Healthwatch Shropshire response to the draft SaTH Quality Account 2022-23

Healthwatch Shropshire (HWS) welcomes the opportunity to comment on the Quality Account. The feedback we received during this period predominantly concerned quality of treatment, waiting lists, general service issues, quality of care and communication. Overall we heard from 281 people, their feedback raised more negative aspects to their experiences (75%) than positive aspects (25%).

Priorities 2022-23

Learning from events and developing a safety culture

HWS is pleased to see that the Trust has achieved 3 or the 4 goals it set out under this priority. It is concerning that achieving the 3 goals, standardising the process for safety huddles throughout the wards, embedding the Quality Governance Framework across the Trust and implementing the Patient Safety Incident Response Framework, has not increased the percentage of staff who would feel secure raising a concern about unsafe clinical practice and feel confident that the Trust would address these concerns, both measures having declined compared to 2021-22 and remain well below the national average.

This issue was identified by the Independent Maternity Review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, "The review team has seen evidence within the cases reviewed that there was a lack of action from senior clinicians following escalation. The review team has also heard directly from staff that there was a culture of 'them and us' between the midwifery and obstetric staff, which engendered fear among midwives to escalate concerns to consultants. This demonstrates a lack of psychological safety in the workplace and limited the ability of the service to make positive changes." Ockenden review: summary of findings, conclusions and essential actions - GOV.UK (www.gov.uk)

We welcome the continued focus on this priority in the coming year but would like to see the continued use of these staff survey questions as a metric to help understanding of progress across the whole Trust.

The Deteriorating Patient

We are pleased to see the progress that has been made in developing the dashboard and implementing the training programme and hope that the continued focus for the coming year will see increased roll out of sepsis screening.

Falls

The progress in this area is very welcome and we are very pleased to see the improved outcomes for patients, especially the reduction in events leading to serious or moderate harm and those reported as Serious Incidents.

Best Clinical Outcomes

HWS is pleased to see that the targets outlined to measure the commitment to ensure teams base their practice on the best recommendations, clinical outcome monitoring, audit, and NICE compliance have been largely achieved. We look forward to the establishment of the new governance process in the coming year.

Right Care. Right Place.

Negative issues around patient discharge reported to HWS during the year have indicated that some patients have not benefited from the work that the Trust has been carrying out. However, we hope the steps taken, especially the integrated approach with other health and social care organisations, will improve the experience for all and we welcome the continued focus next year.

Given some of the poor patient feedback around access and timely care in the Emergency Department that we reported following our call for experiences of Calling for an ambulance in an emergency (Calling for an ambulance in an emergency | Healthwatch Shropshire) the implementation of the Acute Floor at RSH is very welcome and we look forward to seeing evidence of sustained benefits for patients as indicated by the initial successes reported.

Learning from Experience

We really welcome all efforts to put the patient voice at the centre of efforts to improve services. We look forward to seeing the Patient Engagement Strategy published this year and would be interested to work with the Trust to understand how the feedback we gather from our engagement work and regularly share with the Trust will form part of the strategy.

We provide the Independent Health Complaints Advocacy Service for Shropshire and have a wealth of experience of the NHS complaints process. We would be very willing to be involved with the Complaints Peer Review Panel and having just carried out a survey of people's experience of the complaints process would be able to share those insights.

While welcoming the improvement in timely response rates to complaints (53% to 59%) we still hear from many people who have not had a response within time and more importantly have not been informed that they won't have a response in time and when they have chased a response nobody has got back to them. It would also be useful to understand how the quality of learning informed by the information from complaints has improved.

We would like to have seen some examples of the improvement plans that have been implemented in response to patient feedback.

Vulnerable Patients

The development of a Learning Disability Charter and a commitment to adopt it in the coming year is welcomed.

It is disappointing to see that the aim to improve compliance with dementia screening was not achieved and even more so to see that compliance has dropped during the year from a level of just under 70% to around 50% against a target of 90%. Given this and the fact that the dementia PLACE score, although improved, remains below the national average it is disappointing that this work is not listed as a priority for the coming year.

Palliative and End of Life Care (PEoLC)
It is encouraging to see the progress being made ensuring that those nearing the end of life are cared for on the End of Life Care Plan. HWS has long heard of the distress faced by patients and their families when the approaching end of life is not recognised and planned for.

CQC Improvement Plan

The Trust is to be commended on the progress it has made during the year in completing the individual actions outlined in the plan, 92% of the actions completed with 71% of these evidenced and assured. It would be useful to understand when the Trust aims to have all completed and assured so the conditions to Regulated Activity can be removed having been in place for several years.

Participation in clinical audits and confidential enquiries

The Trust's commitment 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 is evidenced through their participation in national clinical audits and confidential enquiries.

Research and Innovation

The development of a Research and Innovation Strategy which recognises the positive relationship between research and patient outcomes is welcomed.

Data Security and Protection Toolkit Attainment

It is encouraging to see that the Trust, while not meeting all 10 standards has increased its status from 'Standards not met' to 'Approaching Standards'. We hope that the Trust will meet all standards at it's next submission in June 2023.

