The Shrewsbury and Telford Hospital
NHS Trust

The Shrewsbury and Telford Hospital NHS Trust

# Quality Account 2023/24

## 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

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 Clostridioides Difficile

## 2.4 Looking forward to our Priorities for Quality Improvement 2024-2025

**Priority 1**

- Integrate learning from both positive and negative incidents
- Continue our work to identify, escalate and timely intervention of deteriorating adults and children
- Reduce the number of inpatient falls and the level of harms
- Improve reporting and missed Radiology results
- Omitted doses of time critical medications

**Priority 2**: Reduce the number of inpatient pressure ulcers.

**Priority 3:** Ensure improved patient experience in our Emergency Departments, reducing waiting times, timely decision making and interventions.

**Priority 4:** 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 5:** Address and improve care with people with diabetes through close working with system partners.

**Priority 6:** Diabetic foot care: Improve foot care for people with diabetes.

**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 Quality Standards and demonstrate NICE guidance for Mental Health training.

**Priority 9:** Improve the care of patients with a Learning Disability and/or Autism cared for in the Trust.

**Section 3: Other Information Relevant to the Quality of Care**

- National Patient Safety Alert Compliance
- Serious Incidents
- Never Events
- Learning from Patient Experience
- Maternity Improvement
- Infection Prevention and Control (IPC)

# SECTION 1: INTRODUCTION

## 1.0 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OFFICER

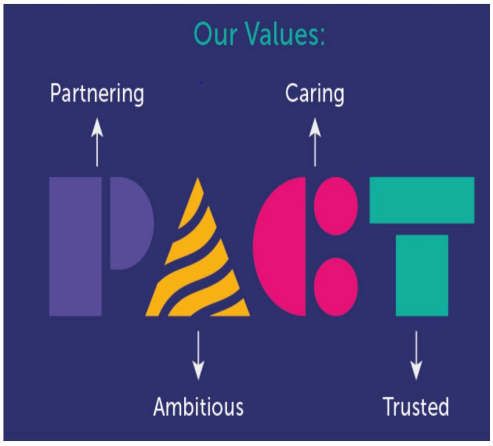
### The Shrewsbury and Telford Hospital NHS Trust

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 2023/24 Quality Account is 30 June 2024. 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

SaTH is an organisation that strives to provide high quality, safe care for our patients in an environment in which our staff feel supported and are proud to work in. As a Trust we have committed to deliver year-on-year improvements to ensure our patients and our staff remain safe and supported at all times. In collating our Quality Account, we have reflected on the last 12 months, which have been a challenging and productive year for the organisation. I am pleased to share some of our improvement work and achievements through the Quality Account for the period 2023/24.

## SECTION 2: PRIORITIES FOR IMPROVEMENT AND STATEMENT OF ASSURANCE

This section outlines the detail behind each of the quality priorities previously agreed for 2023/24 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 2024/2025 are outlined, why we have chosen these and the actions we will take to achieve these throughout 2024/25.

### 2.1 REVIEW OF THE PRIORITIES FOR IMPROVEMENT 2023/2024

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 nine 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 |
| | Priority 6: | Address and improve care for people with Diabetes (System working) |
| **PATIENT EXPERIENCE** | Priority 7: | Learning from experience |
| | Priority 8: | Vulnerable patients |
| | Priority 9: | End of life care |

Our Quality Priorities in 2023/24 were based around these nine priorities and included key actions we planned to take to achieve these overarching quality priority improvements. The priority actions for 2023/24 and our achievements against these are shown below.

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

We have continued to work to embed a forward-thinking patient safety culture across the organisation which is focused on systems learning and genuine quality improvement.

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

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

Throughout 2023/24 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 percentage of staff responding positively to the relevant safety culture elements included in the staff survey.
3. Implementation of the Patient Safety Incident Response Framework (PSIRF) in line with national guidance. Incorporates methods for sharing learning, both positive and negative through a variety of techniques including utilisation of electronic tools and learning forums.

## 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

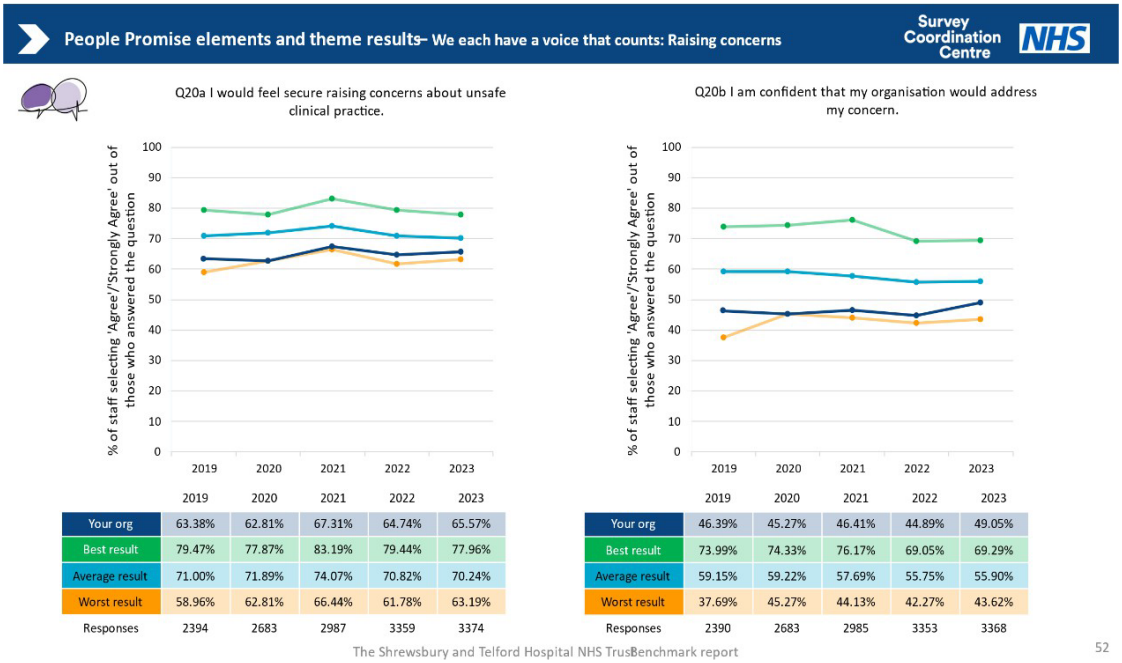
*Achieved*

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

*Achieved*

Nationally, the performance in relation to the questions about raising a concern remained the same this year. The Trust saw an increase in the number of staff who would feel secure raising a concern about unsafe practice and feel confident that the Trust would address these concerns. There remains significant work to do to ensure our teams feel able to raise safety concerns and that these will be addressed.




| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 63.38% | 62.81% | 67.31% | 64.74% | 65.57% |
| Best result | 79.47% | 77.87% | 83.19% | 79.44% | 77.96% |
| Average result | 71.00% | 71.89% | 74.07% | 70.82% | 70.24% |
| Worst result | 58.96% | 62.81% | 66.44% | 61.78% | 63.19% |
| Responses | 2394 | 2683 | 2987 | 3359 | 3374 |

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| Your org | 46.39% | 45.27% | 46.41% | 44.89% | 49.05% |
| Best result | 73.99% | 74.33% | 76.17% | 69.05% | 69.29% |
| Average result | 59.15% | 59.22% | 57.69% | 55.75% | 55.90% |
| Worst result | 37.69% | 45.27% | 44.13% | 42.27% | 43.62% |
| Responses | 2390 | 2683 | 2985 | 3353 | 3368 |

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

***Achieved***

PSIRF was implemented on 1 December 2023, which replaces the Serious Incident Framework. PSIRF is a key element of the overall National Patient Safety Strategy. 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 - it has four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of systems-based approaches 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

The incident management process within PSIRF consists of the following:

- Daily Datix Triage – identifying cases to be further reviewed at the weekly Incident Review Oversight Group (IROG)
- IROG – full weekly MDT review of incidents, commissioning of learning responses and escalation to Review Action and Learning from Incidents Group (RALIG)
- Peer Review Group – weekly quality assurance review of cases, which have been identified at IROG to be presented to RALIG
- RALIG – full weekly MDT reivew of incidents and commissioning of learning response – chaired by Executive Directors
- Duty of Candour Group – monthly assurance group

- Monthly Safety Triangulation/Learning Group triangulate themes and trends from all sources and a forum for shared learning

Processes are undergoing PDSA cycles and will continue to develop throughout 2024/2025.

For 2024/25 we have identified four PSIRF priorities:

1. Deteriorating patient
2. Inpatient falls
3. Omitted doses of time critical medication
4. Radiology – timely reporting

## Quality Priority 2: The deteriorating patient

We have continued with delivering the deteriorating patient programme of work.

### What we said we would do

1. Develop a Deteriorating and Sepsis 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 and response criteria
   - Compliance with the sepsis screening and antimicrobial treatment within 60 minutes for patients identified as high-risk sepsis
   - Serious Incidents linked with failing to recognise the deteriorating patient
   - Unplanned Intensive Care Unit admissions
   - Readmissions to Intensive Care Unit within 48 hours
   - Avoidable inpatient cardiac arrests in hours and out of hours
   - Avoidable term admissions to Neonatal Unit
   - Compliance with antimicrobial review within expected time frames

2. Revise deteriorating patient training to develop a package to include recognition of the soft signs of deterioration and develop and deliver an e-learning programme with competency assessments, for all relevant clinical staff.
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.
4. Strengthen the Deteriorating Patient Group Membership/attendance to include all interconnected systems of the deteriorating patient project and engage key staff in the improvements and reporting.

