	×	Primary care
*Paediatric intensive care (PICaNet)		×	×	Not applicable
Perioperative Quality Improvement Programme		✓	N/A	
Prescribing Observatory for Mental Health (POMH-UK)	*Improving the quality of valproate prescribing in adult mental health services	×	×	Not applicable
	*The use of melatonin	×	×	Not applicable
*Prostate Cancer Audit		✓	✓	All applicable
Renal Audits	Acute Kidney Injury	✓	✓	All applicable
	*Chronic Kidney Disease Registry	✓	N/A	
Respiratory Audits (BTS)	*Adult Respiratory Support Audit	✓	✓	Currently in progress
	*National Outpatient Management of Pulmonary Embolism	✓	✓	27 cases submitted
	*Smoking Cessation Audit – maternity and mental health services	✓	**N/A**	Delayed start
*Society for Acute Medicine's Benchmarking Audit (SAMBA)		✓	✓	All applicable
*Sentinel Stroke National Audit Programme (SSNAP)		✓	✓	All applicable
*Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme		✓	✓	All applicable
*Trauma Audit & Research Network		✓	✓	All applicable
*UK Cystic Fibrosis Registry		×	×	Not applicable
*UK Parkinson's Audit		×	×	Services no longer at Trust

Table 1 – national clinical audits 2022/23			
Title	**Eligible**	**Participating**	**Submission rate (%) / Comment**
[1]UK Registry of Endocrine and Thyroid surgery	✓	✓	67 cases submitted 2022
[1]UK wide acute upper GI bleed audit	✓	✓	All applicable

Based on information available at the time of publication.
***Audits on HQIP commissioned NCAPOP List 2022/2023**
**** from HQIP commissioned NCAPOP list 2021/2022 – action plan received 22/23**
[1]Registered locally
Based on information available at the time of publication.

Table 2: National Confidential Enquiries 2022/2023.

Table 2 – National Confidential Enquiries 2022-23 (6)				
Title		**Eligible**	**Participating**	**Submission rate (%) / Comment**
Child Health Clinical Outcome Review Programme (NCEPOD)	*Transition from child to adult health services	✓	✓	Currently in progress
	*Testicular Torsion	✓	✓	Currently in progress
*Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Community acquired Pneumonia	TBC	TBC	Start delayed
	*Physical Health in Mental Health Hospitals	×	×	Not applicable
	*Crohn's disease	✓	✓	84%
	*Epilepsy study	✓	✓	30%

Based on information available at the time of publication.

***Audits on HQIP commissioned NCAPOP List 2022/2023**

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***
Breast Cancer in Older Patients (NABCOP) (data to 2020) (4735)	• 100% of patients had Breast Cancer Nurse contact on initial visit. An issue with the data was identified and this will be rectified going forward.
BTS pleural services audit (4747)	• Two consultants are now allocated sessions for pleural lists (0.5 PA each) • Thoracic ultrasound working group has been established to discuss thoracic ultrasound training across the trust • The need for a pleural specialist nurse has been included in the pleural business case, which is being worked on by the operational manager • Checklists are now in place for pleural aspiration and chest drains.
National Audit for Care at the end of life (NACEL) 2021 (4724)	• The care plan has been altered to make it a more useable and individualised document • Introduction of supportive ward visits by the Palliative End of Life Care team.
National Bowel Cancer Audit Programme (NBOCAP) annual report 2022 (19-20) (5077)	• Mortality rates and length of stay continue to be within the normal range.
National Comparative Audit of NICE Quality Standard QS138 (4910)	• This small national audit showed poor compliance. A larger re-audit was therefore carried out which showed 98.8% compliance with assessing, identifying, and treating pre-operative anaemia during the first quarter.
National Comparative Audit: Re-audit of the medical use of blood (4328)	• 'Decision to transfuse' stickers for documenting consent and clinical reason for transfusion have been implemented • Indication for transfusion has been added to induction packs received by new doctors.
National Maternity Survey 2021 (4723)	• Work with Maternity Voices Partnership co-produce the infant feeding strategy and raise awareness • The "hello my name is" campaign is to be re-launched.
National Neonatal Audit Programme (NNAP) - Neonatal Care 2021 (2020 data) (4877)	• No concerns identified as current rates are higher than the national rates in most areas • PERIPrem Care Bundle currently being implemented.
Using your HEADS - psychosocial screening in acute admissions in the West Midlands (4664)	• Every patient presenting with mental health was referred to appropriate services • HEADS assessment tool now embedded in the admission proforma to be used while assessing children and young people with mental health problems.

Based on information available at the time of publication.

The Trust also undertook 186 local audits, shown in table 4 below.

Table 4: Trust Local Audits

TABLE 4 – Trust local audits 2022-23 (186)		
CLINICAL SUPPORT – PATHOLOGY & RADIOLOGY AND THERAPIES		
No.	**Audit Title**	**Key actions/improvements following audit**
5216	'Suspicious' and 'non-diagnostic' CT-PA scans	• Results satisfactory, no recommendations necessary.
5219	Accuracy of reporting using voice recognition system	• The audit results show that our performance is adequate.
5298	Adequacy of head and neck FNA specimens comparative audit pre and post Covid	• The audit gave reassurance of the quality of reporting • A re-audit is planned.
5217 And 5306 (re-audit)	Adequacy of the knee joint on magnetic resonance imaging	• An education session for the MR radiographers took place and was developed to provide prompts for radiographers • Re-audit following these changes showed improvements in all except one criterion.
5305	Anatomical image criteria for PA chest radiography	• An explanation of the defect was discussed with the radiographers.
5267	Appropriate use of Modified Wells' score prior to CTPA	• The results of the audit are to be discussed with the medical directorate • A re-audit is planned.
5139	Assessment of the accuracy of MRI for prediction of disease-free circumferential resection margin in staging of rectal cancer	• Mainly compliant with the audit standards. No further actions required.
5264	Awareness of Radiation Risks by Referrers Justifying Radiological Examinations	• Staff training to raise awareness is being carried out • A re-audit will take place following staff training.
5132	Cervical pathology proforma audit	• Cervical biopsies reported on proforma in 100% of cases. The use of a proforma for reporting cervical biopsies is well embedded within the department.
5310	Chest X-rays documentation prior to requests for CTPA being made	• The audit identified significant non-compliance, staff have been informed and reminded of the importance of this.
5055 and 5316 (re-audit)	Compliance with NICE guidelines for CT for traumatic head injury (2019)	• Following delays due to confusion over the correct process, clarification of this was fed back to staff • Re-audit showed improvements, with 96% of scans being carried out within the required timescales, 98% of scans having clearly documented risk factors and 95% of scans reported within 1 hour of being performed.
5136	Compliance with NICE guidelines 2019 for traumatic head injury in regard to CT - re-audit	• Results satisfactory, no recommendations necessary.

TABLE 4 – Trust local audits 2022-23 (186)		
5294	Compliance with the use of the Paris system for reporting urine cytology	• The department meets the audit criteria set out within the *Tissue pathways for diagnostic cytopathology* document.
4864	CT findings when radiologist suspects malignancy on plain film from GP	• Results satisfactory, no recommendations necessary.
5018	CTPA usage across RSH and PRH	• Clinicians were made aware of importance of Wells score.
5263	CTVC for BCSP 2021	• Results satisfactory • A re-audit is planned.
5218	Head CT - Lens Exclusion	• To Improve CT head technique, a presentation on angling the gantry and its benefits was distributed.
5140	Imaging loading audit	• To improve Image loading time and ensure previous imaging is available, a new system is currently in development.
5022 And 5135 (re-audit)	Polytrauma CT imaging in the severely injured patient	• Results showed that visible and suspected injuries were not documented well, falling short of target by 30% and some referrers are unaware of the acceptable criteria for polytrauma CT • A poster to highlight the importance of quality documentation on visible/suspected injuries has been displayed in the Emergency Departments. • Further training carried out on acceptable criteria for polytrauma CT. • A re-audit has been carried out, which showed documentation of injuries improved from 70% to 93%. CT referrals meeting criteria for polytrauma improved from 92% to 100%.
5268	Positive FNA rate of neck lump - re-audit	• Results satisfactory, no recommendations necessary.
5143	Quality of reporting of colorectal mucosal biopsies taken for the diagnosis and assessment of inflammatory bowel disease (IBD)	• Results satisfactory, no recommendations necessary.
5082	Radiography for knee trauma – Compliance with Ottawa Knee Rules	• Posters containing the rules have been displayed within the Emergency Departments.
5142	Radiologist reporting audit trial	• Results satisfactory, no recommendations necessary • A re-audit is planned.
5049	Supervision Survey	• No recommendations made. Poor response rate to survey, further work is required.
5083	The use of PI-RADS v2.1 in pre-biopsy multi-parametric MRI	• The results were discussed with radiologists who report MRI prostate • A re-audit is planned.
5141	TNM staging on PET reports of patients referred from the Upper GI MDT - re-audit	• Following further education of staff after the initial audit, this re-audit showed an improvement in recording of TNM staging.
5297	UK MITRE - Comparison	• Results are comparable with national statistics. No further action required.

TABLE 4 – Trust local audits 2022-23 (186)		
CORPORATE – TRUST WIDE		
No.	**Audit Title**	**Key actions/improvements following audit**
4585	Bereavement feedback questionnaire 2021-2022	• A new SWAN care plan has now been designed. After a successful trial, this was successfully rolled out throughout the Trust • New leaflets have been launched and are now available in SWAN boxes.
5156	Care after Death - July 2022	• The deceased person handover document has been updated to ensure that staff are transferring all the required information.
4907	Care after Death - October 2021	• New ward-based sessions have been embedded into training packages delivered by the End of Life Care Team • A re-audit has been completed.
5128	Care after death box	• All wards now have the care after death boxes.
5111	Comfort Observations in the last hours/days of life	• Supportive care visits are planned for 2023 • A programme of further training is planned.
4906	Compliance with the use of the End of Life Care plan in Clinical Practice, October 2021	• Further training sessions have taken place.
4441	Dementia carer's survey - December 2019	• Several actions have been taken to support carers within the organisation and we continue to work through opportunities for improvement.
4524	End of Life Care Audit T34 Loan Form Aug 2020	• Further communications to be shared with teams. • An annual audit is planned.
5107	Mouth care audit sept-22	• Swan End of Life Care specialist nurses to continue with ward-based mouth care training.
4725	SaTH local audit of care in the last days of life	• A new care plan has been launched and there will be ongoing education and monitoring alongside its use • To improve ownership of care in last days of life by ward and departments, PEOLC champions have now been identified. Education and support materials in place. Future sessions being planned for 2023.
5124	Swan Care Plan for the last hours and days of life review	• Supportive wards visit will continue to assist staff with completing Swan Care Plans.
5067	Swan Model of Care	• Training sessions are planned throughout 2023.
5112	The Grab and Go Syringe Pump Boxes Audit Apr-22	• Work with the housekeepers has been undertaken to provide support to ensure stock required for the grab and go boxes is available.
4884	Verification of expected death by non-medical practitioners (Apr-Nov 2020)	• The Policy has been updated • The importance of time asked to verify death to be highlighted in verification of death training.

TABLE 4 – Trust local audits 2022-23 (186)		
SURGERY - ANAESTHETICS, THEATRES & CRITICAL CARE		
No.	**Audit Title**	**Key actions/improvements following audit**
5170	Anaesthetic Clinical Documentation in Maternity	• Compliance with the GMC document was identified.
5026	Anaesthetic involvement in major obstetric haemorrhage >1.5 litres (Ockenden)	• Annual PROMPT training is being delivered to all health care staff in labour ward • Drills are now carried out in labour ward.
5025	Anaesthetic involvement in obstetric patients diagnosed with sepsis (Ockenden)	• Most patients received antibiotics within 60 minutes • A sepsis audit will be carried out by the obstetric team.
4996	Epidural Cases 2021	• Complication rate is low and patient satisfaction is high • An information leaflet has been created for patients about post-natal neurological symptoms.
4953	General anaesthesia in obstetrics	• The audit was presented in clinical governance to ensure airway assessment is being documented.
5056	Peri-operative Management of Diabetes in Emergency Operations	• The audit results have been presented on the clinical governance meeting and all identified issues discussed.
5115	Workload in Obstetric Emergencies	• Work is underway to review middle grade cover on the labour ward.
SURGERY - HEAD, NECK AND OPHTHALMOLOGY		
No.	**Audit Title**	**Key actions/improvements following audit**
4922	Availability of notes on the OMFS Rapid Access Clinic	• Audit demonstrated compliance with the standards, no actions required.
4872	Casenote & Stamp Max Fax 2021 (Jun-21 pts)	• Issues with stamps for junior doctors were identified. These have been resolved and a re-audit will be carried out.
5020	ENT Casenote Audit 2021 (Jun-21 pts)	• Issues with stamps for junior doctors were identified. These have been resolved and a re-audit will be carried out.
5063	Evaluation of speech valve exchange services at PRH	• Online documentation to be made accessible cross site.
5011	Improving care of patients presenting with facial palsy/Bell's Palsy	• The audit showed poor documentation, resulting in introduction of computerised proforma, with prompts for all aspects of Bell's palsy care • A re-audit is now in-progress.
4957	Look at U3 nodules & follow up	• Work with Radiologists in progress to investigate the possibility of automatically listing patients for FNAC if U3 nodule detected (on screening USG) and FNA already requested by clinician.
5173	Otitis media with effusion (OME) in under 12s: surgery - NICE CG60	• Clinicians have been asked to continue with NICE information leaflets

TABLE 4 – Trust local audits 2022-23 (186)		
		• A standardised history sheet to be considered as part of the audiology extended development plan.
5196	Primary BCC excisions 2022 re-audit	• No recommendations required.
5138	Quality of Morbidity and Mortality meetings in the Oral and Maxillofacial department	• A re-audit is planned for 2023.
5002	Review of head & neck two week wait risk analysis & outcomes	• The two-week wait proforma was updated.
5069	Tinnitus: assessment and management - NG155	• Audiology have updated their audit-base to make it clearer.
SURGERY – MSK		
No.	**Audit Title**	**Key actions/improvements following audit**
5085	Casenotes & Stamp Audit - 2021 (Jun-21 patients) - PRH	• Discharge Checklist developed • The junior doctors trained at induction on use of checklist.
4882	Compliance to ASIA spine chart for spine fractures	• To ensure compliance with the ASIA spine chart, training provided to junior doctors at induction.
4756	Consent form analysis for trauma patients	• Prefilled consent form labels for commonly performed T&O procedures introduced with education provided before implementation.
5064	Orthopaedic Casenotes & Stamp Audit - 2021 (Jun-21 patients) - RSH	• Included in Junior Doctors' induction • A re-audit has commenced.
5127	Prescription chart audit - Orthopaedic PRH 2022 (Jun-21 patients)	• Further training delivered to Junior Doctors.
SURGERY - SURGERY, ONCOLOGY & HAEMATOLOGY		
No.	**Audit Title**	**Key actions/improvements following audit**
5181	4DCT QC audit - 319	• Programme updated to facilitate system testing.
5327	Anal CBCT consistency audit 2022 - 329	• Results generally satisfactory • A re-audit is planned.
5060	Assessment of acute care for patients with decompensated liver disease	• The results show that there is variability in the utilisation of the DCCB when managing patients with decompensated cirrhosis. A teaching session will be provided to junior doctors to ensure standardisation of the bundle is used.
5185	Audit QAP - 323	• No concerns identified; no actions required.
5328	Bladder cbct consistency 2022 - 330	• The documentation was of a good standard including all necessary and useful information. • A re-audit is planned.