Learning from Deaths

We are pleased to see that NHS England has recognised the work the Trust is doing in this area as significant. We particularly welcome the mechanisms set up to share learning across the Integrated Care System, we hope this will bring benefits to care across the system.

Medical Examiner Service

Having explained the aims of the service it would be useful to understand if the service is currently meeting these targets especially given the forthcoming changes and expansion of the services covered.

Commissioning for Quality and Innovation (CQUIN)

It is particularly concerning that the CQUIN linked to 'compliance with timed diagnostic pathways for cancer services' was not achieved as the quarterly rates for the year did not rise above 19% against a target of 55-65%.

Implementing the Priority Clinical Standards for 7 Days Services

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

Encouraging Staff to Speak Up

The continuing work of the Trust to encourage staff to speak up about concerns is fully supported. It is noted that the number of concerns raised with Freedom to Speak Up (FTSU) Guardians has decreased this year which could be due to drop in reportable incidents or a reflection of the lack of confidence staff have in raising concerns, as shown in the 2022 staff survey where the Trust scores just above the worst in the benchmark group for the question, 'if I spoke up about something that concerned me I am confident my organisation would address me concern', 35.6% of staff agreed with this statement. We welcome the priorities laid out in the FTSU Strategy and we hope they will increase the levels of staff confidence.

Guardian of Safe Working (GSW)

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

Core Quality Account Indicators

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

The Trust readmission rate for adults has seen a welcome fall this year however the increase for under 16s to the highest level for 5 years is disappointing. We would have liked to see some indication on how the Trust is proposing to improve discharge for the under 16s.

The Trust Responsiveness to the Inpatients' Personal Needs

The results of the Patient Survey place the Trust 'about the same' as other Trusts. However, it was difficult to locate any actions the Trust is planning to take to improve the patient experience apart from further work to reduce sleep interruptions due to light. We look forward to seeing the results of the local inpatient survey and how they are used to drive improvements.

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

The percentage of staff who have indicated that they would recommend the Trust has fallen consistently for the last 3 years and now sits as at the level of the worst performing Trust. Hopefully the continued focus on working with staff through the continuous improvement timeline will help turn this around.

Venous Thromboembolism (VTE)

The fall in assessment rates is concerning and the causes unclear but hopefully the pilot in AMU will help improve the situation.

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

It is encouraging to see the drop in the rate of Patient Safety incidents but concerning that those resulting in severe harm or death are rising. The Trust continues to be a high reporter of incidents and suggests that this may represent a positive reporting culture. The decline in staff confidence in reporting concerns around clinical care reported earlier would not support this view.

Rate of Clostridium Difficile

After several years of decreasing rates it is disappointing to see the significant rise this year especially as the themes behind the rise continue to be similar to those from previous years.

Waiting Times (Performance against the NHS Oversight Framework)

The continued impact on waiting times due to the pandemic is evident. However, it is disappointing to see the rise in the number of cases of people waiting more than 52 weeks to start consultant-led treatment after several years of reductions. The continued fall in those waiting over 62 days to begin cancer treatment is encouraging.

National Patient Safety Alert Compliance

We are pleased to see the 100% compliance to the timely actioning of the alerts and the robust structure in place to deal with the alerts.

Serious Incidents

It is disappointing to see the increase in Serious Incidents (SIs) but again the assertion that this may demonstrate that staff have increased confidence to report incidents and concerns is not supported by the decline in staff confidence in reporting concerns around clinical care reported earlier.

Never Events

We are pleased to see that the Trust keeps patients and families informed throughout the investigation. In the past we have had reports of this not happening with SIs and the distress that it would cause.

Friends and Family Test (FFT)
It is encouraging to see that the Trust continues to perform well in the FFT and we are pleased to see the efforts they are making to increase the response rates across all departments.

National Inpatient Survey
It would have been useful to hear how the Trust is endeavouring to address the issues raised in the survey other than the issue of light disturbance at night. For example, there was a significant drop in the score of the question 'Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?'

National Maternity Survey
It is noted that the Trust performs about the same or better than all other Trusts. The Trust's proposed focus on the significant decline in 2 key areas where there was a significant decline compared to the previous year; women's concerns during labour and birth being taken seriously and women given the help they needed after contacting a midwifery/health visiting team is welcomed.

Maternity Improvements
We are pleased to see the continued progress in delivering all the actions resulting from the Ockenden Independent Review and also the various other improvements that have taken place. It is reassuring to hear the feedback from the midwifery students about the quality of their training and that they were staying with the Trust when qualified.

Infection Prevention and Control NHSE Review
We are pleased to see that the continued and sustained IPC programme in place means that the enhanced oversight from NHSE will now revert to standard oversight.

Priorities 2023 - 24

Healthwatch Shropshire supports the Trust in the choice of priorities for the coming year and are encouraged to see the continued focus on areas highlighted in this Quality Account where improvements are still sought. The new priority around patient experience in the Emergency Departments is welcomed and hopefully will address some of the findings of our report, (Calling for an ambulance in an emergency | Healthwatch Shropshire). As is the focus on diabetes care around which we are currently gathering patient experience to help inform developments in diabetes care across Shropshire.