## What we have achieved

### 1. Develop a deteriorating and sepsis patient dashboard

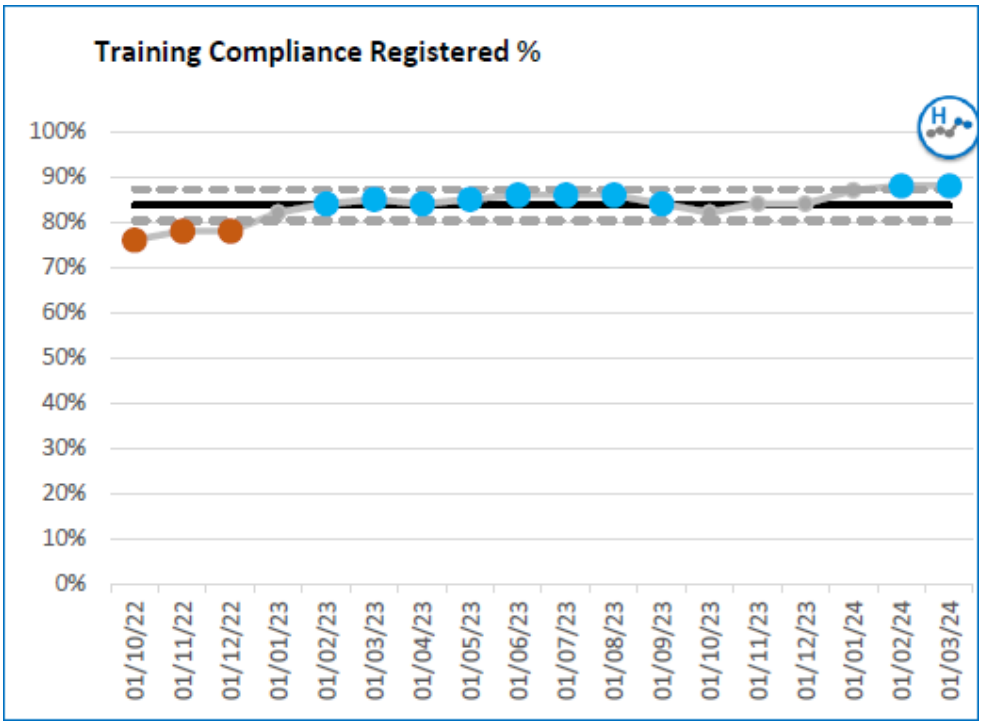
Partially achieved.

deteriorating patient dashboard has been partially developed and available on gather. This will continue to be developed in 2024/25.

### 2. Management programme training for Adult Sepsis to be implemented. 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

***Achieved***

This training has been delivered to clinical areas which had learning needs identified through patient safety and mortality incident review processes. Collectively this provided a trio of training on track and trigger tools, sepsis awareness, and contextual application to clinical practice settings. This has been supplemented by training and resources provided during trust wide update of the digital track and trigger system (Careflow vitals and Vitals Sepsis). The representative data below shows the current figures for deteriorating patient training across our adult services within these different formats.



### 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

Partially achieved

Further work has been ongoing to replicate the successful introduction of the Adult Sepsis LMS module, a maternity version has been produced and it is anticipated other specialist areas may consider following suit.

The Trust has updated the Vitals Sepsis module (within the Trust's electronic EWS system), work on this has incorporated hosting of an education package, assessment and acknowledgement of patient safety impact on the LMS system for all staff groups (in all areas utilising vitals) with a plan to go live on 28 November. This work is undertaken collaboratively with our digital and clinical colleagues.

Processes for escalation of clinical concerns and appropriate plans of care resulting from patient deterioration have been monitored through local deteriorating patient audit and CQUIN 07 (Recording of and response to NEWS2 score for planned critical care admission) data reporting.

This has informed improvement work which aligns with NICE guidance and RCP recommendations to ensure patients are seen by 'the right person at the right time in the right place' thus preventing avoidable death. One example of improvement work in this area has been the trial of individualised Treatment Escalation Protocol (TEP) forms for those patients for whom NEWS2 protocols were not appropriate. The form provides a means of clarifying and communicating ceilings of treatment and decisions regarding the appropriate escalation of treatment to enhance continuity of care across services and out of hours. Initial feedback from teams has been positive and we will report formal feedback in 2024/25.

### 4. Strengthen the Deteriorating Patient Group Membership and attendance to include all aspects of the Deteriorating Patient project and engage key staff in the improvements and reporting

***Partially Achieved***

The Deteriorating Patient Group has reviewed its "Terms of Reference" in 2023/24. The chair of the meeting is the Lead Consultant for the deteriorating patient; there has been better representation at the meetings from various disciplines; it is a requirement that divisions report on the key metrics pertinent to deteriorating patient/sepsis, and present to the group any planned work or improvement plans in relation to these for oversight.

To engage with key stakeholders, the Trust undertook two executive 'deteriorating patient' focused, away sessions.

These involved senior nursing and clinical leadership in addition to system partners, where the deteriorating patient system was looked at from end to end, exploring

intransigent problems and issues pertaining to interconnections, relationships, and processes, to identify next step actions.

Following this and in collaboration with patient safety colleagues and senior leadership teams a high-level action plan has been produced encompassing a variety of short, mid and long-term goals across the breadth of the service, which will guide the ongoing improvement strategy for the coming year.

## 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.

The quality team have continued to support wards with reconditioning activities and have a monthly activity plan to continue this work.

We have also extended this work to include staff members with reconditioning activities taking place in Stretton House and House 2 bimonthly with an end-of-year walk, raising money for SaTH charity, planned.

Monthly reconditioning meetings take place with a project plan to track progress.

### What we said we would do

1. We will continue our work around the principles of cohorting, this will be a main priority for 2023-24 alongside work to help prevent deconditioning. We are going to review our EPS Policy and risk assessment with our Enhanced Patient Supervision Team. 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. We will deliver neurological falls training for all Registered Practitioners and aim to achieve 90% by June 2025
3. 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
4. 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 fall's procedure and best practice
5. Trial the use of care trollies to reduce the need for supervisors to leave a clinical bay areas and reduce the incidents of falls

### What we have achieved

Throughout 2023/24 we have continued with our improvements to reduce the number of falls and patients who sustain harm following a fall in our care.

## 1. Sustain the Enhanced Patient Supervision (EPS) Team in 2023/24 and work undertaken to reduce deconditioning for our patients

*Achieved*

The Enhanced Care and Supervision Policy was approved and is available for staff to access on the Trust's Intranet page and the Enhanced Care Supervision risk assessment has been implemented which raises staff awareness of the need for cohorting or increased levels of supervision.

We have recruited Enhanced Care Support Workers to deliver cross-site continuous care and supervision. Enhanced Care and supervision of patients has been closely monitored and supported to ensure the right patient gets the right level of supervision for the right length of time and the Trust is better sighted on the 1:1 ECS needs of our patients. Patients receiving 1:1 have been fully engaged with reconditioning and therapies to support condition and discharges.

In terms of reconditioning, in total 92 medals have been awarded to SaTH with eight silver and three gold. This is a fantastic achievement and beneficial for our patients to help them to keep moving whilst in hospital, reduce muscle waste and functional decline.

The medals signify an area or individual that has taken part in an activity to increase movement and prevent deconditioning in or outside of the hospital. This started as a national NHSe initiative, and we took the opportunity to take part.

A bronze medal is awarded for the start of an activity, silver for evidence of sustaining an activity, gold for sharing and supporting another area to get involved – these are awarded in house initially following a submission of evidence as part of a national scheme from NHS England this ceased but is now run in house. SaTH was the very first trust to win a medal when the project launched.

A very small number of Platinum awards were handed out nationally by NHS England for outstanding contribution to the national reconditioning games project – as a trust an individual received a platinum award – just 1 of 10 awarded alongside a letter from the Regional Chief Nurse.

The Trust's Quality Team has continued to support wards with reconditioning activities and developed a monthly activity plan to continue to deliver this work. We have a theme every month, such as Valentines Day Walks and Get on Your Feet Britain Day. A celebration event took place during 2023 Falls Awareness Week, celebrating achievements. Other ward-based initiatives have grown from this, and work continues for 2024/25.

2. **To deliver neurological falls training for all Registered Practitioners with the aim to achieve 90% by June 2025** — *Achieved*

We delivered neurological falls training to 92% of our Registered Practitioners by March 2024. We will continue with the training programme during 2024/25.

3. **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** — *Partially Achieved*

We have continued to deliver the National Falls Safe Programme during 2023/4 for all patient-facing staff which is required to be completed on staff induction and then a local online two- yearly update. This has included FY1 and FY2 Doctors who have access to the face-to-face training.

4. **Ensure all patients have a falls multi-professional assessment and care plan completed on admission, and care after a fall adheres to our falls procedure and best practice.** — *Partially Achieved*

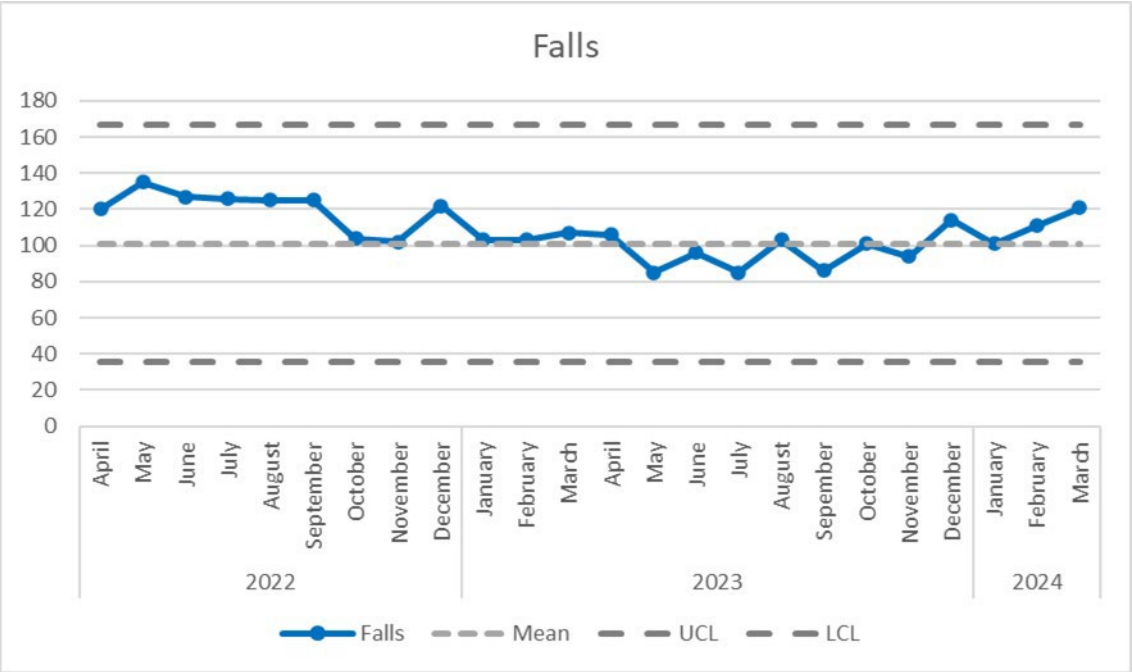
Throughout 2023/2024 we have continued to review daily and monthly the number of patients who had a falls risk assessment completed on admission. The results from these reviews show that we are consistently achieving greater than 90% compliance in both identifying falls risks through the multifactorial assessment and subsequent care plans. This work continues to be monitored via the quality team.