TABLE 4 – Trust local audits 2022-23 (186)		
5179	Bladder PTV outlining - 317	• No concerns identified; no actions required.
5332	Brachytherapy audit - 334	• The majority of patients were treated within correct timeframe.
5323	Breast match to sternum - 325	• The breast IGRT protocol to bring it in line with DIBH treatments and reduce match error.
5326	Breast match to sternum re-audit - 328	• No concerns identified; no actions required.
5283	Caecal Intubation Rate (CIR) Photo documentation re-audit	• No concerns identified; no actions required.
4925	Casenote & Stamp - Urology 2021 (July 2020 patients)	• Junior doctors reminded to obtain and use stamps.
5331	CBCT consistency breast 2022 - 333	• No concerns identified; no actions required.
5336	CBCT consistency lung 2022 - 338	• A reminder was sent to staff to ensure that they document the Spinal cord and Body contour when performing an image match on these patients.
5337	CBCT consistency prostate 2022 - 339	• No concerns identified; no actions required.
4888	Compliance with departmental policy for day case mastectomy	• A management review of service arrangements is being carried out to improve compliance with standards.
5183	Concessions - 321	• Ongoing discussions to implement the West Midland protocol.
4627	COVID-19 Discharge Summary Documentation at SATH (re-audit)	• Re-audit showed the documentation introduced previously has now become part of routine discharge documentation resulting in improvement from 60% to 92% compliance with standard.
4904	Dasatinib, nilotinib and high-dose imatinib for treating imatinib-resistant or intolerant chronic myeloid leukaemia (TAG425) -Re-audit	• No concerns identified; no actions required.
4939	Diverticular disease: diagnosis and management - NG147	• Provision of dedicated patient information sheets on SAU and recording of distribution to patient has been implemented.
5228	Document & Data Control QAP - 310	• The master list of reference documents (4.2.3.4.) is being updated.
5057	Endoscopic thoracic sympathectomy for primary hyperhidrosis of the upper limb - NICE IPG487	• The audit showed full compliance with this NICE guidance.
5229	ERF nonconformities - 311	• Discussed with all staff at the safety meeting, which has resulted in improvements.
5006	Fluid balance	• Audit showed poor compliance, education is in progress.
5338	Gynae CBCT consistency audit 2022 - 340	• No concerns identified; no actions required.

TABLE 4 – Trust local audits 2022-23 (186)		
5343	H+N pre-assessment - 345	• Staff have been reminded the need to record pre-assessments in journal.
5329	Head and Neck CBCT consistency audit - 331	• The results were satisfactory • A re-audit is planned.
5341	Head and neck scan length - 343	• Work is underway to alter the WI reduce the amount of healthy tissue getting irradiated and minimise possible human error when calculating extended scan.
5180	IGRT Handover - 318	• The audit showed that changes made during COVID involving assessment using MS Teams are working well. The changes will remain in place.
5325	Image match results of the first 5 SABR lung patients treated - 327	• The audit results demonstrated a successful introduction of a new technique that has reduced the number of visits for this group of appropriate patients.
5178	IMC audit (June 22) - 316	• The documents have been updated to reflect changes in practice.
5342	Linac QC - optics electrons miscellaneous - 344	• Checks were generally performed according to schedule, but work is underway to ensure higher compliance is achieved.
5324	Marking on audit - 326	• As the audits have shown a benefit from marking on the patient after the initial scanograms, working practice is being changed.
5230	Mortality review over the last 18 months (Oct-20 to Mar-22) - 312	• Learning points identified from review of patients who died in hospital. Review of these patients will continue to be monitored.
4531	Nephrectomy at SATH – Reaudit of operative note documentation and post-operative care	• To improve post op care, patients are now moved to SSDS • A re-audit is planned.
5182	Off-protocol book audit (Jul 2022) - 320	• The local breast and prostate protocols require updating, work is underway to adopt West Midlands Protocols.
5335	Oral contrast - 337	• Results satisfactory, no recommendations necessary.
5226	Patient feedback from West Midlands survey (Oct-21) - 308	• All patients who completed the survey gave the department 5 stars. The results were discussed with management, consultants and other team members.
4942	Prostatitis (acute): antimicrobial prescribing - NG110	• In accordance with this NICE guidance all patients were started appropriately on antibiotics on admission to hospital, all IV antibiotics were reviewed after 48 hours, and stepped down to oral antibiotics. All patients were discharged on oral antibiotics.
5186	QA docs review - 324	• 2 CT documents have been updated and re-issued.
5184	QM+interested parties - 322	• Results satisfactory, no recommendations necessary.
5330	Rectum CBCT consistency audit 2022 - 332	• Overall, the audit results showed a high standard. • A re-audit is planned.

TABLE 4 – Trust local audits 2022-23 (186)		
5334	Review of category 2 patients - 336	• The audit results are now considered when reviewing start dates for cat 2 patients • A re-audit is planned.
5177	Scanning Audit - 315	• Overall, the results from the audit were positive and re-confirmed the process is working well.
5176	Scanning consent (May 2022) - 314	• The audit identified improvements in the quality of scanning and accuracy in storage, as well as process for consent forms • A re-audit is planned.
5339	Signatures audit 2022 Bladder and H&N - 341	• A memo has been sent out to remind staff to ensure signatures are recorded.
5227	Single fraction percentage - 309	• The master list of reference documents (4.2.3.4.) requires updating. This is now in progress.
4818	Subtotal Cholecystectomy: Short- and Long-Term Outcomes	• The audit results confirmed subtotal cholecystectomy is a safe management of challenging cholecystitis.
5231	Systematic Error (S.E) audit 2022 - 313	• Training and refresher training on when to SE for each site and encouragement of re-SEing to reduce total amount of imagining needed is underway.
5340	Systematic Error audit 2022 - 342	• A PowerPoint presentation has been developed for staff training.
5333	Timely delivery of radical radiotherapy - 335	• A re-audit to check cat 2 data with different dates to see if there is any difference is now in-progress.
5233	Upper GI bleeding Audit (January – December 2021) - QS38	• Results satisfactory • A re-audit is planned.
MEDICINE – EMERGENCY MEDICINE		
No.	**Audit Title**	**Key actions/improvements following audit**
4920	A&E Call-backs from RSH	• Review of adult patients who left before being seen to continue.
4613	Dental presentations to A&E during COVID-19 lockdown	• A poster was produced for patient education.
4941	Emergency and acute medical care in over 16s - NG94 & QS174	• Results satisfactory, no recommendations necessary.
5245	Head injury - NICE CG176 & QS74	• A nurse led discharge process for children with minor head injury is being developed • A head injury proforma has been implemented.
5292	Sore throat (acute): antimicrobial prescribing - NICE NG84	• A poster displaying guidance for the treatment of sore throat is now displayed within the ED.
5053	Timeframe between emergency CT head requests & completion	• A re-audit is planned.

TABLE 4 – Trust local audits 2022-23 (186)		
MEDICINE		
No.	**Audit Title**	**Key actions/improvements following audit**
4510	AKI Audit 2020	• Development of an AKI working group with education of junior doctors and nurses is in-progress.
4742	Audit of Standards for Same Day Emergency Care	• A SDEC referral document is being implemented.
5151	CCG5 Treatment of Community Acquired Pneumonia in line with BTS Care Bundle (Quarter 1 - April to June 2022)	• To improve clarity, the CAP antibiotic guidelines are being updated • An admission bundle is being developed to improve compliance.
4830	Cinacalcet use in SaTH (NICE TAG117) re-audit 2021	• Patients are now reviewed at monthly dialysis quality assurance meetings where details are reviewed, and appropriate actions taken.
5104	Discharge process in Same Day Emergency Care (SDEC)	• A Poster in SDEC explaining the flow of discharge process has now been displayed.
5084	Drug Charts Antibiotics Prescription Guidance for Improvement	• Nursing staff have been encouraged to escalate up to doctors when antibiotic reviews are needed, and missing data or errors are identified.
4968	DVLA guidelines for cardiovascular disease re-audit	• Results satisfactory, no actions required.
5035	Idiopathic pulmonary fibrosis – NICE CG163 & QS79	• An aide memoir/ checklist for clinicians to remind them of significant points is in development.
5010 and 5175 (re-audit)	Improvement in delayed and incomplete discharge summaries	• Audit showed poor compliance with timely completion of discharge summaries to required standards. Actions taken included, education and circulation of the audit results, reminder labels and allocation of regular time allocated to write summaries. Results of re-audit showed improved compliance with audit standards.
5175	Improvement in delayed and incomplete discharge summaries - re-audit	• Results satisfactory, no recommendations necessary.
4812	Improving oxygen therapy in patients at risk of hypercapnic respiratory failure	• The proforma has been re-designed • Mandatory training included in induction.
4346	IPC sleeves re-audit	• Re-audit showed an improvement in compliance with the audit standards to 82%.
4414	Medication Chart audit	• Results satisfactory, no recommendations necessary.
4931	Pneumonia (hospital-acquired): antimicrobial prescribing - NG139	• Ongoing improvement work in progress with the sepsis team to ensure that sepsis patients are better identified, and antibiotics started without delay.

TABLE 4 – Trust local audits 2022-23 (186)		
4993	Pre-admission medications restart plan after an episode of Acute Kidney Injury (AKI) - re-audit	• This re-audit showed an improvement in compliance with the standard from 36% to 60%.
5086	Prescription Audit	• The errors highlighted in the audit were discussed with the junior doctors. Further observations have shown improvements have been made. • A re-audit has been completed.
5122 and 5235	Prescription Audit (re-audit - 2nd cycle) And 3rd cycle	• An email was sent to junior doctors to highlight the BNF prescription writing standards • A re-audit has been completed which showed improved compliance with the BNF standards for prescription writing.
5023	Review of management of giant cell arteritis at SaTH	• A patient management protocol has been formulated and presented in the ground round meeting and is now available in the SDEC and acute care areas • A re-audit is planned.
4278	Semaglutide (GLP1 agonist) in type 2 diabetes - NG28	• The audit showed appropriate use of Semaglutide. No further action required.
4915	Sustainable Respiratory Care Audit	• Patients are referred to the Respiratory Nurses for ongoing demonstration of inhaler technique.
4813	Tazocin prescription in an acute setting	• Periodical e-mail reminders are being sent with the Tazocin Guidelines • A reminder poster has been displayed in the On-call room.
5007	To improve the quality of prehospital medication prescription in medical clerking	• Junior Doctors given access to the summary care record to improve prescribing of pre-hospital drugs for admitted patients.
5129	Tolvaptan for treating autosomal dominant polycystic kidney disease - TAG358	• Results satisfactory, no actions required.
WOMEN & CHILDREN'S		
No.	**Audit Title**	**Key actions/improvements following audit**
4240	Anaphylaxis in children	• An anaphylaxis leaflet with signposting to VR codes to EpiPen videos, red flag signs of Anaphylaxis and Patient support groups is being designed.
5146	Antenatal Electronic Fetal Monitoring	• Compliance with standards was very good • The Findings were circulated to all maternity staff for information.
5360	Badgernet system audit for preterm birth communication	• A discussion will be held at neonatal maternity governance meeting on how to increase documentation in maternity BadgerNet EPR.
5205	Booking risk assessments for preterm birth (Maternity incentive scheme (CNST) – year 4)	• The audit demonstrated that the requirements of Clinical Negligence Scheme for Trusts (CNST) Year 4 - Safety Action 6 are being met and exceeded. Practice is embedded and regular monitoring is ongoing to ensure that the care provided remains in line with agreed best practice and national guidance.

TABLE 4 – Trust local audits 2022-23 (186)		
5120	CNST and SBL - Fetal growth surveillance for maternal BMI of 35 and over	• The audit identified good compliance with all the standards audited.
4883	Colposcopy patient satisfaction survey 2021	• The survey had good feedback from patients.
5149	Consultant handover and review of complex in-patients	• Work is underway to identify and allocate staff to a working party to undertake improvement strategy.
5202	Continuous Electronic Fetal Monitoring in Labour – Quarter 2 2022-23	• As routine, a second midwife 'buddy' is allocated for 2nd stage and/or when transferring to theatre, to support the primary midwife, with the inclusion of support with CTG assessments / Fresh Eyes / documentation.
5157	Continuous Electronic Fetal Monitoring in Labour – Quarter 1 2022-23	• A laminated reminder onto every CTG on delivery suite to remind staff to complete chronic hypoxia sticker has been reintroduced.
5081	CPR at newborn resuscitation	• It was agreed that an early post-handover review is held for every baby receiving CPR during the last 24 hours with the team to ensure that the clinical team have documented their interventions and the baby's responses, and to identify any learning. This update was added to the huddle for a two-week period to ensure staff were aware of the changes.
5147	Delay in Decision to Delivery intervals - Emergency Caesarean Section	• The audit showed good compliance. Standards will be continued to be monitored through the Ockenden casenote review.
5001	Diabetes Ketoacidosis	• Overall, the audit showed improvement in compliance with DKA guideline and hence reduced complications of hypoglycaemia • The Trust is participating in a regional audit to monitor and compare compliance.
5259	Discharge from Maternity to Local Authority Care (Foster Care)	• An email was sent to children's social care management to advise them of the documentation maternity services will be requesting from them prior to discharge • The 'Transfer to Foster Care Checklist' (Guideline Appendix 1) has been reviewed and amended and awaiting approval before publication • A memo was sent to all relevant staff to remind them of standards • A re-audit is planned.
4486	Elective minor laparoscopies: necessity of group and save blood test	• The guideline for Day Surgery is being updated to reflect the need of one blood sample for G&S only.
5209	Fetal growth assessment by USS in women with a booking BMI>35kg/m2	• The audit showed good compliance with the standards.
4928	Gynaecology Casenote audit 2021	• To improve the use of GMC stamps, staff will be asked to obtain one at induction.