5. **Trial the use of Care Trolleys to reduce the need for supervising staff to leave a clinical bay area** — *Achieved*

A trial of the use of care trollies was undertaken on ward 4 as recommended by the Falls steering Group. This trial saw a reduction in the number of patient falls and will be rolled out across the Trust in 2024/25.

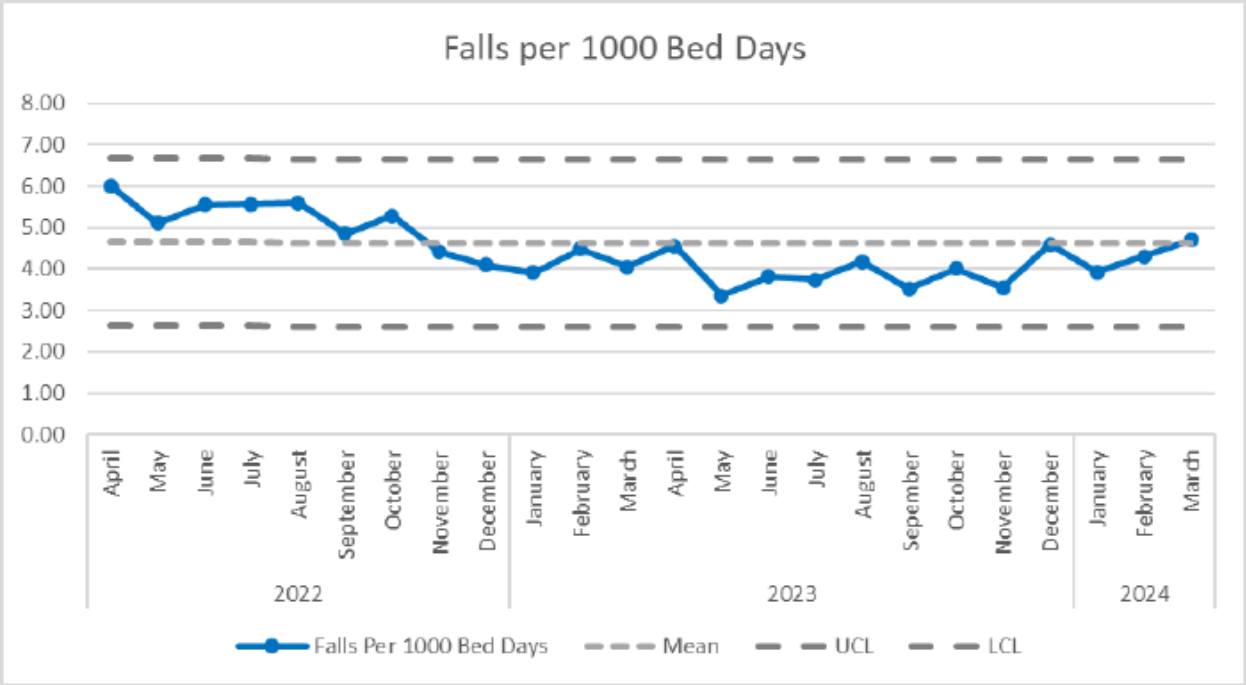
## Impact of the achievements made in 2023/2024

Number of inpatient falls increased in 2023/2024 as shown in the graph below:



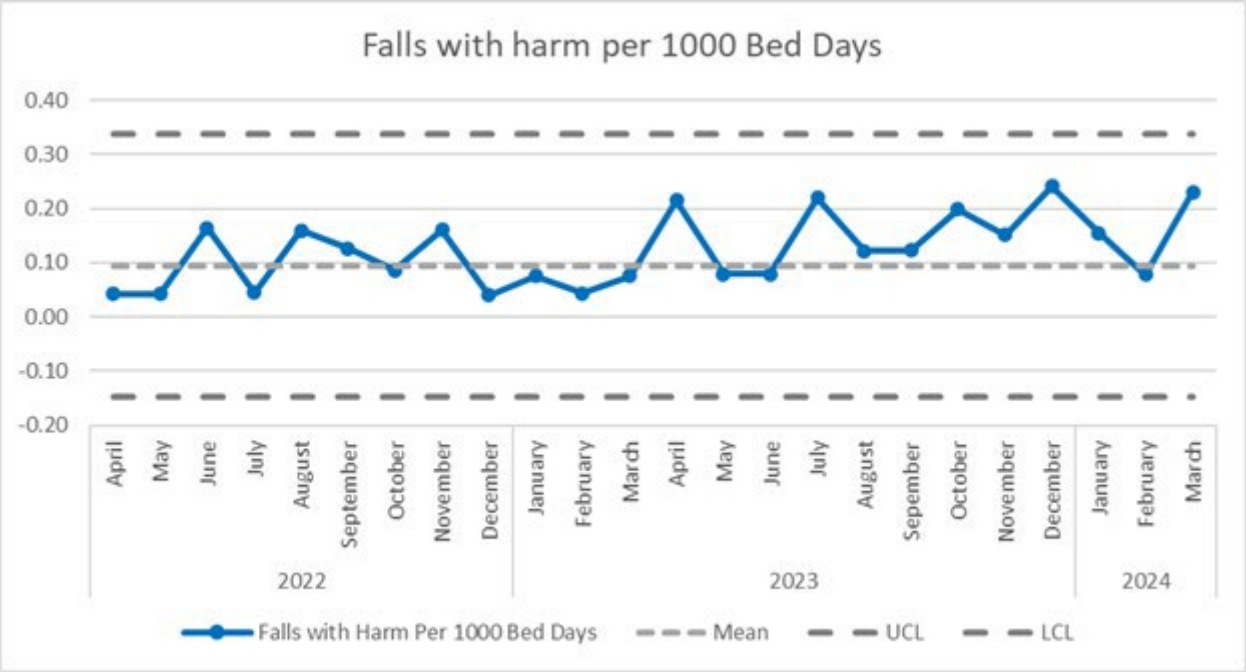

**The number of falls per 1000 bed days are shown below:**

**Falls per 1000 bed days**




This graph shows a downward trend of falls per 1000 bed days. Consistently below or just on the mean line throughout the year.

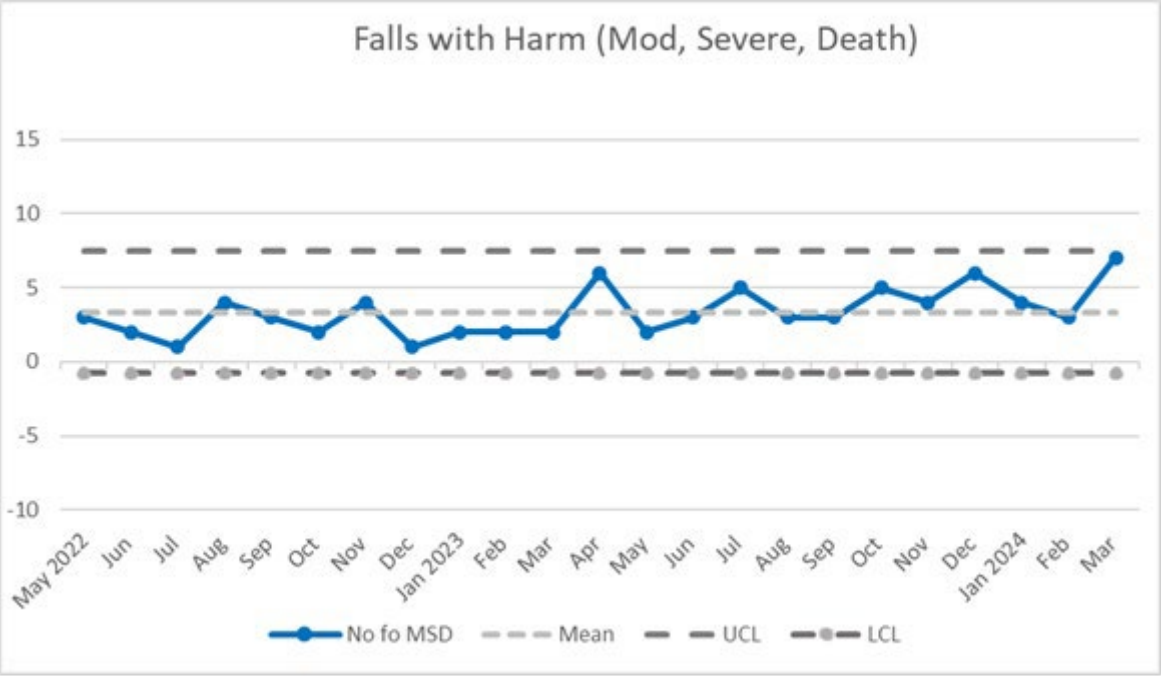
**The number of falls with harm per 1000 bed days is shown below**:




The graph shows that the Trust had 4 peaks of harm throughout the year, but subsequent months these peaks reduced towards the mean line.

The trend remains below the upper control limit throughout the year.

**The number of falls with harm (Moderate, Severe, Death) are shown below:**




In 2023/24 the Trust had 17 patients who sustained severe harm and 32 patients who sustained moderate harm.

The graph shows that the 2 peaks nearer the mean line were around the same time of year suggesting that this could be a seasonal increase. The ratio of falls per 1,000 bed days is an important indication of whether our falls interventions are having a positive impact.

A full review of falls with harm was completed to identify any themes however there were no themes identified. All pre- falls documentation and interventions were in place to mitigate against a fall occurring.

Our improvement work will continue through 2024/25 and will develop through with the leadership of our reconditioning practitioner and will be aligned to the Trust's PSIRF Inpatient falls priority.

## Priority 4: Best clinical outcomes

Ensuring we do the right things in the right way for all our patients, especially in our Emergency Departments to reduce waiting times, more timely decision making and interventions by the use of innovation and ensuring our teams base their practice on the best recommendations, clinical outcome monitoring, audit, patient experience and NICE compliance has remained a key priority throughput 2023/24.

### What we said we would do

1. Further development of clinical standards for all specialties.
2. Consistently review and monitor clinical standards and identify areas for improvement through the development of specialty 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. Ensure improvements in patient experience in our Emergency Departments, reduce waiting times, timely decision making and interventions.
6. Aim to ensure maximum use of NICE guidance by:

    - Achieving a target of 98% completion of templates within target timescales
    - Maintaining overall completion of applicable NICE guidance templates at 99.9%
    - Development of NICE Facilitator roles within the Clinical Audit Department with specific responsibility for review, benchmarking, tracking, and monitoring NICE guidance
    - Delivery of further training in NICE benchmarking for staff to ensure that templates are completed correctly, and action plans are developed to address areas of non-compliance

- Refinement of systems for ensuring local guidelines incorporate relevant NICE guidance

## What we have achieved

1. **Further development of clinical standards for each specialty, including Emergency Departments.** *Partially Achieved*

Throughout 2023/24 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. Clinical standards for all medical specialties within the organisation have been formulated. In addition, standards have been drafted for the following: Emergency Medicine, Same-Day Emergency Care, Short Stay Wards, Frailty, medical outliers, ENT and Urology. The standards are based upon national best practice parameters (e.g. NICE and specialty societies) and include a balance of quality, safety and operational metrics, so focus on quality improvement alongside operational performance.

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

Progress has been made with the development of audit templates of the quality metrics for Acute and Emergency Medicine on Gather. These templates have been 'tested' through the activities of our quality matrons by entering data for specific patients. Upon refinement, the results of the data collection 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.

The Senior Clinical Lead for the Levelling Up Clinical Standards has been in liaison with an ENT colleague following their department's efforts to collect data for each of the chosen standards on a quarterly basis. Information was obtained for each of the standards, but initial feedback is that it was a very time consuming process and by the time the analysis had taken place, the information was of historic value. Consequently, the Senior Clinical Lead will liaise with colleagues within the Clinical Audit and Quality Improvement teams.

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** *Partially Achieved*

Significant work has been carried out during 2023/24 to benchmark local maternity clinical guidelines to NICE guidance. This work will be rolled out to other specialties during 2024/25. Clinical Policies and Standard Operating Procedures are agreed and approved at the Quality Operational Committee chaired by our Medical Director. Work was undertaken during 2023/24 to establish a new governance process for the approval and sign-off of these documents and this will be implemented during 2024/25.

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

The Clinical Audit programme is 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 2023-24 further national audit clerks have moved into the central Clinical Audit Department, ensuring that the results of these audits which benchmark the Trust against all others nationally are disseminated and acted upon.

Work has been undertaken to benchmark local clinical guidelines against NICE guidance in maternity, ensuring that the ongoing programme of local guideline audits reflects evidence-based standards of care within this national guidance. Development of two NICE facilitator roles in the Clinical Audit Department has helped support this work, with further work underway with the Departmental Clinical Audit Leads to prioritise case-note audits to provide assurance that this national guidance is being implemented. All Trust clinical audits are carried out against both local and national standards and as our own key clinical standards are being developed, we can monitor performance against them through our audit programme in a constant cycle of review and improvement.

5. **Ensure improvements in patient experience in our Emergency Departments, to reduce waiting times, timely decision making and interventions** *Partially Achieved*

Following the Adult Inpatient Survey 2022 being published the subsequent actions have been taken in 2023/24:

- Results have been shared with Specialist Patient Experience Groups to inform improvement work that will feed into an overarching action plan.
- Measures to reduce waiting times for a bed such as the Next Patient initiative, Test of Change Week, MADE events and establishment of Sub-acute Wards have been introduced to support work being driven by the Emergency Department Transformation Project. This will continue into 2024/25.
- An acute medical floor and Acute Medical Facilitators have been established at RSH to support flow and access to timely treatment.

- An external company has been commissioned to undertake an audit on flow and emergency pathways.
- Pharmaceutical vending machines are being introduced to support access to frequently dispensed medication and discharge medicines.

To note, the impact of the implementation of the above actions is detailed in the priority 5 section.

### 6. Aim to ensure maximum use of NICE Guidance by achieving a target of 98% completion of templates within target timescales

*Partially achieved*

During 2023-24, our performance against NICE guidance within target timescales was achieved for 95% of NICE guidance overall, which is an increase from 92% in 2022-23. This falls slightly short of the target for the year and reflects the challenges of benchmarking increasingly complex NICE guidance, requiring input from multiple clinical teams but still represents a significant improvement on compliance achieved during 2020-21. Factors contributing to this sustained overall improvement include delivery of NICE training to staff, development of two NICE Facilitator roles in the Clinical Audit Department to constantly monitor and track NICE compliance and action plans and development of a more detailed NICE tracker, which highlights outstanding actions.

#### Percentage of guidance published during the year completed within target timescale

| Percentage of guidance published during the year completed within target timescale | | | | |
|---|---|---|---|---|
| | **2020/2021** | **2021/2022** | **2022/2023** | **2023/2024** |
| Clinical guidelines (NG) | 93% (28/30) | 92% (11/12) | 80% (12/15) | 60% (3/5) |
| Quality Standards (QS) | 62.5% (5/8) | 100% (3/3) | 100% (1/1) | 100% (2/2) |
| Interventional Procedural Guidelines (IPG) | 67% (12/18) | 100% (26/26) | 97% (32/33) | 100% (29/29) |
| **Total** | **80% (45/56)** | **98% (40/41)** | **92% (45/49)** | **95% (34/36)** |

Maintaining overall completion of applicable NICE guidance templates stands at 99.9%.

Focused work in this area has resulted in achievement of 100% of all published guidance completed for the first time during 2023-24. This has increased annually from 99% in 2020-21 to 99.9% in 2021-22 and reflects the work undertaken by the NICE Facilitators in supporting completion of templates.

## Overall percentage of all published NICE guidance completed

*Partially achieved*

| Percentage of all published guidance completed | | | | |
|---|---|---|---|---|
| | 2020/2021 | 2021/2022 | 2022/2023 | 2023/2024 |
| Clinical guidelines (NG) | 97% (283/291) | 99.6% (289/290) | 99.7% (297/298) | 100% (297/297) |
| Quality Standards (QS) | 99% (195/197) | 100% (197/197) | 100% (198/198) | 100% (200/200) |
| Interventional Procedural | 99% (543/544) | 100% (552/552) | 99.9% (576/577) | 100% (598/598) |
| **Total** | **99% (1021/1032)** | **99.9% (1038/1039)** | **99.9% (1071/1073)** | **100% (1095/1095)** |

During 2024-25 the Trust aims to achieve over 98% of guidance reviewed within target timescales and maintain overall completion of guidance at 100%. To succeed in achieving these targets dedicated NICE Facilitators will monitor and track NICE guidance using an updated dynamic tracker, further training will be delivered to both support staff and clinical staff, and regular updates will be given on progress with compliance at Clinical Governance Meetings to raise awareness.

## Development of NICE Facilitator roles within the Clinical Audit Department with specific responsibility for review, benchmarking, tracking, and monitoring NICE guidance

*Achieved*

Two NICE facilitator roles have been developed in the Clinical Audit Department. This has enabled constant review and monitoring of compliance with NICE guidance, ensuring that this is used to inform development of local guidelines. Together with the introduction of an updated dynamic NICE tracker, it has been possible to undertake focused work on progressing completion of outstanding actions relating to NICE compliance. Having dedicated NICE Facilitators has enabled development of stronger links with clinical staff, and going forward this will improve compliance with target timescales.

## Delivery of further training in NICE benchmarking for staff to ensure that templates are completed appropriately, and action plans are developed to address areas of non-compliance

**Achieved**

Training sessions on completion of NICE benchmarking templates were held during 2023/2024, and in combination with support provided by the NICE facilitators has resulted in improved completion of benchmarking templates, with accurately completed and up-to-date action plans. Further training is scheduled for 2024/2025.

### Refinement of systems for ensuring local guidelines incorporate relevant NICE guidance

Achieved

Implementation of an updated NICE tracker has facilitated an improved system for notifying clinical leads when local guidelines need to be updated in response to new and updated NICE guidance. Going forward this will help to ensure that local clinical guidelines are constantly updated when required, and that updated local guidelines are audited to ensure compliance. Work for 2024/2025 will include an automated email reminder system to support this process.

## 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 complex discharge process to streamline planning and reduce time from the patient being Medically fit to discharge

2. Develop and implement, a Trauma Assessment Unit and Oncology Assessment Unit, facilitating treatment in the most appropriate and timely place and reducing the number of patients moved across wards during their stay in hospital unless clinical indicated.

3. Improve the utilisation of the discharge lounges to support earlier patient flow from the emergency departments.

4. Improve Same Day Emergency Care (SDEC) access

### What we have achieved

#### 1. Further reviews and development of the IDT to streamline planning processes.

*Fully achieved*

A new “transfer of care” document was rolled out across the adult wards in the Trust in 2023/24 to streamline processes and information. Social workers are also now onsite in the Trust to support earlier conversations and assessments. We also implemented a daily management tracker to improve the timeliness of discharge and length of stay from Medically fit for discharge to discharge. We have revised the Choice policy The purpose of this Policy is to ensure that people can be discharged safely and timely with an individual plan of care, and that choice is managed as sensitively and consistently as possible throughout the discharge process. When implemented consistently, this Policy should reduce the number, and length, of delayed discharges and result in people being successfully transferred to services or support arrangements where their needs for health and care support can be met. Ultimately it aims to improve outcomes for people.