TABLE 4 – Trust local audits 2022-23 (186)		
3914	Heavy menstrual bleeding - NG88 (includes QS47)	• The outcome of audit was discussed in the departmental meeting to share learning.
5249	Joint case note entries on the Neonatal Unit - re-audit	• Results satisfactory, no recommendations necessary.
5092	Management of Early Endometrial Cancer 2022 re-audit	• A review of the 2ww pathway is underway to consider changes to improve wait times. • A breech meeting is held every few months to ensure learning is continued.
5004	Management of hypoglycaemia in the at risk neonate	• The audit identified gaps in care/monitoring of hypoglycaemia. Concerns are being addressed at the relevant meetings.
5172	Management of Ovarian Cancer	• A guideline is being written for management of patients with ovarian cancer.
5222	Maternal Early Warning Score (Early Recognition of the severely ill Woman) Audit (CQC requirement)	• A full guideline review is underway to incorporate the current tools and technology utilised by staff and to clarify the management of cases in which there is a BadgerNet MEWS score of one or more due to proteinuria.
5189	Midwifery Electronic Record Keeping Audit	• Information has been shared with students to remind them of the need to complete their own documentation and how to access support • The audit highlighted the need for further training. Focused information to be shared with maternity staff via safety huddles / newletters / Badgernet teaching workshops /SaTH Maternity Forum Facebook page to inform of the importance of tick box / drop box / smart forms wherever available during electronic documentation.
5118	Multiple pregnancy - QS46 & NG137	• A reminder was sent to all midwives via Daily Ward Huddles to reiterate the importance of BP/Urinalysis in routine care for multiple pregnancies due to the increased risk of hypertensive disorders and the importance of documenting the reasons testing was not undertaken (e.g. woman unable to provide a urine sample) • Twins Trust Patient Information Leaflets have now been added to Badgernet to be provided to all women with a multiple pregnancy • All women with a multiple pregnancy, not already being seen in the Twins Clinic, will have scheduled contact with the Multiples Midwife (either face to face or by phone), for the provision of the midwifery-based information in line with the Multiple Pregnancy Antenatal Care Pathway.
5078	Multiples audit: NNU team attendance at birth	• Plans are ongoing to split the Tier 2 rota from Paediatric Tier 2 • The guideline has been amended to include Neonatal Nurses should be called to attend with the Neonatal Tier 2.
5080	Neonatal parenteral nutrition (PN) - NG154	• Separate guideline on neonatal parenteral nutrition, incorporating recommendations from the

TABLE 4 – Trust local audits 2022-23 (186)		
		network guidance and NICE guidance, including consideration of the earlier use of 'stock bags' to avoid undue delay in commencing PN is currently underway.
5013	Nurse led telephone/video follow-up for ladies with endometrial cancer	• To improve response rates, CNS will notify patients that they will receive a survey with their clinic letter which was agreed with the medical secretaries.
5131	Ockenden documentation review 2021	• Review of BadgerNet usage and strength of training programme to use the workflows has been incorporated into the maternity transformation programme • Training for Community Midwives and development of Maternal Medicine Networks and implementation of criteria for referral has been incorporated into the maternity transformation programme.
5208	Percentage of pregnancies where a risk status for fetal growth restriction (FGR) is identified and recorded using a risk assessment pathway at booking and at the 20-week scan	• The audit showed good compliance with the standards.
5207	Raising Awareness of Reduced Fetal Movement - element 3	• Quarterly reviews are taking place to monitor compliance for use of RFM checklist.
5103	Review of proforma audit	• The proforma has been revised and presented to the clinical governance meeting and clinical guidelines meeting along with updated SOP • Improvement work is underway in CMDU-to increase capacity.
5243	SaTH guideline for recognition and treatment of sepsis in pregnancy and the postnatal period Version 2.2	• A new leaflet has been developed and this will be included within the new guidelines • A new sepsis guideline is being developed. This includes significant changes to the guidance, the Sepsis Screening Tools and the Sepsis Pathway Tools. There will be training rolled out and a guideline launch.
5223	Saving Babies Lives – Reduced Fetal Movements	• New process in place for documentation of compliance.
5204	Smoking cessation – Referral of women with a CO measurement of ≥4ppm at booking	• The audit showed good compliance with the standards.
5201	Trial of assisted vaginal delivery	• The Trust guideline has been updated • A re-audit is planned.
4810	VTE of postnatal patients before discharge from hospital	• VTE prescriptions are now being completed before transfer to postnatal ward to avoid missed prescriptions and delays in giving anti-coagulant.
5148	VTE risk assessment during AN and PN period	• Re-audit of compliance with standards will be carried out following the move to Badgernet system.

Clinical Audit Outcomes

The reports of 200 clinical audits were reviewed by the provider and a compliance rating against the standards audited agreed. However, 28 (14%) of these local audits demonstrated significant non-compliance with the standards audited. On completion of the audit, the lead auditor fills in a sign-off form with the audit conclusions, recommendations and action plan. Within this they are required to give an overall rating of compliance with the standards audited. Significant non-compliance is rated as red and denotes less than 50% overall compliance with the standards audit. These are reported to the speciality governance meetings and divisional governance meetings and then through to the Quality Operational Committee chaired by the Medical Director. SaTH 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 (N=28)

Table 5 – audits demonstrating significant non-compliance with standards audited		
CLINICAL SUPPORT – PATHOLOGY & RADIOLOGY AND THERAPIES		
No.	**Audit Title**	**Recommendations - actions**
5310	Chest X-rays documentation prior to requests for CTPA being made	• The audit identified significant non-compliance, staff have informed and reminded of the importance of this.
5218	Head CT - Lens Exclusion	• To Improve CT head technique, a presentation on angling the gantry and its benefits was distributed.
5140	Imaging loading audit	• To improve image loading time and ensure previous imaging is available, a new system is currently in development.
4910	National Comparative Audit of NICE Quality Standard QS138	• This small national audit showed poor compliance. A larger re-audit was therefore carried out which showed 98.8% compliance with assessing, identifying, and treating pre-operative anaemia during the first quarter.
CORPORATE – TRUST WIDE		
No.	**Audit Title**	**Recommendations - actions**
5111	Comfort Observations in the last hours/days of life	• Supportive care visits are planned for 2023 • A programme of further training is planned.
SURGERY - ANAESTHETICS, THEATRES & CRITICAL CARE		
No.	**Audit Title**	**Recommendations - actions**
5056	Peri-operative Management of Diabetes in Emergency Operations	• The audit results have been presented at the clinical governance meeting and all identified issues discussed and addressed.
SURGERY - HEAD, NECK AND OPHTHALMOLOGY		
No.	**Audit Title**	**Recommendations - actions**
5368	Post Thryoidectomy Bleed Monitoring	• Further “SCOOP” boxes (thyroid emergency kit) provided

Table 5 – audits demonstrating significant non-compliance with standards audited		
		• Post-operative instructions amended to specify SCOOP box use • Training provided on SCOOP boxes to deal with post operative haematoma and post operative observations.
SURGERY – MSK		
No.	**Audit Title**	**Recommendations - actions**
4882	Compliance to ASIA spine chart for spine fractures	• To ensure compliance with the ASIA spine chart, training provided to junior doctors at induction.
SURGERY - SURGERY, ONCOLOGY & HAEMATOLOGY		
No.	**Audit Title**	**Recommendations - actions**
5060	Assessment of acute care for patients with decompensated liver disease	• The results show that there is variability in the utilisation of the DCCB when managing patients with decompensated cirrhosis. Teaching provided to junior doctors to ensure standardisation of care bundle.
4888	Compliance with departmental policy for day case mastectomy	• A management review of service arrangements is being carried out to improve compliance with standards.
5006	Fluids, charting the unknown	• Audit showed poor compliance. Education programme has been developed and is now being delivered.
MEDICINE – EMERGENCY MEDICINE		
No.	**Audit Title**	**Recommendations - actions**
4642	RCEM: #NOF 2020	• An ED pro-forma for the care of these patients is now being used.
5292	Sore throat (acute): antimicrobial prescribing - NICE NG84	• A poster displaying guidance for the treatment of sore throat is now displayed within the ED.
MEDICINE		
No.	**Audit Title**	**Recommendations - actions**
4747	BTS pleural services audit	• Two consultants are now allocated sessions for pleural lists (0.5 PA each • Thoracic ultrasound working group has been established to discuss thoracic ultrasound training across the Trust • The need for a pleural specialist nurse has been included in the pleural business case, which is being worked on by the operational manager • Checklists are now in place for pleural aspiration and chest drains.
5151	CCG5 Treatment of Community Acquired Pneumonia in line with BTS Care Bundle (Quarter 1 - April to June 2022)	• To improve clarity, the CAP antibiotic guidelines are being updated • An admission bundle is being developed to improve compliance.

Table 5 – audits demonstrating significant non-compliance with standards audited		
5035	Idiopathic pulmonary fibrosis – NICE CG163 & QS79	• An aide memoir/ checklist for clinicians to remind them of significant points is in development.
4903	Outpatient Management of Pulmonary Embolism Audit – BTS	• Action plan has been developed to address key patient safety issues.
5023	Review of management of giant cell arteritis at SaTH	• Patient management protocol has been formulated and presented in the ground round meeting and is now available in the SDEC and acute care areas • A re-audit is planned.
WOMEN & CHILDREN'S		
No.	**Audit Title**	**Recommendations - actions**
5092	Management of Early Endometrial Cancer 2022 re-audit	• A review of the 2ww pathway is underway to consider changes to improve wait times • A breech meeting is held every few months to ensure learning is continued.
5360	Badgernet system audit for preterm birth communication	• A discussion will be held at neonatal maternity governance meeting on how to increase documentation in maternity BadgerNet EPR.
5081	CPR at newborn resuscitation	• It was agreed that an early post-handover review is held for every baby receiving CPR during the last 24 hours with the team to ensure that the clinical team have documented their interventions and the baby's responses, and to identify any learning. This update was added to the huddle for a two-week period to ensure staff were aware of the changes.
5004	Management of hypoglycaemia in the at risk neonate	• The audit identified gaps in care/monitoring of hypoglycaemia. Concerns are being addressed at the relevant meetings.
5259	Discharge from Maternity to Local Authority Care (Foster Care)	• An email was sent to children's social care management to advise them of the documentation maternity services will be requesting from them prior to discharge • The 'Transfer to Foster Care Checklist' (Guideline Appendix 1) has been reviewed and amended and awaiting approval before publication • A memo was sent to all relevant staff to remind them of standards • A re-audit is planned.
5222	Maternal Early Warning Score (Early Recognition of the severely ill Woman) Audit (CQC requirement)	• A full guideline review is underway to incorporate the current tools and technology utilised by staff and to clarify the management of cases in which there is a BadgerNet MEWS score of one or more due to proteinuria.
5131	Ockenden Casenotes Review 2021	• Review of BadgerNet usage and strength of training programme to use the workflows has been incorporated into the Maternity Transformation Programme

Table 5 – audits demonstrating significant non-compliance with standards audited		
		• Training for Community Midwives and development of Maternal Medicine Networks and implementation of criteria for referral has been incorporated into the maternity transformation programme.
5243	SaTH guideline for recognition and treatment of sepsis in pregnancy and the postnatal period Version 2.2	• A new leaflet has been developed and this will be included within the new guideline • A new sepsis guideline is being developed. This includes significant changes to the guidance, the Sepsis Screening Tools and the Sepsis Pathway Tools. There will be training rolled out and a guideline launch.
5103	Review of proforma audit	• The proforma has been revised and presented to the clinical governance meeting and clinical guidelines meeting along with updated SOP • Improvement work is underway in CMDU-to increase capacity.
5200	Management of shoulder dystocia	• Process for de-briefing staff following shoulder dystocia delivery has been changed • Staff given further training on completion of pro-forma • Guideline being updated.

REREARCH AND INNOVATION

Research & Innovation have this year developed a co-produced R&I Strategy with the ambition to ***"make research and innovation a fundamental part of care"*** at SaTH. Given the positive relationship between research and patient outcomes there is a clear obligation for the Trust to create a successful research environment.

The number of patients that have been recruited to participate in research during the financial year of 2022/23 was 629 (for studies approved by a Research Ethics Committee and the Health Research Authority).

Research Activity	Number of Studies
New research projects open in year	34
Total number of research projects open in year*	170

**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 2022/23 year the Trust continued to support and submit a number of research grant applications, to national funding bodies with a number of successes. This includes being successfully jointly awarded a large NIHR programme grant working in collaboration with the University of Cardiff to deliver a multi-site post-partum bleeding study called OBS-UK.

SaTH has continued to contribute to a number of Urgent Public Health Measures Studies including SIREN and PREG-COV. This year we have seen a surge in interest for clinician lead studies and staff interested in wanting to get involved in research. This has led to the Team developing a research

training programme in line with 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 2022/23 the Research and Innovation Department has 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.

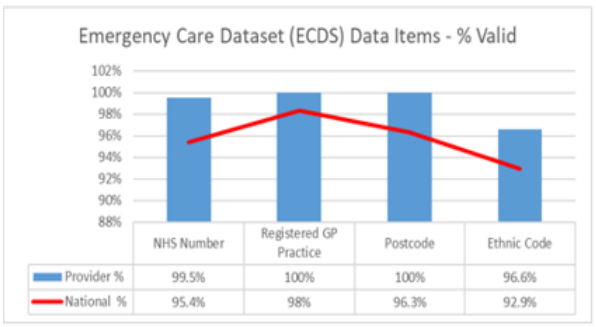
The Trust is an active contributor to a regional approach to looking at research governance at an Integrated Care System level (SSherpa) to ensure safe, timely set-up of research that fits with the needs of our population and to improve the experiences of patients that access our services.

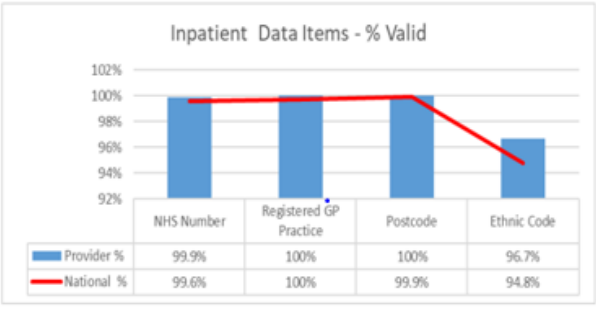
Our strategic partnerships with the University of Keele were successfully launched in 2022/23, with clinical academic appointments and research fellows to further develop the relationship between our organisations and develop joint homegrown research projects. This has recently resulted in our Director of Research and Innovation being offered a professorship across the organisations.

In 2023/24 the Research and Innovation Department will continue to focus on supporting patients, carers and staff to access high quality research and to work closely with the education, improvement and audit teams to ensure that a culture of research, innovation and education, is embedded as part of core business at the Trust.

NHS NUMBER AND GENERAL MEDICAL PRACTICE CODE VALIDITY

SaTH submitted records during 2022/23 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.





Reporting period is April 2022 to February 2023 (latest data available).