2. **Develop and implement, a Trauma Assessment Area and Oncology Assessment Area, 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.**

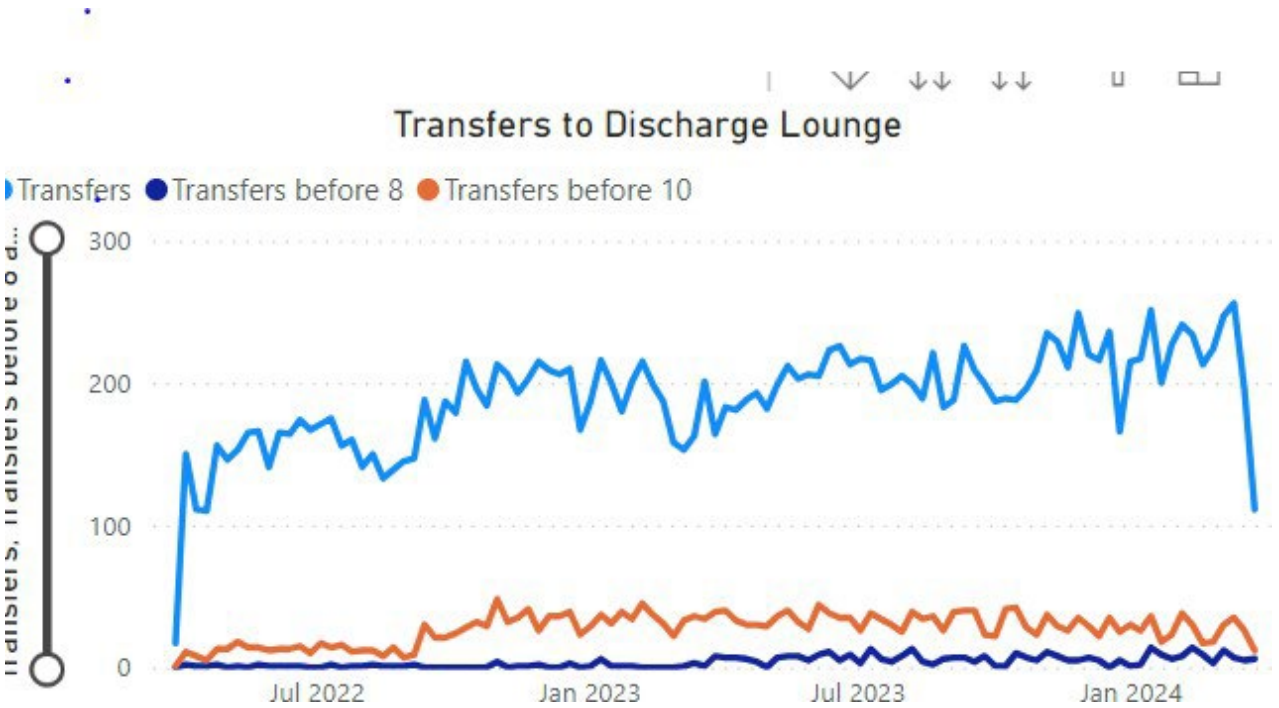
*Partially Achieved*

An oncology assessment area has been established on the RSH site; this enables patients to be seen in the most appropriate area for their condition. This area has also been used flexibly to facilitate chemotherapy treatments to reduce waiting times. A Trauma assessment area has been established on both sites. The on-call team can accept referrals to the unit from GP practices, and the Emergency Department for assessment and investigation if deemed appropriate for the area. This ensures that patients get timely treatment for their condition.

3. **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. The discharge lounge team, work in conjunction with the wards, to highlight those patients who are for discharge the next day using the H for home visual aid to ensure all staff are aware and patients are prepared for transfer to the discharge lounge. This has enabled our beds to be freed up early for patients requiring admission. Also, the capacity in the discharge lounges is able to be flexed between beds and reclining chairs to ensure the area is able to meet demand.



### 4 Improve Same Day Emergency Care (SDEC) access

*Partially Achieved*

We have been working with NHSE to improve our utilisation of the Same Day Emergency Care (SDEC) facilities on both sites. Test of change improvement weeks have been carried out at both PRH and RSH, the outcomes of which are shown below. Following these weeks a comprehensive action plan has been developed to further improve access to SDEC. This is being taken forward through our Emergency Care Transformation Programme.

RSH

| | Pre test of change baseline (20th- 26 November) | Target | Post test of change (27th-30th November) | % change against baseline |
|---|---|---|---|---|
| New SDEC admissions (avg. per day) | 12 per day | 18 per day | 16.3 per day | 36% |
| New SDEC admissions via Emergency A&E (avg. per day) | 15.40% | 30% | 16.70% | 8% |
| Average time in A&E pre SDEC admit (min) | 590 | NA | 353 | -40% |
| Average time in SDEC (min) | 362 | NA | 336 | -7% |
| SDEC to admissions conversion (No.) | 15.5 | NA | 16.9 | 9% |

PRH

| SDEC performance measures | Pre test of change baseline (12th – 16th Feb) | Target | Test of change (19th – 23rd Feb) | Post test of change (26th Feb – 1st Mar) | Post test of change (4th – 8th Mar) | % change against baseline |
|---|---|---|---|---|---|---|
| New SDEC admissions (avg. per day) | 15 per day | 18 per day | 17 per day | 18 per day | 16 per day | 7% |
| New SDEC admissions via Emergency A&E (avg. per day) | 12% (2 admissions) | 8 per day | 34% (6 admissions) | 40% (7 admissions) | 41% (7 admissions) | 241% |
| % NEL admissions via ED | 27% | 35% | 28% | 29% | 26% | - 4% |
| SDEC to admissions conversion (%) | 27% | N/A | 28% | 23% | 22% | - 19% |
| Average time in A&E pre SDEC admit (min) | 484 mins | N/A | 732 mins | 438 mins | 337 mins | - 30% |
| Average time in SDEC (min) | 350 | N/A | 343 mins | 276 mins | 293 mins | - 16% |
| Follow up appointments | 6 | N/A | 5 | 4 | 3 | - 50% |

## Priority 6: Address and improve care with people with diabetes through close working with system partners.

Our ambition is to improve care for patients with diabetes through close system working with system partners.

### What we said we would do

1. To participate in the system-wide Diabetic Transformation Programme; Including how to support people and manage living with their condition, design new pathways for Type 1 and Type 2 diabetes, access to specialist staff and psychological support.

2. Through our clinical audit programme complete Diabetic audits.

3. Participation in the implementation of OPAT by November 2013 for people with diabetes.

## What we have achieved

1. To participate in the system-wide Diabetic Transformation Programme; Including how to support people and manage living with their condition, design new pathways for Type 1 and Type 2 diabetes, access to specialist staff and psychological support.

*Partially achieved.*

The system wide Diabetic Type 1 strategy lead is Dr Syed Gillani, consulting GP at Wolverhampton Diabetes Centre and GP at Donnington Medical Practice. We have participated in the development of a system wide implementation plan. This has been agreed and submitted to NHSE for new NICE TA 943 which sets out criteria for people with Type 1 Diabetes to have access to a Hybrid Closed Loop (HCL) system, where sensor technology speaks to a pump to deliver insulin as needed.

The diabetic priorities set out in the plan include:

- Diagnosis of adults with Type 1 Diabetes
- Treatment and Management of adults with Type 1 Diabetes on Multiple Daily Injectable Therapy
- Treatment and Management of adults with Type 1 Diabetes on Insulin Pump Therapy
- Structured Education for adults with Type 1 Diabetes
- Phycological Support
- Digital Inclusion

In 2024/25 we will continue to participate, work, and contribute to deliver these diabetic priorities.

The Type 2 pathway lead is Dr Sarah Farr, GP from the Churchmere Group. In 2023/24 the Type 2 Pathway was initially developed and will be further refined in 2024/25 considering the implications of the Long-Term conditions Strategy.

In 2024/25 we will continue to participate in the system wide diabetic programme. Priorities for 2024/25 include: the diabetic foot pathway, routine foot screening for people with Type 1 and Type 2 Diabetes, high Risk Management of people with Type 1 and Type 2 Diabetes and Childrens Services.

2. Through our clinical audit programme complete National and Trust Diabetic audits.

*Achieved.*

Throughout 2023/24 we have used our clinical audit programme to support and complete our diabetic audits. All our eligible patients participated in the National Adult Diabetic Audit (NDA) in 2023. We look forward to receiving the outcomes in 2024/25.

We participated in The National Paediatric Diabetic Audit in 2021/22 and our results showed ongoing improvements in care processes and achievements in better than national average in all cases.
We have also completed local Trust Audits. As a result of the complex diabetic clinic audit completed in 2023/24 psychological support in the diabetic clinic is to be reviewed in 2024/25.

3. Participation in the implementation of the Outpatient Parental Antimicrobial Therapy Service (OPAT) by November 2013 for people with diabetes.

*Partially Achieved.*

The OPAT allows adult patients who are medically stable and whose only reason for inpatient stay is the requirement for intravenous antibiotics to be safely and effectively treated in an outpatient setting.

This service does not only enhance patient care and make it more accessible, but it also improves outcomes by reducing the length of time patients need to spend in our hospital or by helping them to avoid an admission altogether.

OPAT is a joint venture with our partners at Shropshire Community Health Trust, referring clinicians retain responsibility for their patients with the OPAT team providing clinical oversight.

In 2023/24 four pathways for OPAT have been implemented. These are Bronchiectasis, skin and soft tissue infections, bone and joint infections and complicated urinary tract infections.

Utilisation and progression of the OPAT service will be crucial in 2024/25 to release beds within our hospital 3for those patients who are most in need of inpatient care continue to progress. Further pathway will be rolled out in 2024/25.

## Priority 7: Learning from experience

We aim to create a positive experience for both our patients and service users, the people important 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 are heard. Demonstrating that as a Trust we are learning and improving patient, carer and public experience through complaints, patient surveys, feedback and compliments.