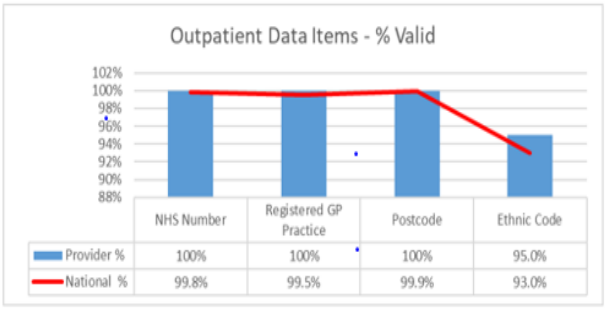
Percentage of records which included valid NHS Number was:

- 99.5% 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 ED
- 100% for Inpatients
- 100% for Outpatients

All percentages were above national results and remained the remained



The data quality measures are reported in the Data Quality Maturity index (DQMI) reported by NHS Digital.

the same as in 2021/22 with the exception of:

- The percentage of records with NHS number recorded in ED decreased slightly to 99.5% from 99.7%
- The ethnic code for all three datasets compared reduced slightly compared to 2021/22

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 10 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.

NHS Digital has kept the extended DSPT submission date of 30 June 2022. For the 21/22 self-assessment our Trust status was increased from Standards not met to Approaching standards due to the improvement plan which NHS Digital approved and accepted.

The improvement plan related to only eight evidence items. These include:

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

Three of the above evidence items have been completed and five remain with work ongoing.

The Trust is due to submit their 22/23 submission by 30 June 2023.

LEARNING FROM DEATHS

Learning from Deaths remains a key component of the Trust 'Getting to Good' Improvement Programme with SaTH. Progress is monitored through the Trust Learning from Deaths Group and the Trust Getting to Good Operational Delivery Group.

Over the last 12 months considerable progress has been made to address the key improvement targets identified within the 2021-2022 Quality Account. This significant progress has been recognised by the NHS England (NHSE) Better Tomorrow: Learning from Deaths, Intensive Support for Challenged Systems Team.

Improvements achieved for 2022-2023

- The Learning from Deaths Dashboard has been developed and delivered operationally during this year in collaboration with NHSE and the Trust Performance Team. The dashboard provides a summary of key performance indicators (KPIs) relevant to the Learning from

Deaths agenda and has been incorporated as a standard agenda item in the monthly Trust Learning from Deaths meeting. Performance relating to these KPIs is summarised in quarterly reporting and supports the monthly integrated performance reporting to the Board of Directors.

- A standardised template has been developed for the Divisional Quality Governance teams to complete and report the outcomes of triangulated learning from care provided to patients who die in the Trust to the Trust Learning from Deaths meeting as a standard agenda item.
- Job descriptions for medical staff undertaking structured judgement mortality reviews (SJRs) have been developed and will be used in the current recruitment drive to increase resource at this level and improve compliancy rates for SJR completion. Further work is required to ensure that work undertaken by SJR reviewers is evidenced within appropriate job plans for medical staff.
- The Corporate Learning from Deaths Team continues to work closely with the Trust Patient Safety Incident Response Framework (PSIRF) Steering Group. This has been developed to assist the planning and implementation of the new approach to Patient Safety across the Trust later this year. A review is underway to identify how the learning from deaths process will support and integrate with this programme of work to promote the identification of themes and trends and inform priorities for wider improvement work across the organisation.
- Case selection for SJR through Medical Examiner scrutiny and online SJR mortality screening has been reviewed. Improvements have been made to ensure duplication of investigative reviews is minimised and that each case is following the most appropriate case review methodology. Case selection for SJR is monitored through the weekly operational Mortality Triangulation Group meeting.
- The weekly operational Mortality Triangulation Group maintains oversight of all deaths across the Trust is now firmly established as an integral part of the governance process, supporting learning from deaths within the organisation. The output of the group is monitored through monthly reporting to the Trust Learning from Deaths Group.
- Professional relationships have been established with key stakeholders within the Shropshire, Telford and Wrekin (STW) Integrated Care System to ensure identified learning from deaths can be disseminated appropriately and in a timely manner.
- The Corporate Learning from Deaths Team continue to refine integrated working practices with the Palliative and End-of-Life Care Teams to ensure learning identified though the Learning from Deaths agenda, especially relating to concerns raised by the Medical Examiner Service. This learning is shared with the STW Integrated Care System End-of-Life and Palliative Care Steering Group to inform wider improvement work across the System.
- A quarterly Mental Health and Learning Disability Lead update has been incorporated into the Trust Learning from Deaths meeting. This is to ensure that following a Learning Disability Mortality Review (LeDeR) learning is identified from the avoidable deaths of people with a learning disability and appropriately disseminated. Specialist mental health input with the mandated review of care provided to patients who have died and have a diagnosed serious mental health illness, has been identified following the recruitment of additional resource within the Mental Health Team.
- All 19 recommendations from the Shropshire Independent Review of Deaths and Serious Incidents (NICHE Phase 2 review), commissioned by the former STW Clinical Commissioning Group were completed during this year and the action plan was formally closed in November 2022

- An onsite external review undertaken by NHSE was completed in December 2022 including qualitative assessment of completed SJRs. The formal report concluded that significant improvements have been made within the Trust in the way it learns from deaths. Constructive feedback is being used to inform local education and training and quality assurance initiatives to further develop the Learning from Deaths agenda.

- Building on improvement work undertaken during 2021/22 to replace the paper-based mortality review tool known locally as the CESDI form, an SJR has been completed for over 4% of all deaths that occurred across the Trust within 2022/23. This data supports learning from deaths identified through sepsis validation work, serious incident investigations, divisional investigations, complaints and coronial proceedings, and helps to inform improvement work across the Trust. A targeted approach to recruitment is underway to provide additional multi-disciplinary resource to increase the number of SJRs undertaken for deaths that occur during 2023/24.

- The online SJR mortality screening tool developed within 2021-2022 has continued to be widely utilised across the Trust over the last 12 months. All deaths are scrutinised by an independent Medical Examiner where both positive and negative learning may be identified, and in addition, approximately 45-50% of all deaths during 2022/23 received online SJR screening by clinical teams.

- The online SJR tool (SJRPlus) developed by NHSE migrated to a new digital platform in December 2022. The updated tool has introduced new questions to improve potential analysis of themes and trends, for example part postcode for the deceased, as well as the ability to monitor the timeframe with which reviews are undertaken.

Summary of key improvement targets and actions to be taken for 2023-2024

- Increase the number of SJRs undertaken for deaths that occur within the Trust during 2023/24, to maximise learning opportunities and inform quality improvement work across the organisation.
- Mortality review data to be made available to support consultant appraisals.
- Establish a local programme of education and training to support the learning from deaths agenda including the completion of high quality SJRs, and address areas of improvement recommended following the NHSE external review that took place in December 2022.
- Increase multidisciplinary clinical team involvement in the completion of SJRs to promote a greater holistic approach to the learning from deaths agenda.

Medical Examiner Service

A Medical Examiner is required to review the care and treatment the patient has received during their final admission within the hospital setting and once they have held a discussion with a treating clinician, they discuss and agree an accepted cause of death. This information is then offered to the bereaved relatives so that they have an opportunity to speak with an independent clinician about the care their relative received, and to have the cause of death explained to them so they understand what has happened to their relative before they proceed with registering their death.

Scrutiny of the care given is also an opportunity to identify any potential learning, whether this be positive or negative, and for the Medical Examiner to identify cases where potential failings have occurred to undergo further, appropriate review, such as structured judgement review.

The Medical Examiner Service aims to review 100% of deaths that occur on both our hospital sites and achieve issuing Medical Certificate of Cause of Death (MCCD) for non-coronial cases within three calendar days to facilitate registration within five days as stated in the national target. This performance is measured on a quarterly basis to the national Medical Examiner and is reported to the Trust Board.

In July 2020, the National Medical Examiner communicated to all acute organisations in England and set out what local health systems need to do to prepare for the statutory Medical Examiner system which commences in April 2024. The established Medical Examiner services at SaTH, as the local acute organisation, will therefore be extending its services to provide independent scrutiny of all deaths not taken for investigation by a coroner to all local community providers. The service will see an increase in demand from circa 2,000 acute death reviews per year to circa 5,164 acute and community deaths per year.

In 2022-2023 the Medical Examiner service has been working towards ensuring there are plans in place when the statutory requirement commences and has been liaising closely with all community providers within the STW Integrated Care System. The Medical Examiner Service expansion of our service will take place proportionately to ensure we have enough staff in place to take on this additional work and there are robust systems and processes in place for referrals into the service and feedback to providers either for additional learning or sharing good practice.

Summary of key improvement targets and actions to be taken for 2023-2024

- The Medical Examiner Service aims to review 100% of deaths that occur on both our hospital sites.
- To achieve issuing Medical Certificate of Cause of Death (MCCD) for non-coronial cases within three calendar days to facilitate registration within five days as stated in the national target.

The Medical Examiner services at the Trust is extending its services to provide independent scrutiny of all deaths which are not taken for investigation by a coroner, this will include deaths occurring for all local community providers within the STW Integrated Care System.

COMMISSIONING FOR QUALITY AND INNOVATION

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care. The CQUINs were suspended due to the COVID-19 pandemic but recommenced in 2022/23.

The Trust was expected to report on all `nine schemes Quarterly throughput 2021/22 (with the exception of CCG1 where reporting commenced in Q3). The CQUIN financial incentive (1.25% as a proportion of the fixed element of payment) was earnable on five indicators as agreed by the Commissioners, for 2022/23. These were: CCG1, CCG 3, CCG6, CCG 8, CCG 9. Performance against the nine CQUINs is shown for Q1-3 (Q4 data unavailable at the time of collating the Quality Account).

CQUIN	CQUIN	National CQUIN	Target	Q1	Q2	Q3	Q4
CCG1	Staff Flu Vaccination	N	70-90%				44%
CCG2	Appropriate antibiotic prescribing for UTI in adults aged 16+	N	40-60%	56%	52%	59%	50%
CCG3	Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	Y	20-60%	52%	73.90%	68%	62.5%
CCG4	Compliance with timed diagnostic pathways for cancer	Y	55-65%	19%	16%	5.70%	12.7%

	services						
CCG5	Treatment of community acquired pneumonia in line with BTS care bundle	Y	45-70%	7%	13%	13%	6%
CCG6	Anaemia screening and treatment for all patients undergoing major elective surgery	Y	45-60%	98.80%	100%	100%	86.3%
CCG7	Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service	N	0.5-1.5%	0.90%	1.00%	1.56%	1.3%
CCG8	Supporting patients to drink, eat and mobilise after surgery	Y	60-70%	86%	97.80%	95.7%	93.5%
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients	Y	20-35%	1%	63.60%	26.7%	10.3%

IMPLEMENTING THE PRIORITY CLINICAL STANDARDS FOR SEVEN-DAY HOSPITAL SERVICES

There are four priority standards for Seven-day Hospital Services:

- Standard 2: Time to Consultant review
- Standard 5: Access to diagnostics
- Standard 6: Access to Consultant-directed interventions
- Standard 8: On-going review

SaTH 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.

ENCOURAGING STAFF TO SPEAK UP

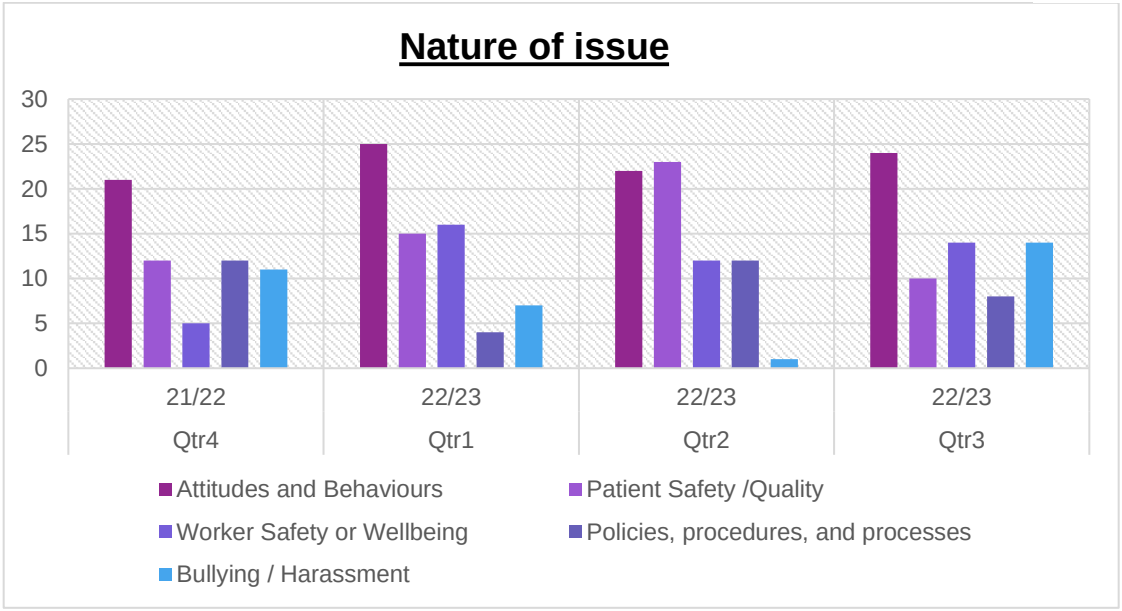
Speaking up is about anything that gets in the way of providing good care. At SaTH, we know it is really important that our staff feel able to speak up so that potential harm is prevented. Even when things are good, but could be even better, we want to ensure our staff feel able to say something and feel listened to. Our Freedom to Speak Up (FTSU) team has continued to work hard in 2022/2023 to ensure that staff across the organisation are enabled to speak up about their concerns.

In 2022/23, YTD the FTSU team received 223 concerns (YTD), this is a decrease from the previous year. Year-on-Year comparator can be seen below:

YEAR	Q1	Q2	Q3	Q4	Total	Increase	National Average Increase/Decrease
2022/23	71	73	79	N/A	223	N/A	Not Available Yet

2021/22	100	113	90	66	**369**	↑18%	0%
2020/21	41	82	103	78	**302**	↑208%	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

The themes are also denoted in the graph below. This shows that 32% of concerns raised in 2022/2023 YTD related to attitude and behaviour, a reduction from 37% in the 2021/2022.



In October 2022, the Trust FTSU vision and strategy was signed off by board with four key priorities,

- **Priority 1 Ensure all groups who face barriers to speak up are supported with a focus on people of colour (BAME)**

The FTSU unit launched the 30 voices project to document experiences or witness of racism. In total 48 people submitted their testimonia. These findings have been shared with stakeholders in the EDI, HR and Corporate team and are being used to drive discussions that will strengthen policies and make awareness of zero tolerance to racism more accessible in the Trust.

- **Priority 2 Ensure FTSU processes are fit for purpose in line with best practices**

An internal audit reviewed the FTSU team's case management from April 2021 to September 2022. The audit reported best practice in the following areas:

  - Improved staff engagement through their visibility in hospital areas and engagements
  - Interdepartmental collaboration to improve speak up culture.

- **Priority 3 Working with leaders to listen up and follow up**

Mandatory training for all workers including managers has been implemented across the Trust. There remains further work to do, YTD 53% of our managers have completed the training.
.

- **Priority 4. Alongside our cultural team, lead the civility and respect social movement**

In 2022/23 the Trust launched its Civility and Respect Programme across all staff groups. Feedback so far has been excellent with over 600 members of staff having taken part in the workshops.

GUARDIANS OF SAFE WORKING

The SaTH Guardian of Safe Working (GoSW) remains a member of, and regularly reports to the Medical Leadership Team.

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 liaisons with key stakeholders introducing locally employed doctors to the exception reporting processes
- 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.

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).

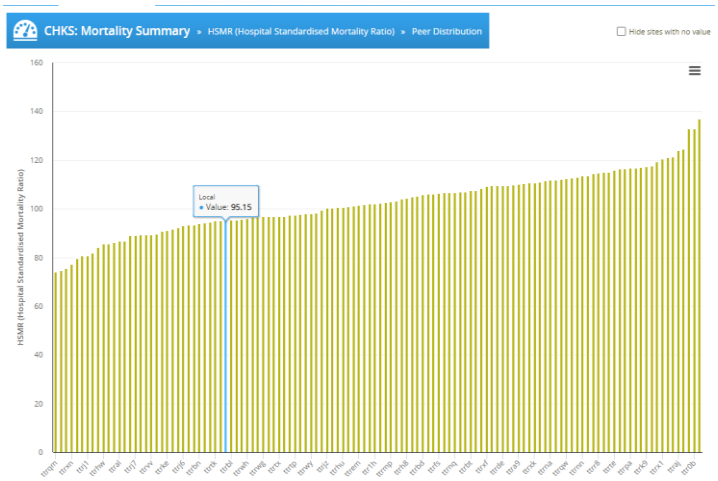
The majority of core indicators are reported by financial year, e.g., from 1 April 2022 to 31 March 2023, however some indicators report on a calendar year or partial year basis. Where indicators are reported on a non-financial year time period this is stated in the data table. It is important to note that some national datasets 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**.**

The SHMI data for 2022/2023 shows that the index for the SaTH is 95.15 which is in the “as expected” banding.

The graph shows the distribution across non-specialist acute NHS Trusts in England and the SaTH position in comparison.



Indicator	Summary Hospital-Level Mortality Indicator				
Domain	Preventing people from dying prematurely				
SaTH 2022/23	Peer Comparator 2022/23	2021	2020	2019	2018
95.15	136.84	97.65	110.83	101.64	110.83
Data source - CHKS iCompare Based on peer distribution group (rolling 12 months Jan23). HEC data used against peer.					

SaTH considers this data is as described as it is taken from a well-established national source.

PERCENTAGE OF 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.

	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 2022/23	National Average 2022/23	Highest Score Trust 2022/23	Lowest Score Trust 2022/23	SaTH 2021/22	SaTH 2020/21	SaTH 2019/20	SaTH 2018/19
28.54%	39.1%	70.4%	6.46%	20.65%	23.40%	22.19%	21.03%

Data source - CHKS iCompare FCE (Finished Consultant Episode) deaths with specialised palliative are code Z515. Based on peer distribution group (rolling 12 months Jan23). HES data used against peer.

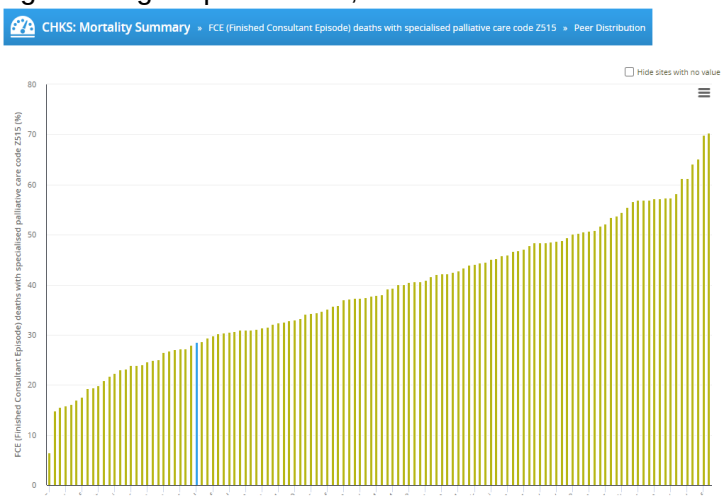
SaTH considers this data is accurate as it is taken from a well-established national source.

The data for 2022/23 shows that the Trust is below the national average with a score of 28.54% compared to 39.1%. The graph shows the distribution across each non-specialist acute NHS Trusts and the SaTH position in comparison to other hospital providers.

The Trust regularly monitors mortality data at the Trust Mortality Review Group to improve this score, and the quality of its services.

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 two 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. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and associated data fields used to link the PROMs-HES data.

Redevelopment of the linkage processes for PROMS-HES was still outstanding in 2022/23 meaning the PROMs data is not available.

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 2023/22	National Average 2020/21	Highest Score Trust 202/23	Lowest Score Trust 2022/23	SaTH 2020/21	SaTH 2019/20	SaTH 2018/19
Hip Replacement	No data available	1.0 (full health)	-0.59(worst health)	No data available	0.47	0.43
Knee Replacement	No data available	No data available	No data available	No data available	0.37	0.32
Data source - Patient Reported Outcome Measures (PROMs) - The Shrewsbury And Telford Hospital NHS Trust (hed.nhs.uk) Patient Reported Outcome Measures (PROMs) - NHS Digital Patients undergoing elective inpatient surgery for elective procedures; hip replacement and knee replacement are asked to complete questionnaires before and after their operations to assess improvement in health as perceived by the patients themselves. Data publications are released biannually by the NHS Digital, usually in February and are labelled as full data releases. In 2021 significant changes were made to the processing of Hospital Episode Statistics (HES) data and its associated data fields which are used to link the PROMs-HES data. Redevelopment of an updated linkage process between these data are still outstanding with no definitive date for completion at this present time. This has unfortunately resulted in a pause in the current publication reporting series for PROMs at this time.						

SaTH 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 RE-ADMITTED 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 two categories: the percentage of people under the age of 16 years and the percentage of patients 16 years and over.

Indicator	Readmission rate got patients admitted to a hospital within 28 days of being discharged						
Domain	Helping people to recover from episodes of ill health or following injury						
Age band	SaTH 2022/23	Highest performing 2022/23	Lowest performer 2022/23	SaTH 2021/22	SaTH 2020/21	SaTH 2019/20	SaTH 2018/19
0-15	14.90%	19.31%	0.31%	13.85%	12.91%	13.57%	12.65%
16 and Over	7.92%	13.06%	3.13%	8.53%	8.82%	8.44%	8.72%
Data source -CHKS iCompare HES data used. Readmissions within 28 days, patients filters where the age is less than or equal to 15 and where is the age is greater than or equal to 16. Rolling 12 months.							

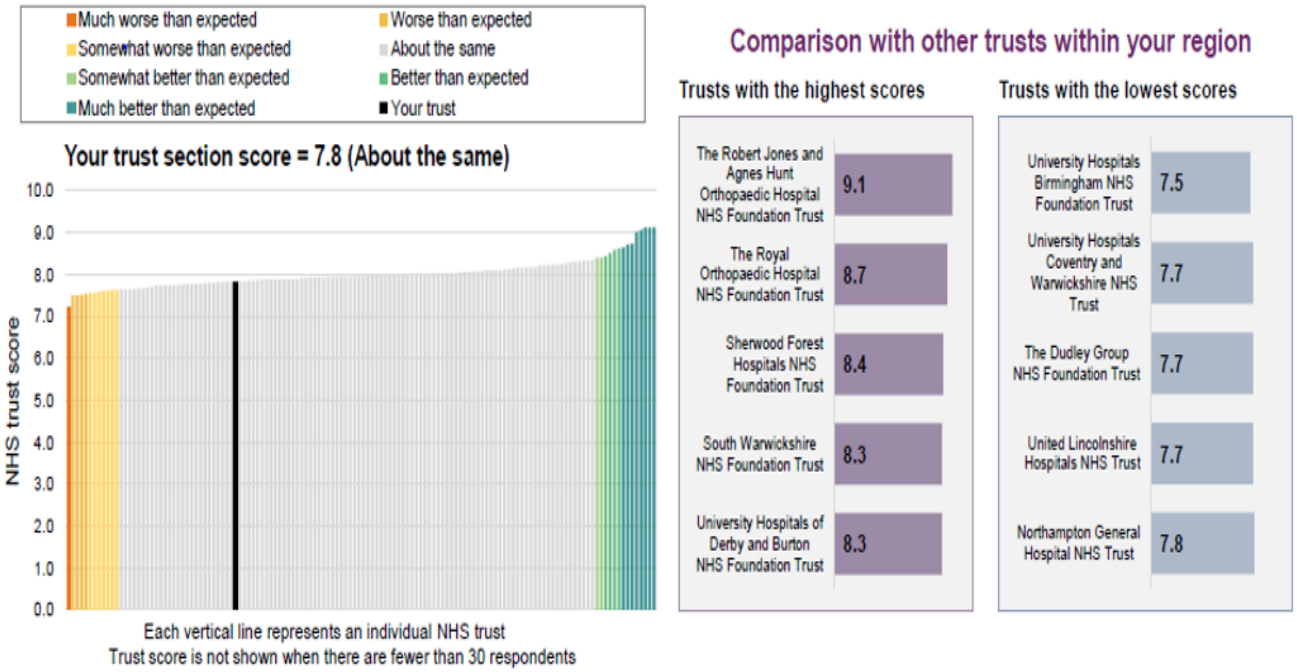
SaTH considers this data is as described as it comes from the CHKS, a well-established national data provider.

The data is collected so that SaTH can understand how many patients discharged from the Trust are readmitted within less than a month. This enables 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. Improving discharge planning processes for our patients is a key priory for 2023/24.

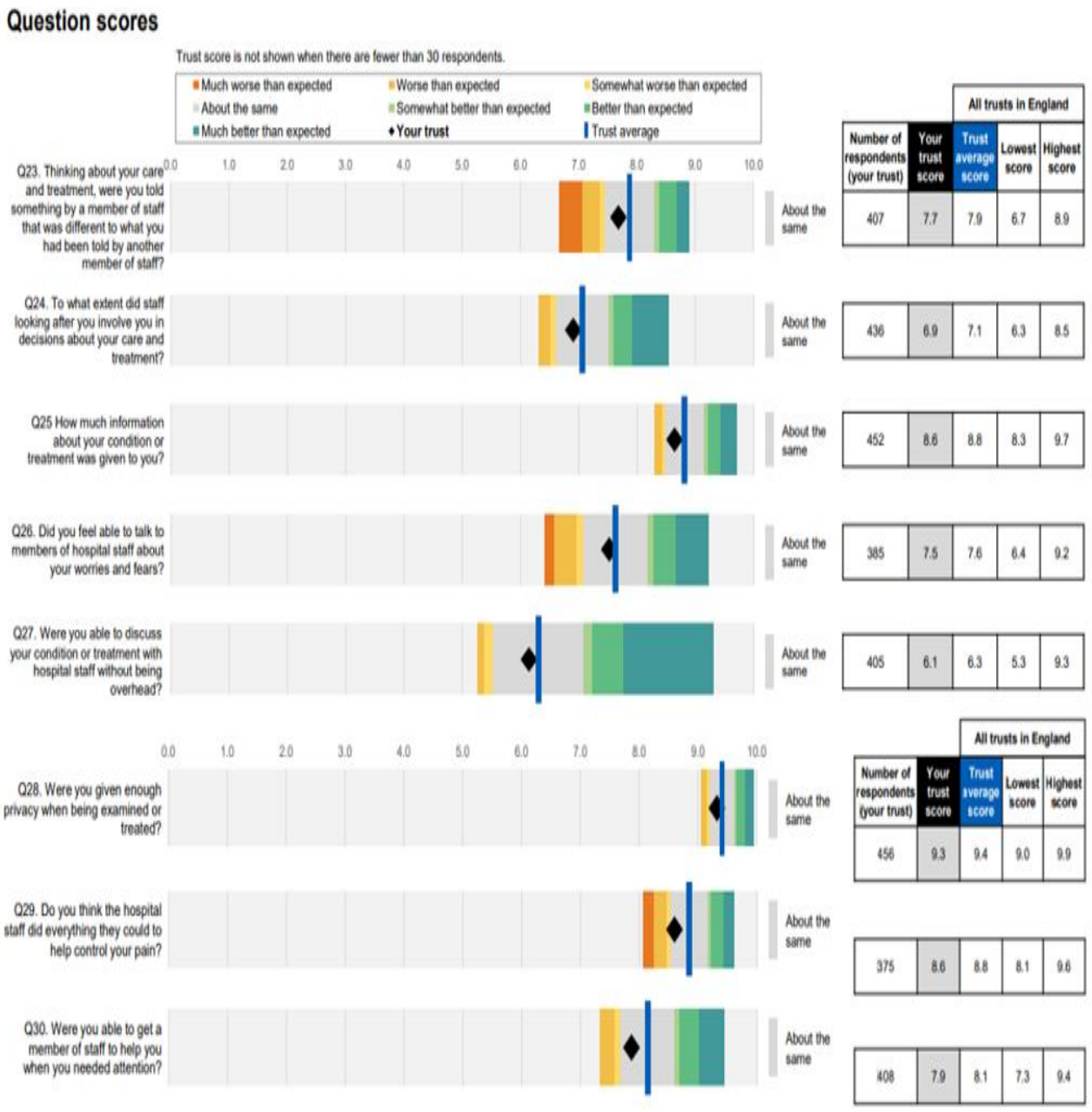
THE TRUST RESPONSIVENESS TO THE INPATIENTS' PERSONAL NEEDS

The results for 2021 Inpatient Survey which were published in 2022 are included in the Quality Account. The graph below shows SaTH as the black line compared to the other individual NHS Trusts, with the Trust section score being 7.8, meaning it is rated as "about the same" as other Trusts.



SaTH considers this data is accurate as it is taken from a well-established national source.

Comparison with other Trusts in the West Midlands region is also shown. It must be noted that as a result of the "expected range" analysis techniques used, a Trust could be categorised as "about the same" whilst having a lower score than a "worse than expected" Trust or categorised as "about the same "whilst having the same score than a "better than expected " Trust.



Actions in relation to the Inpatient Survey results and improvements are outlined in the National Survey section of this Quality Account.