### What we said we would do

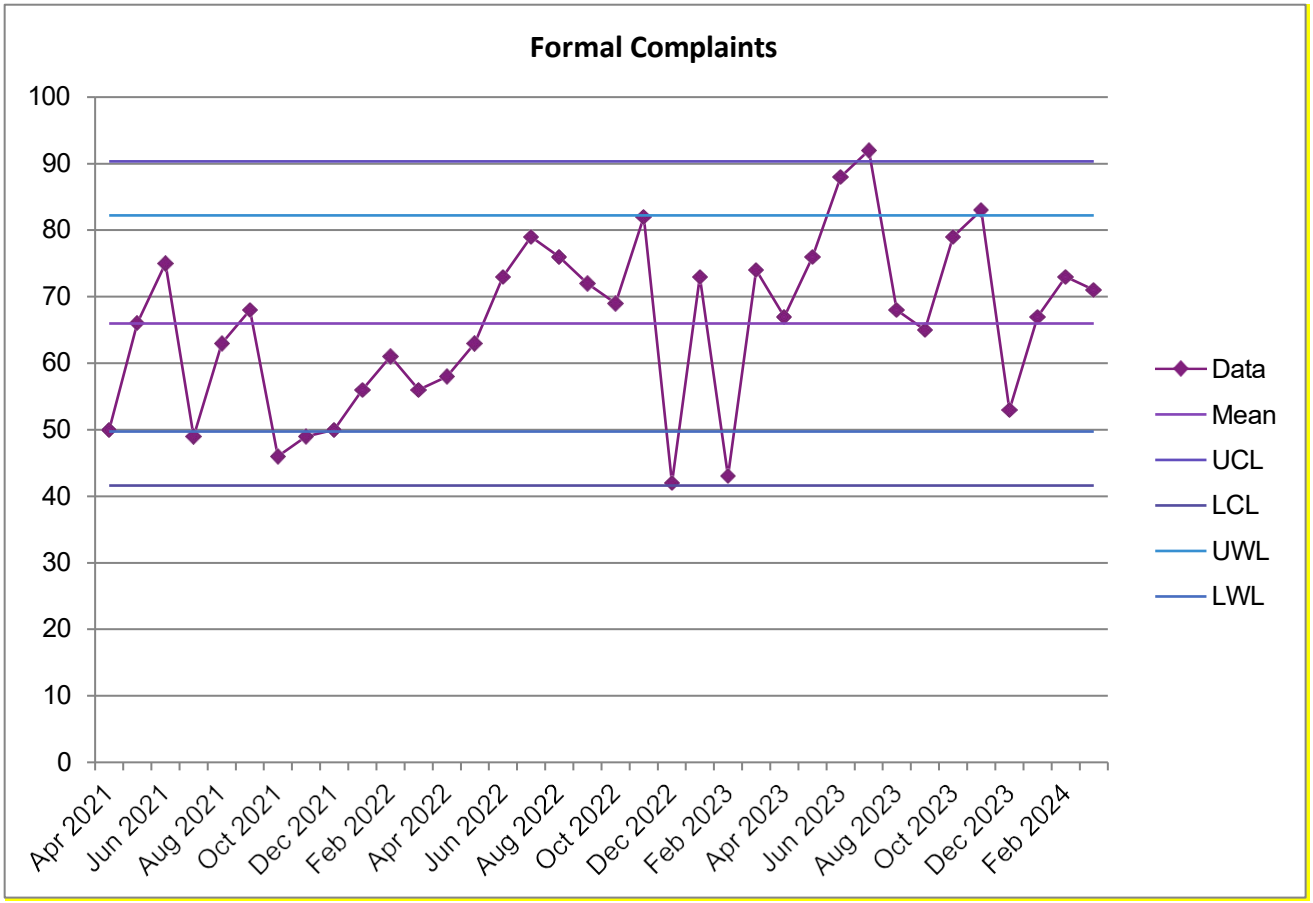
1. Evidence of the learning from complaints within our services
2. Functioning speciality PACE panels
3. All wards to have a “You said, We did” Quality Board
4. Improve our ratings in the national staff survey for the question *“I would be happy for a member of my family to receive care in the Trust”*
5. Improve complaint response performance, reduction in complaints with related themes and completion of actions and evidence of learning

### What have we achieved

#### 1. Evidence of the learning from complaints within our services

***Achieved***

During 2023/24, the Trust received 883 complaints. There has been an increase in the number of complaints received in the Trust, however this reflects an increase in activity in the Trust and represents less than one in every 1000 patients making a formal complaint (0.85). The graph below shows the number of complaints received within the last three years.




The Trust is committed to ensuring that each complaint is seen as an opportunity to reflect, learn and make improvements in the areas that matter most to our patients, and their carers and families. Some examples of learning and changes in practice that have arisen from complaints and PALS cases are set out below:

- Following a complaint about care on the Surgical Assessment Unit, work is being undertaken to ensure that staff clearly explain to patients the reasons why they cannot eat or drink until certain investigations are taken. Work is ongoing with the Pain Management Team to develop information booklets on pain relief to assist patients in understanding the different types of pain relief and their effects and to ensure staff communicate clearly about pain relief
- Following a complaint about conflicting information received in the Same Day Emergency Care Centre, discharge processes have been changed to ensure that patients leave with a clear plan, and follow-up and outcome forms are completed promptly. The team has also developed patient information leaflets to explain to patients how the unit works and what to expect.
- A patient raised concerns about the information they were given prior to their cataract surgery and about the facilities. The letter sent out to patients has been updated with further information and new chairs with arm rests have been ordered.
- Following a data breach, the case was shared with all staff. Additional confidential

waste bins were put in place so that these are located at the entrances and exits to the ward and are highly visible to staff, and posters have been displayed around the ward, reminding staff to ensure that their handover sheets are disposed of correctly. Senior nursing staff have implemented regular check to ensure that documentation is correctly locked away and that handover sheets are disposed of correctly.

- Following a complaint about difficulties in obtaining medication when a patient was discharged from the ED, this case has been shared with the team. TTO packs of Trimethoprim are now stocked in both EDs and further guidance has been published on issuing FP10s out of hours
- As a result of feedback in complaints about Badgernet, a number of additional measures have been put in place to assist staff and women. A dedicated email has been set up to allow users to contact the digital midwifery team directly for support with the app and the team has recently expanded to enable efficient resolutions to be delivered. A new function is available for staff within Badgernet which indicates whether the service user has accessed the app previously. This enables staff to provide the correct advice when setting up a new account. Booking co-ordinators are contacted service users within five working days to give access to the app and aware of how to create a new account for those who have used the app previously. A fictional account is now available to ensure staff understand what users can see.
- A patient raised concerns about monitoring prior to discharge. The Discharge Lounge has now introduced an electronic system for capturing patient observations, and there is now an information board, where key information is recorded for staff awareness, such as any patients who are diabetic. The complaint was shared with the team to reiterate the importance of ensuring that all observations are completed and documented, and that staff ensure that they monitor blood glucose levels for diabetic patients.
- Following a complaint about palliative care and delays in the transfer of the patient to the hospice, the Discharge Assessor is now present on the morning board rounds to allow better oversight of patients and to identify if patients are end of life or have a more complex discharge route. There is now a structured discussion about any patients who may require a palliative care referral, with plans being put in place to make sure that this is enacted in a timely manner. Staff have been reminded of the importance of the ongoing review of a patient's discharge arrangements and to ensure that they are checking the patient's and family's understanding of this.
- As a result of feedback about the Surgical Assessment Unit (SAU), the team has developed a poster for the waiting room which explains the process in the assessment area and the reason for the long waits such as waiting for blood test and any other further investigations. They are also developing a leaflet that can be given to patients

### Parliamentary and Health Services Ombudsman

During 2023/24, the PHSO contacted the Trust in relation to 12 cases, dating from 2020 to 2023, however it has only opened formal investigation into two cases. In one case, it requested a local resolution meeting to which the Trust agreed, however the family then

decided not to proceed and the PHSO closed the case. The other case relates to a case that was managed through the Serious Incident process rather than the Complaints process, and is still under review.

The PHSO also closed two other cases in 2023/24. In one case, it was not able to continue their investigation due to missing notes, and the Trust wrote to family to apologise for this and advise what actions it has taken to prevent notes being lost. In the other case, the family raised issues that had not previously been raised, and so the PHSO closed the case and asked the family to contact the Trust directly for a further investigation.

The PHSO published its new complaints standards at the end of 2022/23. All Complaints Case Managers have attended the PHSO training on these standards, and the Trust Complaints Policy has been updated to reflect these standards. The Trust also has a working group that meets regularly to review progress against these standards.

***Achieved***

### 2. Functioning speciality PACE panels

Speciality Patient Experience Groups have been established within eight specialties across the site, bringing together patient partners, and staff to work collaboratively to review feedback and co-design improvement plans to enhance the experience of care delivered to people accessing services. The Speciality Patient Experience Groups report into the Patient and Carer Experience Panel that is Chaired by the Director of Nursing with a patient partner as Co-Chair.

### 3. All wards to have a "You said, We did" Quality Board

***Achieved***

The introduction of new quality boards across the Trust provides oversight of quality, safety, and patient experience performance indicators in one place. Boards are positioned where people accessing the area can view them, for information and transparency.

The quality boards include a "You Said, We Did" section, enabling areas to demonstrate actions taken in response to feedback. "You Said, We Did" actions are recorded on Gather, a quality measurement tool used within the Trust, providing a record of how patients, and the people important to them, have been listened to and how each area has responded to the feedback to make improvements within the area.

Feedback can be through any form such as verbal, through FFT, local inpatient survey, PALS, a compliment, or a complaint.

### 4. 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"*

***Achieved***

Within the national NHS Staff Survey (2023) staff reported an increase in the percentage who agreed that if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.'' Whilst the increase reflects an improvement, this correlates with the lower national parameter and will continue to be an area of focus for the Trust (figure 1).

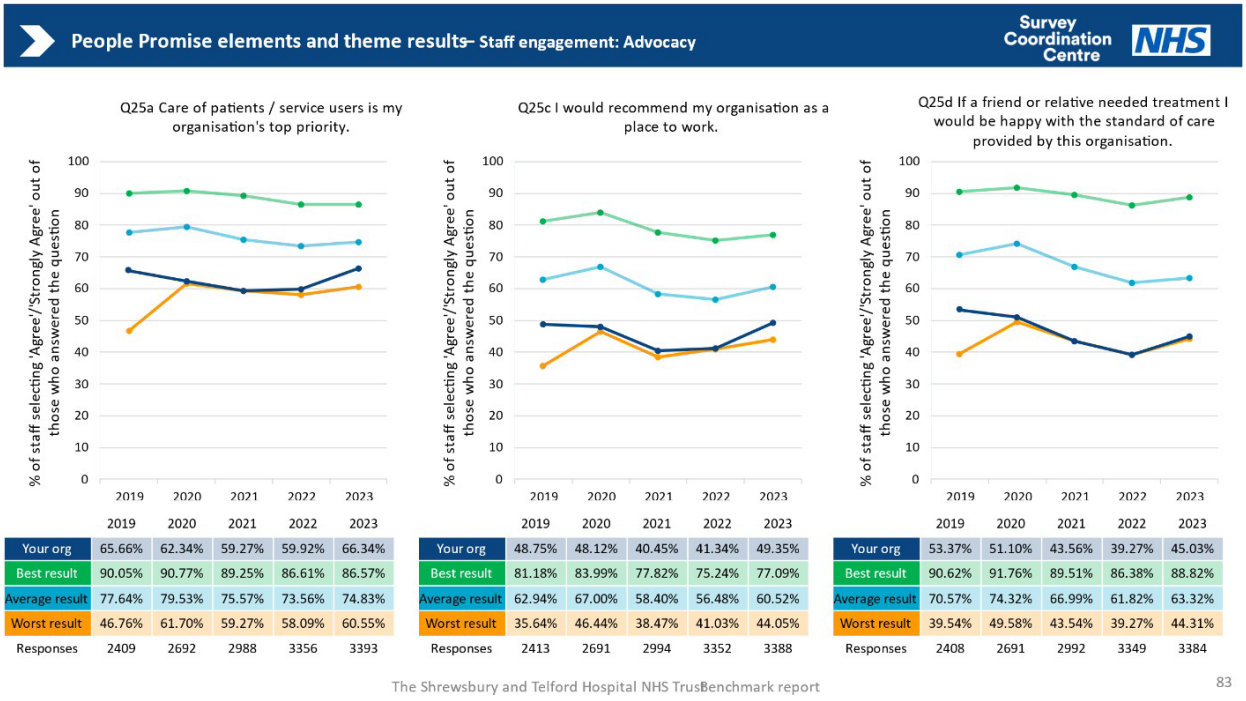



*Figure 1 – Advocacy Section Scoring and Benchmark Position* (National NHS Staff *Survey, 2023)*

## Improve complaint response performance, reduction in complaints with related themes and completion of actions and evidence of learning

Each complainant is given a timescale for response, which will vary depending on the complexity of the complaint and the level of investigation required. Where it is not possible to respond within the initial timescale agreed, the complainant is contacted and advised of the delay and given a new timescale. In 2023/24, 50% of complaints were responded to within the initial agreed timescales, which is significantly below the Trust's target. The main reason for this is due to investigations being delayed as a result of clinical pressure in the Trust impacting on the time it takes divisions to look into complaints. During 2023/24, the Trust has reviewed the complaints processes to strengthen and streamline these, with the new processes being introduced in quarter four of 2023/24. This more targeted approach will help the Divisions to investigate and respond to complaints in a more timely manner.

It should be noted that the Surgery, Anaesthetics, and Cancer Division, and Clinical Support Services Division continue to perform better, with responses rates of 69% and 88% respectively.

## Priority 8: Vulnerable patients

In 2023/24 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 in 2023/24 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 2023/24 had achieved compliance across all our safeguarding training with the exception of MCA/DoIs training which remains below the 90% compliance and the safeguarding Level 3 training which fell slightly at the end of Q4.

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 | 100% | 97% | 93% | 94% |
| Safeguarding Level 2 Adults | 95% | 95% | 96% | 95% |
| Safeguarding Level 2 Children | 94% | 95% | 96% | 95% |
| Safeguarding Level 3 Children | 88% | 92% | 92% | 92% |
| Safeguarding Level 4 Training | 100% | 100% | 100% | 100% |
| Safeguarding Level 3 Adults | 91% | 91% | 90% | 89% |
| Safeguarding Level 4 Adults | 100% | 100% | 100% | 100% |
| MCA/DOLS | 82% | 79% | 78% | 81% |
| Prevent – WRAP | 93% | 93% | 93% | 93% |

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

*Not Achieved*

Throughout 2023/24 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.

*Partially Achieved*

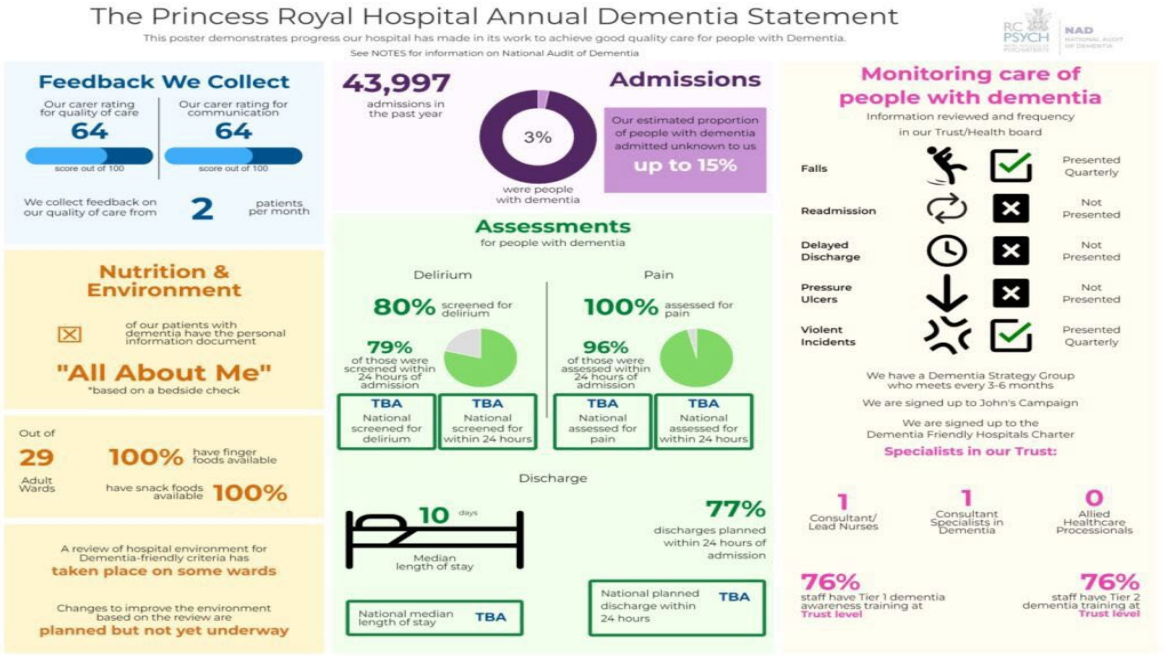
A draft Learning Disabilities Charter was previously developed. The Charter was developed with the involvement of our patients with a learning disability, their carers/families, and staff.

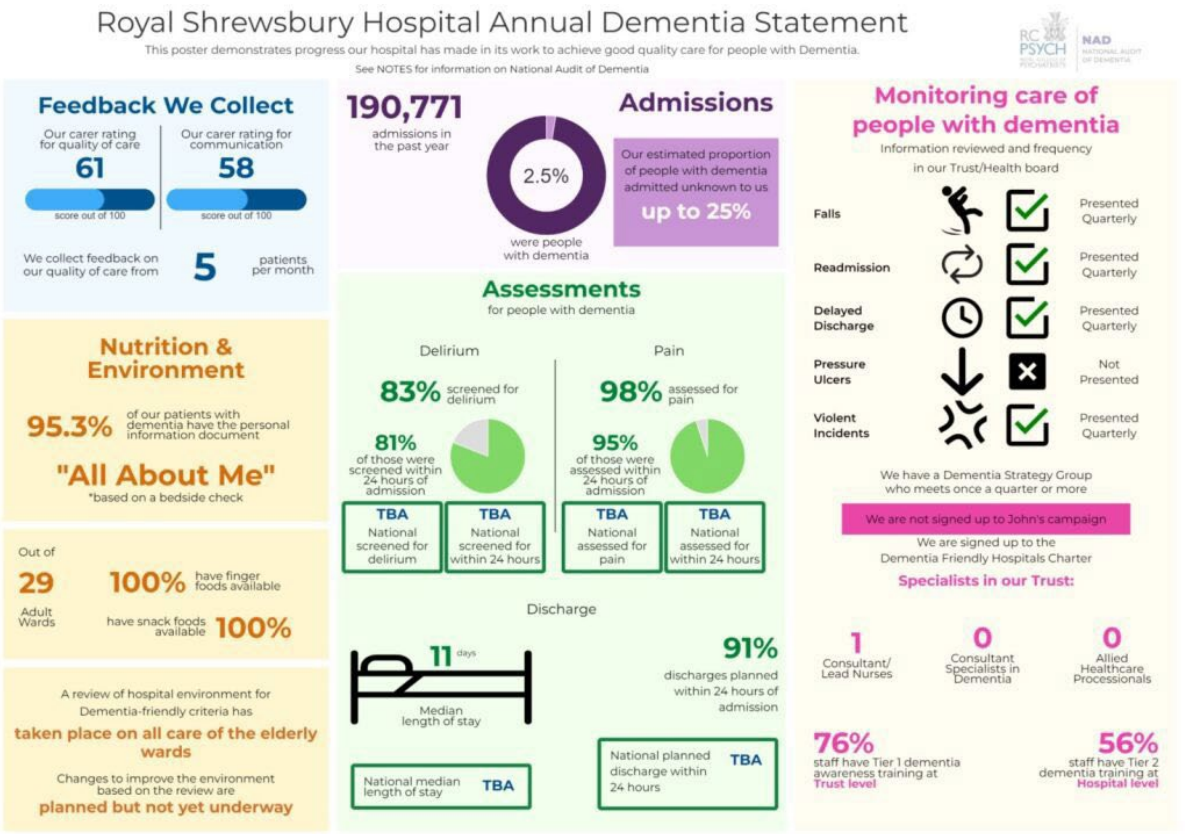
In 2024/25 the Learning Disability Charter will be agreed and endorsed by our Trust Board and launched across the Trust to drive the improvements in care for our patients with LD. This is an important step in our ambition to ensure all patient with LD are treated with respect and dignity and will be 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 as shown by the Annual statement audits for each site:


The Princess Royal Hospital Annual Dementia Statement
This poster demonstrates progress our hospital has made in its work to achieve good quality care for people with Dementia.
See NOTES for information on National Audit of Dementia
Feedback We Collect
Our carer rating for quality of care
64
score out of 100
Our carer rating for communication
64
score out of 100
We collect feedback on our quality of care from
2
patients per month
Nutrition & Environment
of our patients with dementia have the personal information document
"All About Me"
*based on a bedside check
Out of
29
Adult Wards
100%
have finger foods available
have snack foods available
100%
A review of hospital environment for Dementia-friendly criteria has
taken place on some wards
Changes to improve the environment based on the review are
planned but not yet underway
43,997
admissions in the past year
3%
were people with dementia
Admissions
Our estimated proportion of people with dementia admitted unknown to us
up to 15%
Assessments
for people with dementia
Delirium
80%
screened for delirium
79%
of those were screened within 24 hours of admission
TBA
National screened for delirium
TBA
National screened for within 24 hours
Pain
100%
assessed for pain
96%
of those were assessed within 24 hours of admission
TBA
National assessed for pain
TBA
National assessed for within 24 hours
Discharge
10
days
Median length of stay
National median length of stay
TBA
77%
discharges planned within 24 hours of admission
National planned discharge within 24 hours
TBA
Monitoring care of people with dementia
Information reviewed and frequency in our Trust/Health board
Falls
Presented Quarterly
Readmission
Not Presented
Delayed Discharge
Not Presented
Pressure Ulcers
Not Presented
Violent Incidents
Presented Quarterly
We have a Dementia Strategy Group who meets every 3-6 months
We are signed up to John's Campaign
We are signed up to the Dementia Friendly Hospitals Charter
Specialists in our Trust:
1
Consultant/ Lead Nurses
1
Consultant Specialists in Dementia
0
Allied Healthcare Processionals
76%
staff have Tier 1 dementia awareness training at Trust level
76%
staff have Tier 2 dementia training at Trust level




## The Dementia Care Team has continued 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 85% of these within 24 hours of admission

- Volunteers: Work with SaTH volunteers to support cognitive stimulation on wards commenced August 2023 on Ward 11 and 28. This will be rolled out to other wards in 2024/25

- Training: Training has continued throughout 2023/24, with Tier 1 Dementia Training sitting at 88% and Tier 2 at 85%

- Work with the Nutritional Steering Group to relaunch protected mealtimes, good practice in completion of oral food charts
- A Delirium Steering Group has been established to improve the management of Delirium and the use of the Delirium screening tool (4AT) in the Trust.
- The Dementia Steering Group has replaced the AMT (Initial Screening Tool) used on admission for all patients 75 years and over to the six cognitive impairment test questions (6cits)

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

*Partially 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 Assessments took place during October and November 2023 at RSH and PRH and the results were issued 22 February 2024.