PERCENTAGE OF STAFF WHO WOULD RECOMMENED THE TRUST TO A FRIEND 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".

or	The percentage of staff who would recommend the Trust as a provider of care for their friends and family.						
Domain	Ensuring people have a positive experience of care						
SaTH 2022	National Average 2022	Best performing Trust 2022	Worst performing Trust 2022	SaTH 2021	SaTH 2020	SaTH 2019	SaTH 2018
39.2%	61.9%	86.4%	39.2%	43.5%	51.1%	53.3%	52.4%
Data source – Local results for every organisation | NHS Staff Survey (nhsstaffsurveys.com) For every organisation participated in the NHS Staff Survey a benchmark and breakdown report is available. This benchmark report for The Shrewsbury and Telford Hospital NHS Trust contains results for the 2022 NHS Staff Survey, and historical results back to 2018 where possible. These results are presented in the context of best, average and worst results for similar organisations where appropriate*. Data in this report are weighted** to allow for fair comparisons between organisations. For the 2021 survey onwards the questions in the NHS Staff Survey are aligned to the People Promise.							

SaTH 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 2022/23 by 4.3%. Nationally there was also a 5% decline in the average for this question in the national staff survey. The Trust will continue to implement actions to further understand the experience of our staff and improve the quality of its staff's experience of working at the Trust throughout 2023/24, which includes:

- Continue our cultural and leadership improvement journey
- Review our staff experience improvement plans at Corporate and Divisional level to review and modify actions and ensure improvements
- Complete Quarterly Pulse Survey for staff so we can review progress and keep on track
- Use our Staff Survey continuous improvement timeline to implement, review and monitor our progress as outlined below.

Staff Survey Continuous Improvement Timeline

Initial Results

January/February

Internal Results comparable via service provider (QH),
Heat Map to be shared with Senior Managers and BP's

Divisional and Corporate packs to be released - action plan template and a year of listening document

Discussions with BI team ref: reporting

People pulse out

Detailed Reports

February

WRES and DES results to arrive in Trust.

Potentially early full NHS results to be shared

End of Feb beginning of March Script and Video to be finalised as soon as we receive full NHS Results.

People pulse results

SLC update

Workshops #ImprovingTogether

March

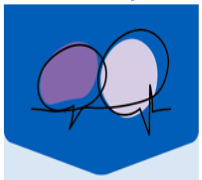
Embargo Lifted, Half day workshops to share results with Divisions. Workshops to be opened by CEO and Facilitated by Director of People and OD.

Top Line results presented including comparison to sector, region, previous results and next steps.

Line managers and BP workshops and on line offer (March and April) to understand their data - Involvement of QI

Dashbaord to be shared

Action Planning & Focus Groups



March/ April

Additional reporting to be made available (demographic analysis, free text reporting, local questions).
BP's to hold Individual Meetings with each Division/Corporate Triumvirates to review last years action plan and to identify top 3 and bottom 3 areas and to review EDI data. Divisional to engage with staff and to identify service SS champions.

Divisions/Corporate to hold focus groups to support their leaders to develop local action plans and to ensure colleague involvement.
People Pulse out

Action Plans Signed off

May

Action plans to be agreed and submitted to BP's by the end of first week in May

Focus group themes and findings and action plan's to be shared.

Communicate findings to Divisional/Corporate Champions to share with colleagues.

People pulse results

Board Assurance

June

Board and OPG to receive a paper outlining the agreed action plans from Divisions/Corporate areas and full results.

Action plans to highlight achievements from previous years and continuation of actions.
Action plans to be shared locally at Divisional, Centre, Service Level and Corporate areas.

Hierarchy in ESR to have data cleanse

Refresh Communication plan and incentives for 2023 survey Launch to be signed off.

Continuous Improvement Loop

Board and Local assurance

June/July - October

Board and OPG to receive quarterly assurance for action plans, communication and engagement plans, from Divisions and Corporate areas. Ensuring that action is being taken at team levels.

SS Targets and objectives to be added in Talent conversation/appraisals

Planning Time - ongoing

July /August

People Pulse out in July and results in August

OD to hold SS roadshows – promoting champion role Recognition for high achievers.

Embed engagement discussions into every day routines

We listen and act together

September

Communication to highlight the progress on previous year prior to Launch in October.

Communication to run throughout the year about results "you said – we listened".

Divisions / Corporate areas to hold focus groups throughout the year.

Staff Survey Launched

October /November

Communication throughout the year around the results - staff survey to be on every cascade – divisional updates, you said we listened.

Action planning and focus groups,

Communication to be launched to highlight progress prior to Launch.

8 week detailed communication – ss bus

Field work begins

Reflection

December

Communication throughout the year around the results - staff survey to be on every cascade – divisional updates, you said we listened.

Action planning and focus groups,

Communication to be launched to highlight progress prior to Launch.

8 week detailed communication – ss bus

Field work begins

Continuous Improvement

Continuous Engagement and Feedback

Sharing results via a controlled means affords the chance for teams to start earlier with their responses to feedback. It builds a better foundation for outcomes

Therefore, we will be able to share more positive improvements that are already in place putting us in a more favourable position for the 2023 survey.

Continuous Improvement Loop

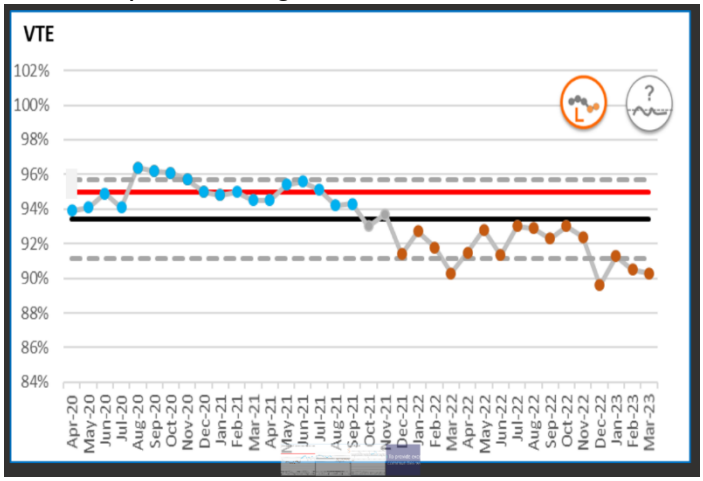
A venous thromboembolism is a blood clot that forms in a vein. The Department of Health requires all Trusts to assess patients who are admitted for their risk of having a VTE. This is to try to reduce preventable deaths that occur following a VTE while in hospital. We report our achievements for VTE against the national target (95%).

Indicator	**The percentage of patients who were admitted to hospital and who were risk assessed for**			
Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm.**			
SaTH 2022/23	**SaTH 2021/22**	**SaTH 2020/21**	**SaTH 2019/20**	**SaTH 2018/19**
90.5% (Feb 2023) Reporting one month in arrears	93.8% (Feb 22)	94.5%	94%	95.8%
Data source - Statistics » Venous Thromboembolism (VTE) Risk Assessment (england.nhs.uk) From April 2019 the data collection changed to include 16 and 17 year old patients. From December 2019 the collection and publication of the VTE data paused due to the COVID-19 pandemic. In 2021/22 the Trust reinstated the monitoring of VTE. The figure provided is taken from the current PAS system (SemaHelix) and Vital pack system.				

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. It is also monitored at Divisional level through the monthly Divisional Performance Review Meetings. Compliance with VTE has declined in 2022/23, particularly since December 2022. Improvement work in relation to compliance is being led by our Medical Director.

Actions being undertaken to improve compliance include:

- A pilot is being undertaken on AMU to use prompts on the patients' case notes to ensure the completion of VTE assessments.



- Ongoing communication with Divisional medical directors, clinical directors, consultants, matrons and ward managers to identify any outstanding VTE assessments and ensure completion in a timely manner.

PATIENT SAFETY INCIDENTS AND THE PERCENTAGE REPORTED THAT RESULTS 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. Due to a change in reporting, NRLS no longer produces reports in the same way and therefore there is no comparator data.

The number and, the rate of Patient Safety Incidents reported within the Trust during 2022/23 and the number and percentage of such Patient Safety Incidents that resulted in severe harm or death.

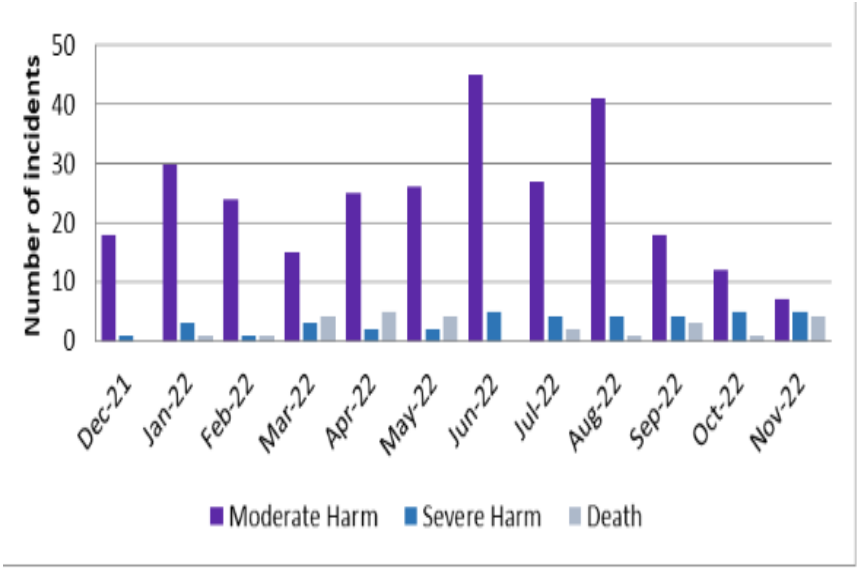
1. rate of incidents reported per 1,000 bed days
2. rate of incidents that resulted in severe harm or death per 1,000 bed days
3. number of incidents resulting in severe harm or death
4. % of severe harm or death over number of reported incidents are shown.

Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm**			
	SATH 8-- month period 1 Apr 2022-30 Nov 2022	**SATH 2021/22**	**SATH 2020/21**	**SATH 2019/20**
Number of Patient Safety Incidents	1,3756	18,000	13,011	13,984
Rate of Patient Safety incidents per 1,000 bed days	72.3	74.75	65.06	57.9
Severe harm or death	51	56	35	28
Percentage of Patient Safety Incidents which resulted in severe harm or death	0.37%	0.31%	0.27%	0.20%
Rate of Severe/death incidents per 1,000 bed days	0.29*	0.23	0.16	0.1

Data Source - For incidents occurring in England from 1 April 2022 to 30 November 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/

SaTH continues to be a high reporter of incidents which may represent a positive reporting culture.

The graph below identifies the number of incidents reported per month alongside the number resulting in moderate and severe harm, from December 2021 to November 2022.



RATE OF CLOSTRIDUIM 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 2022/23 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 twoor over**		
Domain	**Treating and caring for people in a safe environment and protecting them from avoidable harm**		
SaTH 2022/23	SaTH 2021/22	SaTH 2020/21	SaTH2019/202
20.63	12.6	13.64	19.44
Data Source - https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-byprior-trust-exposure			

SaTH 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 for the Trust for 2022/23 was no more than 33 cases of Clostridium Difficile, there were 60 cases in total meaning the Trust did not achieve its target this year.

All Clostridium Difficile cases attributed to the Trust continue to have a Root Cause Analysis (RCA) Investigation undertaken. Common themes remaining similar to previous years: Antibiotics usage, timely obtaining of stool samples and isolation continue. The Trust has invested in more Redi-rooms (portal isolation facilities) to increase the capacity to isolate patients in a timely way, provided more education in relation to taking stool samples and will be working with the multi-disciplinary team internally and across the Integrated Care System in relation to anti-microbial prescribing and the use of medication such as Proton Pump Inhibitors which increase the risk of these infections.

2.4 Looking forward: Our Priorities for Quality Improvement 2023/2024

The quality priorities for 2023/24 are based on the Quality Strategy and key workstreams which we want to continue to develop or implement in 2023/2024. The quality priorities for 2023/24 include our known areas of risk, themes from the regulatory compliance work-stream, and the requirement to implement the NHS Patient Safety Strategy.

QUALITY PRIORITIES 2023/2024

1. **SAFE:**

Learning from Events and Safety Culture	Measurement
Priority 1: Integrate learning from both positive and negative incidents, utilise electronic communications, newsletters, staff briefs and forums, safety boards, quarterly learning and sharing forums and an annual Trust safety conference.	• Implementation of PSRIF • Safety Conference • Shared learning • Safety Huddle rollout • Safety boards
Deteriorating patient	**Measurement**
Priority 2: Identify, escalate and timely intervention of deteriorating adults and children.	• Training course implementation and compliance • BLS/PLS compliance • Treatment Escalation Form (TEP) form implementation • Reduction in incidents relating to these themes.
Inpatient falls	**Measurement**
Priority 3: Continuing work on the principles of cohorting will be a main priority for 2023-24 alongside work to help prevent deconditioning. We will implement a new Trust Falls training programme which is two-yearly across all nursing and AHPs and develop a bespoke training programme for our medical staff. We are going to review our EPS Policy and risk assessment and continue to recruit and our Enhanced Care Supervision Team in	• Reduction of falls • Revised Policy and Risk Assessment. • Recruitment and implementation of EPS team, • Evaluation of EPS Team via audit • Re-conditioning Dashboard • Training Compliance

2023/24 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.	

2. EFFECTIVE:

Right care, right place, right time	Measurement
Priority 4 Ensure improved patient experience in our Emergency Departments, reducing waiting times, timely decision making and intervention.	• Activity Data • Reduction in incidents relating to these themes Performance data • Audits – SOPs & National Standards • Triage performance • Reduction in incidents relating to these themes • Acute Floor Data
Priority 5 Improve our admission and discharge processes through the Trust, ensuring our patients are receiving the right care, in the right place at the right time.	Dashboards to outline: • Number of discharges < 10am, 12 midday • Reduction in number of patients with no criteria to reside • Discharge process audits • Roll out Criteria Led Discharge
Best Clinical Outcomes	**Measurement**
Priority 6 Address and improve care with people with diabetes through close working with system partners	• Establishment of commissioning agreement for diabetic services with ICB • Evidence of meetings of system clinical advisory group • Reduction in hospital admissions with primary diagnosis of complication of diabetes • Reduction in amputations in people with diabetes • Development of OPAT service for suitable patients with diabetes associated infections • Evidence of MDT educational programme for secondary, community and primary care Training compliance • Audit compliance • Reduction in incidents relating to these themes

3. PATIENT EXPERIENCE

Learning from Experience	Measurement
Priority 7: Demonstrating that as a Trust we are learning and improving patient, carer and public experience through complaints, patient surveys, feedback and compliments,	• Evidence of the learning from complaints within our services • Functioning speciality PACE panels • All wards to have a "You said, We did" Quality Board • Improve our ratings in the national staff survey for the question *"I would be happy for a member of my family to receive care in the Trust"* • Improve complaint response performance, reduction in complaints with related themes and completion of actions and evidence of learning.
Vulnerable Patients	**Measurement**
Priority 8: Improve the care of patients with a Learning Disability or Autism cared for in the Trust	• Agree and embed the LD and Autism Charter • Oliver McGowen training compliance for frontline staff • User feedback.
Palliative and End of Life Care	**Measurement**
Priority 9: Continue with delivering the Trusts PEOLC strategy with a focus on improving our care after death through ongoing education, support and monitoring	• Delivery of strategy milestones • Compliance with Care after Death Training. • Wards completing PEOLC Supportive Ward Visit Programme • Audit data • New PEOLC Education Programme following benchmarking • PEOLC training compliance

3.0 OTHER INFORMATION RELEVANT TO THE QUALITY OF CARE

3.1 PERFORMANCE AGAINST THE RELEVANT INDICATORS AND PERFORMANCE THRESHOLDS

SaTH 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.

Indicator	Performance against the NHS Oversight Framework					
Oversight theme - Quality of care, access and outcomes	**2022/23**	**Best Trust 2022/23**	**Worst Trust 2022/23**	**2021/22**	**2020/21**	**2019/20**
Total patients waiting more than 52 weeks to start consultant-led treatment.	Jan 23 3169	Jan 23 0	Jan 23 27988	Mar 22 2282	Mar 21 3271	Mar 20 37
Total patients waiting more than 78 weeks to start consultant-led treatment.	Jan 23 401	Jan 23 0	Jan 23 4227	No data collection – new standard introduced to Operational plan 2022.		
Total patients waiting more than 104 weeks to start consultant-led treatment.	Jan 23 0	Jan 23 0	Jan 23 226	Mar 22 61	Mar 21 0	Mar 20 No data collection pre-COVID-19
Total patients waiting over 62 days to begin cancer treatment (% referral to treatment time – National Target 85%)	Apr – Feb 23 48.5%	Jan 23 90.4%	Jan 23 27.7%	Apr-Mar 62.5%	Apr-Mar 75.1%	Apr-Mar 73.3%
Proportion of patients meeting the faster cancer diagnosis standard (National target 75%).	Apr – Feb 23 60.7% (Cancer data reported one month in arrears)	Jan 23 87.5%	Jan 23 35.3%	Aug-Mar 22 61.1% Data collection began in August 2021 – new standard introduced to Operational plan.		

3.2 OTHER QUALITY INFORMATION

NATIONAL PATIENT SAFETY ALERT 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. 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 SaTH 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. Any new NPSA alerts go to the weekly Review, Action and Learning from Incidents Group (RALIG) and an Executive lead is nominated by the Medical Director (Chair of RALIG), to link in with the relevant team; the NPSA alerts are then presented at RALIG and approved for closure. The Medical Director and Director of Nursing monitor the NPSA alerts via a Quarterly report presented at the Quality Operational Committee.

During 2022/2023 the Trust received 11 National Patient Safety Alerts (to date). All have been actioned, none have breached their deadline.

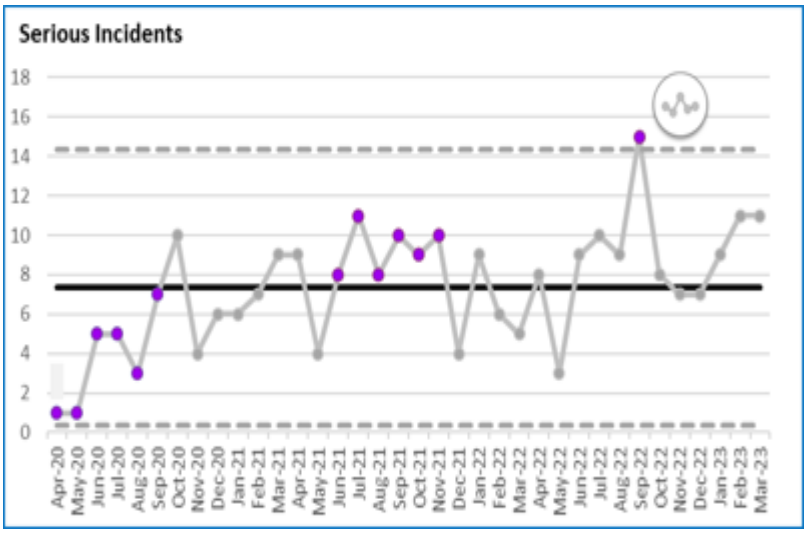
Alert Identifier	Alert Title	Issue Date	Closure Target Date	Date Closed	Open/ Closed
NatPSA/2022/002/MHRA	Philips Health Systems V60, V60 Plus and V680 ventilators – potential unexpected shutdown leading to complete loss of ventilation	05/04/2022	31/05/2022	26/04/2022	Closed
NatPSA/2022/003/NHSPS	Inadvertent oral administration of potassium permanganate	05/04/2022	04/10/2022	21/06/2022	Closed
NatPSA/2022/004/MHRA	NovoRapid PumpCart in the Roche Accu-Chek Insight insulin pump: risk of insulin leakage causing hyperglycaemia and diabetic ketoacidosis	26/05/2022	26/11/2022	09/06/2022	Closed
NatPSA/2022/005/UKHSA	Contamination of hygiene products with Pseudomonas aeruginosa	24/06/2022	03/07/2022	01/07/2022	Closed
NatPSA/2022/006/DHSC	Shortage of alteplase and tenecteplase injections	03/08/2022	10/08/2022	10/08/2022	Closed
NatPSA/2022/007/MHRA	Recall of Mexiletine hydrochloride 50mg, 100mg and 200 mg Hard Capsules, Clinigen Healthcare Ltd due to a potential for underdosing and/or overdosing	04/08/2022	12/08/2022	10/08/2022	Closed
NatPSA/2022/008/MHRA	Recall of Tarocid 200mg powder for solution for injection/infusion or oral solution, Aventis Pharmac Ltd due to the presence of bacterial endotoxins	21/10/2022	26/10/2022	21/10/2022	Closed
NatPSA/2022/009/MHRA	Prenoxad 1mg/ml Solution for Injection in a pre-filled syringe, Macarthys Laboratories, (Aurum Pharmaceuticals Ltd), caution due to potential missing needles in sealed kits	10/11/2022	17/11/2022	11/11/2022	Closed

NatPSA/2023/001/NHSPS	Use of Oxygen Cylinders where patients do not have access to piped medical gas	10/01/2023	20/01/2023	19/01/2023	Closed
NatPSA/2023/002/CMU	Supply of Licenced and Unlicenced Epidural Infusion Bags	23/01/2023	27/01/2023	27/01/2023	Closed
NatPSA/2023/003/MHRA	NIDEK EyeCee One preloaded and EyeCee One Crystal preloaded Intraocular Lenses (IOLs): risk of increased intraocular pressure	01/02/2023	16/02/2023	09/02/2023	Closed

SERIOUS INCIDENTS

All Patient Safety Incidents (PSI) are reported on the hospital electronic incident management system (Datix). All PSIs are reported, monitored and reviewed to identify learning that will help prevent reoccurrence. During 2022/2023 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.

Review, Action and Learning from the 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	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
2019/20	3	2	3	2	3	5	5	6	8	12	2	5	56
2020/21	1	1	5	5	3	7	10	4	6	6	7	9	64
2021/22	9	6	8	11	8	10	9	10	4	9	6	5	95
2022/23	8	3	9	10	9	15	8	7	7	9	11	11	107

T10he incidents reported as Serious Incidents (SIs) are monitored via the Quality Operational Com1mittee and Quality and Safety Assurance Committee and reported to Board as part of the Incident Management Overview Report. In 2022/2023 the Trust saw an increase in the number of incidents reported as Serious Incidents, with 107 SIs reported compared to 95 in 2021/22.

NEVER EVENTS 2022/23

Never Events are serious, largely preventable PSIs that should not occur if the available preventative measures have been implemented. In 2022/2023 SaTH had three incidents which met the definition of a Never Event. Thorough investigations are undertaken for Never Events and robust action plans are developed to prevent similar occurrence.

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

Never Event			
SATH 2022/23	**National Average 2022/23**	**Best Performing Trust 2022/23**	**Worst Performing Trust 2022/23**
3	2.3	1 (But nil reporters do not appear on the list)	9

Date	Description of Never Events 2022/23 at SATH
June 2022	Retained foreign body
November 2022	Wrong site procedure
January 2023	Retained product

Learning from the Never Events in 2022/2023 included:

- Work to incorporate LOCCSIPS chest drain checklist into chest drain packs for Emergency Departments
- Replacement of old equipment and equipment included in theatre count
- Reinstate use of primary beam markers for plain film X-rays which was stopped due to IPC guidance during COVID-19 (reinforced via huddles and team meetings and currently with ongoing audit).

FRIENDS AND FAMILY TEST

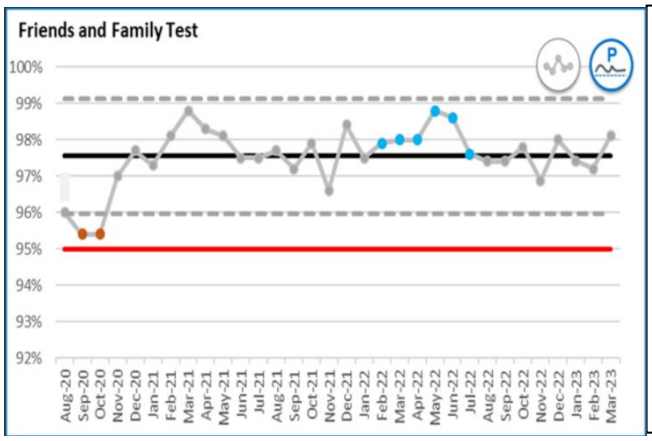
The Friends and Family Test (FFT) is a national survey which was introduced to provide an easy way for people accessing services to provide feedback. The feedback measures how satisfied the person was with their experience of the service. FFT scores are available for each ward and department, by Division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

A national standardised question is asked:

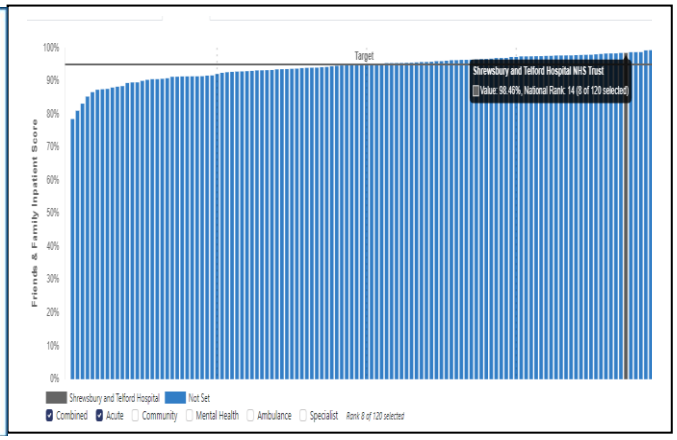
'Thinking about [the area accessed], overall, how was your experience of our service?'

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. Performance for the FFT score throughout the year is shown.

FFT Score



Comparison of SaTH (black line) with other Trusts



The Trust continues to perform well, with the monthly FFT score above the national target of 95% throughout 2022/23.

Whilst national reporting of the response rate ceased from 1 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.

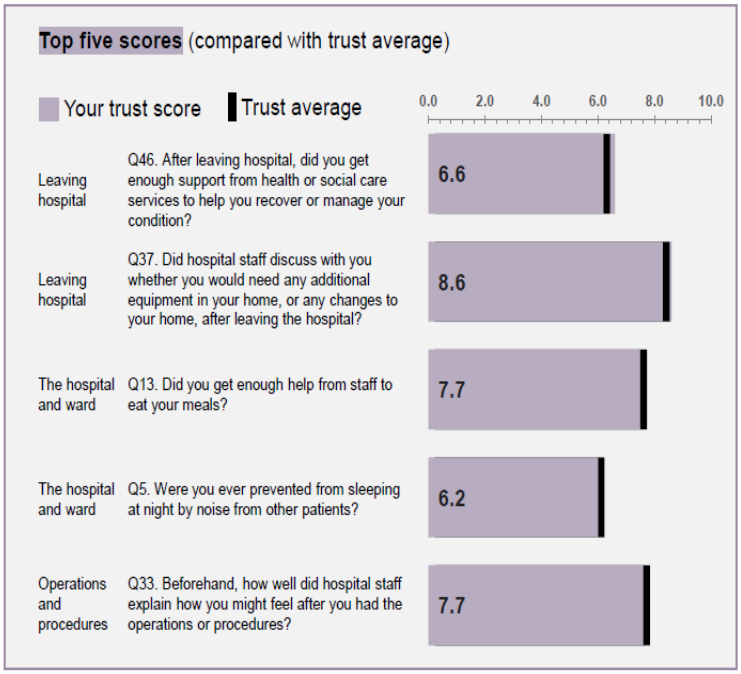
The FFT response rates across the Trust were higher in Quarters 1 to 3 in 2022/2023 in comparison to the previous year in inpatient areas at 16.8% (increase of 3%), however response rates were lower in A&E at 1.04% (reduction of 2.36%) and in Maternity (birth only) at 5.8% (reduction of 7.8%). Improving 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.

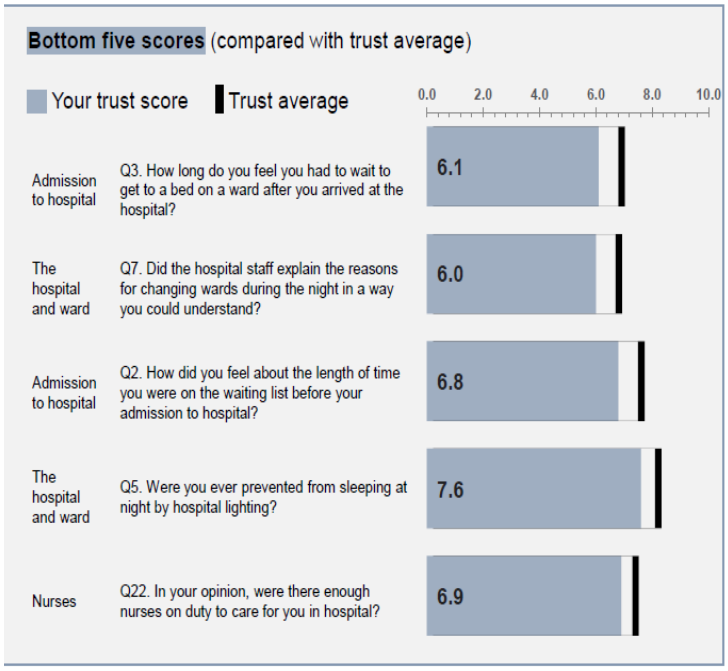
Friends and Family feedback can be provided through completion of paper cards, and via the Trust website. A QR code to provide FFT feedback has been introduced to patient discharge summaries. Posters and laminated cards with QR codes have been provided to Wards and Departments to promote and encourage patients to provide feedback. Volunteers are being recruited to support capturing patient feedback, including FFT responses and a trial of 'Short Message Service' (SMS) texting for gaining feedback will commence for the Emergency Departments in 2023/24.

NATIONAL INPATIENT SURVEY

The National NHS Adult Inpatient Survey (2021) was undertaken between January and May 2022 and included patients meeting the eligibility criteria who were discharged from the Trust in November 2021. Patients were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. The Trust had a response rate of 39%, which was 4% below the 2020 Trust response rate however, comparable to the national average (39%). Of the completed responses, 84% relate to urgent/emergency admissions and 16% to planned inpatient admissions.

The best and worst performance relative to the Trust average are calculated comparing the Trust results against the national average across England, identifying the bottom and top five scores. The bottom and top results for the Trust were:





In the 2020 National Inpatient Survey, the Trust scored low in response to questions relating to noise at night. However, in the 2021 survey the Trust scored high compared with the Trust average for disruption to sleep due to noise from other patients and demonstrated a statistically significant improvement in patients reporting being disturbed due to noise at night from staff. Whilst this suggests a positive impact in relation to increased emphasis across clinical teams, disturbed sleep due to lighting requires further focus.

Results have been reviewed and used to inform questions used within the local inpatient survey. The survey has been updated to inform focused work and measure improvements at a local level and will be introduced from the 1 April 2023.

NATIONAL MATERNITY SURVEY

The National NHS Maternity Survey (2022) was undertaken between April and August 2022 and included women meeting the eligibility criteria who had a live birth in February 2022. The Trust had a response rate of 46.2%, comparable to the national average (45%).

The Trust performed 'about the same' as other Trusts for the majority (45) of questions and no questions scored worse than expected. The Trust scored 'better' than most Trusts for two questions, and 'somewhat better' than most Trusts for 4 questions.

The results of the survey provide the Trust with two important measures of how they have performed. Firstly, a comparison of the Trust's score for each question compared to the previous year and secondly a comparison of how the Trust performed compared to other participating Trusts.

Comparing the eight sections in the survey, the illustration below demonstrates the Trust's comparative position between 2022 and 2021, reflecting an improvement in the section relating to feeding.

	2021 *(rating compared to 2019)*								**2022** *(rating compared to 2021)*						
	Much Worse	Worse	Somewhat Worse	About the same	Somewhat Better	Better	Much Better		Much Worse	Worse	Somewhat Worse	About the same	Somewhat Better	Better	Much Better
The start of your care during pregnancy				■								■			
Antenatal check ups				■								■			
During your pregnancy				■								■			
Your labour and birth						■						■			
Staff caring for you					■							■			
Care in hospital after birth					■							■			
Feeding your baby				■										■	
Care at home after birth				■								■			

When comparing the Maternity Survey results for 2022 to the preceding 2021 results, there was a significant decline in two key areas; women's concerns during labour and birth being taken seriously and women given the help they needed after contacting a midwifery/health visiting team. It is important to note that neither of these questions were statistically worse than any other Trusts nationally, however, they will be a key area of focus for improvement which will be monitored by the Maternity Team.

LEARNING FROM PATIENT EXPERIENCE

The Patient and Carer Experience (PaCE) Panel consists of public and staff representatives who work together in a collaborative approach towards quality improvement and patient experience within the Trust. A new structure for the PaCE Panel was agreed and commenced in 2022. The PaCE Panel is chaired by the Director of Nursing and co-chaired by a patient representative, strengthening the patient voice.

Speciality Patient Experience Groups have been established in Medicine, Urgent & Emergency Care, Surgery, Anaesthetics & Cancer, Clinical Support Services and Corporate Services, Maternity and Women's Health. A Children & Young People Patient Experience Group is in the process of being established to seek input and engagement of young people in improvement work.

The Trust has recruited additional patient representatives to support the Speciality Patient Experience Groups which remain in their infancy and people accessing services within the Trust are being encouraged to apply to further increase the number of patient partners involved in these workstreams.

The Speciality Patient Experience Groups are reviewing feedback at a local level to enable themes to be identified from a range of sources including Friends and Family Test responses, national survey results, local surveys, compliments, concerns, and complaints. The groups have identified priorities on which to focus to support improvement through co-development.

MATERNITY IMPROVEMENTS

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.

The final report of the independent review of maternity services at the Trust was published on the 30 March 2022. The report outlined repeated failures in the quality of care and governance at the Trust throughout the last two decades. 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 SaTH. Throughout 2023/2024 the Trust will continue its commitment to implement all actions to ensure these improvements are achieved.

With regards to the overall responsibility for leading on the delivery of all the required actions (both reports), the breakdown is shown:

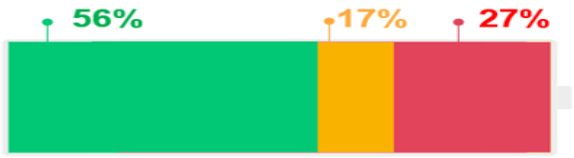
LEAD AGENT	NUMBER OF ACTIONS
Internal (Trust only)	172
External (combined Trust- external agencies)	38

The update in in relation to the progress against these actions is shown.

First Ockenden Report (2020) **Final Ockenden Report (2022)**

In relation to the First Ockenden report of the 52 actions:

- 42/52 Actions (80.8%) 'evidenced and assured'
- 5/52 actions (9.6%) 'delivered, not yet evidenced'
- 5/52 actions (9.6%) 'not yet delivered'.



In relation to the final Ockenden Report, of the 158 actions:

- 88/158 actions (56%) 'evidenced and assured'
- 27/158 actions (17%) 'delivered, not yet evidenced'
  43/158 actions (27%) 'not yet delivered'.

Progress is monitored monthly at the Ockenden Transformation Committee which the public can attend.

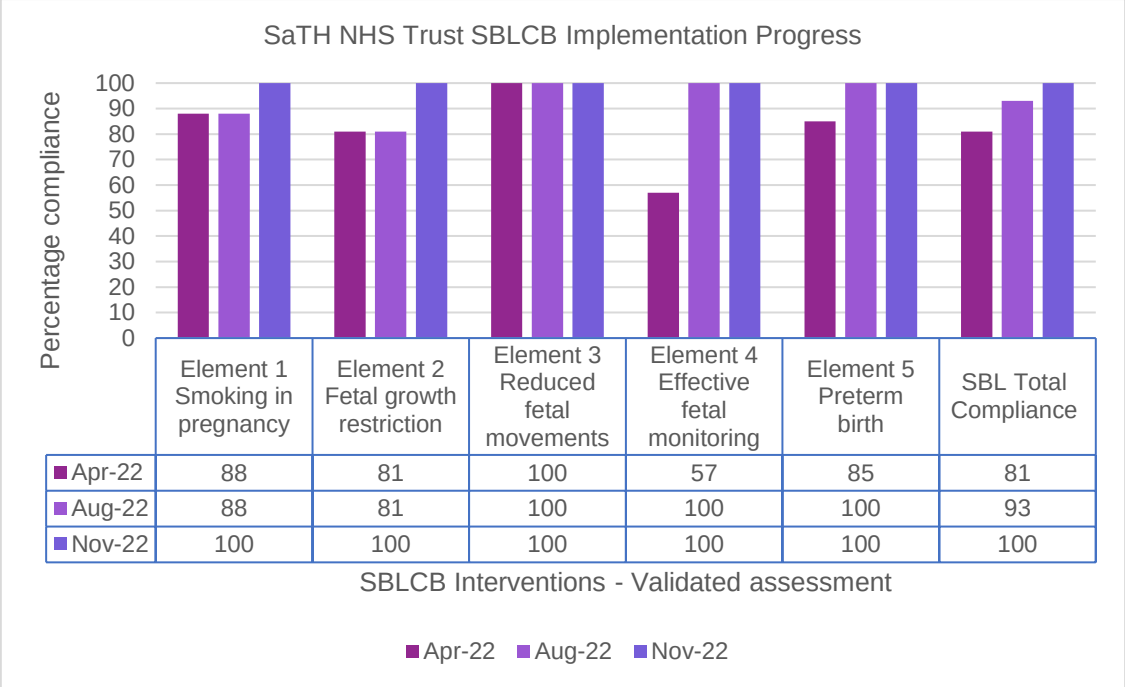
MATERNITY IMPROVEMENT WORK

1, Health Education England's Pre-Registration Quality Intervention Review Report for pre-registration midwifery placement experience was published in 2022. The results were positive, outlining that:

- Midwifery students felt that there is a wealth of learning opportunities available to them, and that they felt supported and valued as a member of the team.
- Students within their final year of their programme felt listened to when they have offered feedback and recommendations for improvements, and that the changes which have been implemented have enhanced their programme experience.
- All Pre-registration Midwifery students that the HEE panel met with advised that they would recommend the Trust as a place to train, with a student advising 'honestly, I think it's the best place to train'.
- The HEE panel also recognised that the Trust retained 100% of their final year Pre-registration Midwifery students who qualified in 2021 and are now employed as Newly Qualified Midwives at the Trust.

2. The Trust Maternity Services were finalists at the Patient Experience National Network Awards (PENNA) for its co-produced Maternity User Experience (UX) initiative. A brilliant example of how our services working with the Maternity Voices Partnership (MVP) to listen and respond to our families to ensure we are providing safe, kind and compassionate care.

3. Achievement of the Saving Babies' Lives Care Bundle and Clinical Negligence Scheme for Trusts (CNST- SA6) Year 4 achieving full compliance with the 10 safety maternity actions to support safety improvements in maternity.



INFECTION PREVENTION AND CONTROL NHSE REVIEW

Throughout 2022/2023 the Trust has worked hard to ensure high standards of IPC practices are maintained, working with NHSE/I who have undertaken sustainability visits. In March 2023 the sustainability visit demonstrated a continued and sustained IPC programme was in place across the Trust, our Green RAG rating was maintained, and it was confirmed that as such the enhanced oversight from NHSE will now revert to standard oversight moving forward.

Section 4: Statements from External Organisations

Healthwatch Telford & Wrekin

Review and Feedback – Shrewsbury and Telford Hospital NHS Trust (SaTH) Quality Account April 2022 – March 2023

Healthwatch Telford & Wrekin (HWT&W) has closely engaged with SaTH since our foundation in 2013. Our role is as the independent champion for patients, relatives and the community to work with all public Health and Care providers in the ICS footprint (Telford and Wrekin) to seek continuous improvement of all relevant services.

We support the journey of SaTH in all parts of your quality improvement programme in your aim "Getting to Good". This we note includes all actions to improve your CQC rating overall as inadequate and needing improvement in a number of areas, including your actions to improve A&E services and performance along with care of children and young people with mental health issues. Also, your interface with Care Services to improve the outcomes of discharge of older and more vulnerable patients. We support your Ockenden action plan to improve all Women's Maternity services and the work of your Hospital Transformation programme to improve your estates and provision of improved medical equipment.

We have reviewed all parts of your Quality Accounts including the Eight Priorities for quality improvement:

- Learning from events and developing a safety culture
- Care for the deteriorating patient
- Reducing inpatient falls
- Achieving the best clinical outcomes
- Right Care, right place, right time
- Learning from Experience
- Care of Vulnerable Patients
- End of Life Care.

We have reviewed each priority and note what has been achieved, what has not yet been achieved and where there is still significant work to do:

- We welcome the emphasis on regular staff huddles, the growth of a safety culture, staff able to raise concerns and multi–disciplinary teamwork
- Early action on any deterioration and care re sepsis plus risk assessments for falls and reduction of deconditioning by building self-confidence and mobility.
- Best outcomes through innovation, NICE standards and Clinical Audits.
- Right care through Discharge to Assess, Improvement Groups, reducing ward changes Acute Floor, and Trauma Assessment and the improved Discharge Lounge.
- Better Patient Engagement and Feedback and improved Complaints procedures,

We particularly welcome improved Safeguarding Training, Dementia Screening, and A Dementia Friendly Hospital approach with improved approaches to Learning Disabilities and Mental Health services. We welcome improved actions on Palliative and End of Life Care. We note the detail of the actions and outcomes of your Clinical Audit Tables.

HWT&W will continue to support SaTH in its continuous improvement programme and look forward to working with your team.

Simon Fogell

Chief Executive

Healthwatch Telford and Wrekin

Meeting Point House

Southwater Square

Shropshire

TF3 4HS

Integrated Care System
Shropshire, Telford and Wrekin

Our Ref: VW/ICBQA

6 June 2023

For the Attention of Hayley Flavell

Executive Director of Nursing

The Shrewsbury and Telford Hospital NHS Trust

Dear Hayley

Re: Quality Account 1 April 2022 - 31 March 2023

Thank your request for feedback on this year's quality account. Please find the ICB feedback below.

NHS Shropshire Telford and Wrekin Integrated Care Board are pleased to have had the opportunity to review the Shrewsbury and Telford Hospital NHS Trust (SaTH) Quality Account for 2022/23.

It is the ICB's view that the account accurately reflects the achievements made by SATH in 2022/23 and the priority areas identified. SaTH has worked collaboratively with partners in the integrated care system (ICS) as we grow our ICS to address the needs of the population and improve the quality of healthcare services within it.

The ICB has been fully sighted on the challenges of flow in the Emergency Department as well as ensuring safe and effective discharge and acknowledges that this remains a significant challenge which the system will focus on into 2023/24.

It is pleasing to note the ongoing improvements particularly in palliative and end of life care, falls prevention and right care in the right place. The report also reflects the extensive work which is ongoing in relation to CQC feedback in the Getting to Good Programme, as well as the nationally mandated quality indicators. The staff survey results are a priority area for improvement as is the ongoing work around the deteriorating patient, venous thromboembolism (VTE) and measured health care associated infections.

Maternity services have been under considerable scrutiny over recent years, and it is positive to see the marked improvements in outcomes and achievement of all 10 safety maternity actions to support safety improvements in maternity. The feedback from the women and families that use these services are key, and there are some associated improvements in the National Maternity Survey. There is strong governance around this agenda and support to further progress this as a system and with the voice of those who use the service.

In conclusion, the ICB views the 2022/3 Quality Account as an accurate picture of the challenges the Trust faces and evidence of improvements in key quality and safety measures. The ICB recognises the Trust's commitment to working as a partner in the system to ensure the ongoing delivery of safe, high-quality services for the population of Shropshire Telford and Wrekin and our neighbours.

Yours sincerely

Vanessa Whatley

Director of Quality and Safety/Deputy Chief Nurse

NHS Shropshire, Telford and Wrekin

E: vanessa.whatley@nhs.net

M: 07813965359

T: @whatleyvj

PA: Lisa.Rowley2 - email@nhs.net

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