A summary of the Trust's results is shown:

| | PRH (%) | RSH (%) | Organisational score (%) | National Average (%) |
|---|---|---|---|---|
| Cleanliness | 99.87 | 99.35 | 99.63 | 98.1 |
| Food | 93.5 | 89.23 | 91.52 | 90.86 |
| Organisational Food | 90.97 | 90.97 | 90.97 | 91.17 |
| Ward Food | 97.06 | 88.50 | 93.08 | 90.98 |
| Privacy, Dignity and Well Being | 77.44 | 71.23 | 74.56 | 87.49 |
| Condition, Appearance and Maintenance | 98. 82 | 97.85 | 98.37 | 95.91 |
| Dementia | 74.69 | 69.71 | 72.38 | 82.54 |
| Disability | 78.38 | 73.49 | 76.11 | 84.25 |

The boxes in the table highlighted in red are the areas that fell below the national.

- Cleanliness and Condition, Appearance and Maintenance are above the national average
- Privacy, Dignity and Well-being, Dementia and Disability were between 6% and 16% below the national average

### 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*

During 2023/24 we have continued to regularly audit the quality of the care provided to patients with mental health issues, learning disabilities, autism or dementia to ensure patients receive safe, dignified and person-centred individualised care. Audits include risk assessments, restrictive interventions and application of the Mental Health Act (1983).

We have continued to monitor and review the quality of care provided to our patients with mental health, LD and those living with dementia.

Working with our mental health service partners we have continued to audit our compliance in relation to the Mental Health Act (1983) and its application within an acute hospital. Ensuring we are meeting the needs of our patients, that we are following the correct legal framework and that our patient's rights are upheld. These audits have demonstrated positive results.

Quarterly audits for restrictive interventions have continued to be undertaken. There is ongoing improvement work related to the use of restrictive interventions. Staff training for the emergency departments is expanding with a particular focus on de-escalation, an understanding and awareness on reducing restrictive interventions.

## Priority 9: Palliative and End of Life Care (PEoLC)

We have continued with delivering the Trusts PEoLC strategy with a focus on improving our care after death through ongoing education, support and monitoring during 2023/24

## What we said we would do

1. Develop new PEoLC strategy and implementation of the Trust's PEOLC strategy milestones
2. Continue with delivering Care after Death training to achieve training compliance
3. Continue with Audit programme against the EOLC plan
4. Continue to deliver and improve compliance with PEOLC training for all staff including revising the medical statutory PEOLC training.
5. Wards completing PEOLC Supportive Ward Visit Programme

## What we have achieved

### 1. Implementation of the PEoLC strategy 2024-27 and commence implementation of the Trust's PEoLC strategy milestones

*Partially Achieved*

The Trust's new PEoLC strategy (2024-27) has been developed and agreed via the PEoLC steering group and Quality Operational Committee which sits under the Trust's clinical strategy and is aligned with ICS and national strategy for EOLC.

Ten broad aims with objectives of how to progress and achieve these have been developed. These will continue to be reviewed in 2024/25 at the PEoLC Steering Group and inform the Trust's overarching improvement plan.

### 2. Continue to deliver and improve compliance with care after death training

*Partially Achieved*

We introduced a care after death training mandatory video in October 2022 and compliance in 2023/24 achieved 92.8%.

Care after death training was reaudited in mid-2023 and unfortunately no clear significant improvement in care had been demonstrated through the audit. Audit results were disseminated via various means such as weekly nursing meeting, divisions, steering group and one-minute briefs. The team will continue to monitor this during 2024/25.

| Palliative and End of Life Care Dashboard | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Metric | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-23 | Feb-23 | Mar-23 | Average / Total | Target |
| **Nursing Quality Assurance - adult inpatient wards** | | | | | | | | | | | | | | |
| Palliative/End of Life Care - Nursing Quality Audit | 98.5 | 98.4 | 98.6 | 98.2 | 97.5 | 97.3 | 97.4 | 98.5 | 98.8 | 94.9 | 99.6 | 97.6 | 98 | 80-90 |
| ReSPECT and DNA/CPR | 94.3 | 95.2 | 96.4 | 95.7 | 93.3 | 95.4 | 93.8 | 94.3 | 93 | 93.9 | 95.1 | 93.9 | 94 | 80-90 |
| **Training - across the Trust** | | | | | | | | | | | | | | |
| End of Life Care 3 Yearly | 88.3 | 89.81 | 90.69 | 89.76 | 90.25 | 89.81 | 89.15 | 90.29 | 89.95 | 87.24 | 87.89 | 87.81 | 89.23 | 80-90 |
| T34 Pump Training | 85.19 | 86.42 | 86.72 | 86.15 | 85.4 | 85.44 | 85.54 | 87.71 | 87.25 | 88.08 | 89.22 | 89.14 | 86.92 | 80-90 |
| Care After Death Training | 79.94 | 84.23 | 86.64 | 86.42 | 88.02 | 89.52 | 90.19 | 91.86 | 93.03 | 92.31 | 92.82 | 93.5 | 89.07 | 80-90 |

### 3. Continue to deliver the EOLC Audit programme.

*Achieved*

The following audits have been completed in 2023/24

| | |
|---|---|
| **Symptom control**<br><br>**(all patients i.e. palliative and last days of life care)** | Showed good improvement in symptom control for patients under care of PEOLC team. To be reaudited in 2024. |
| **Care after death** | Despite good compliance with the new mandatory training video, this audit did not show this training coming through as improved care. Audit results being disseminated widely and video promoted in order to address this. To be re audited in 2024. |
| **National audit for care at the end of life. (NACEL)** | Cancelled by the national team in 2023 in order to develop this important national benchmarking audit further for the future. Anticipated to start again in 2024. |
| **SWAN care plan and anticipatory meds**<br><br>**(last days of life care plan)** | Showed good uptake of the plan when appropriate and good compliance against guidelines for completion of the plan.<br>Improved documentation of last days of life care compared to previous audits. Good prescribing of anticipatory medications (94%)<br>To be re-audited in 2024 |
| **Mouth Care** | Small improvement in staff knowledge around mouth care at EOL demonstrated by the audit. However, numbers included in the audit were small.<br>Plan to combine with a larger Trust wide audit, not specific to EOLC in future. |
| **Bereavement feedback survey** | Continuous feedback, collated quarterly by audit dept and discussed via steering group.<br>Distribution list recently updated.<br>Actions list currently under development.<br>This is so that we do more with this valuable feedback other than just monitoring for assurance purposes. |
| **Palliative care patient satisfaction feedback survey**<br><br>**(Views on care)** | Good feedback received by the PEOLC team received from patients regarding their input to care. |

An audit programme for 2024/25 has been developed

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

*Partially Achieved*

- All training modules delivered in 2023/25 have been well evaluated and show a clear correlation in increased levels of confidence, knowledge, and skill
- The qualitative data is excellent for the sessions and delegates review the sessions as being well led and effectively delivered
- We have continued to face challenges regarding attendance at modules due to clinical work commitments as numbers of delegates have been low on some occasions
- In 2024/25 we will be developing a database for EoLC champions, and this will allow us to support Champions and encourage them to attend the required modules for the role
- The modules will be further developed in 2024/25 as these will be updated to reflect changes in best practice and changes to the service

### 5. Continue with wards completing the Supportive Ward Visit programme

*Achieved*

We have continued with the Supportive Ward Visit programme, wards supported in 2023/24 have included 28, 24,17,15,16,37, and both AMUs.

The supportive ward visit programme will continue in 2024/25.

**Our future quality priorities for 2024/25 includes:**

1. Increase the Trust target for Care after Death mandatory training to 90% and continue to monitor all mandatory education provided
2. Continue to update the EoLC eLearning package, to reflect best practice and to comply with different learning styles
3. Embed Level two training in the Palliative and End of Life Care Modules, promoting and increasing the awareness of this session
4. Continue to make further improvements in the PEoLC Training Modules

## 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 2023/24 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.

### STATEMENT REGARDING REGISTRATION WITH THE CARE QUALITY COMMISSION (CQC), PERIODIC/SPECIAL REVIEWS and OUR IMPROVEMENT PLAN

SaTH is required to register with the Care Quality Commission and its current registration status is registered with conditions.

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 2023/24 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:<br>• Patients<18 years of age who present with isolated acute mental health needs<br>• 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<br>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.<br>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.<br>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:<br>• Patients<18 years of age who present with isolated acute mental health needs<br>• Do not have physical health needs that require inpatient assessment and treatment |

The Care Quality Commission has not taken enforcement action against SaTH during 2023-24.

The Trust has not been subject to any special reviews or investigations by the Care Quality Commission during 2023/24.

Between 10 and 11 October 2023, the CQC inspected services provided by the trust across 2 locations. The CQC carried out an unannounced inspection of End-of-Life Care, Medical Care (including older people's services) and Urgent and emergency services at the Royal Shrewsbury Hospital. The CQC carried out an unannounced inspection of Children and young people, End of Life Care, Maternity as part of the national maternity inspection programme, Medical Care (including older people's services) and Urgent and emergency services at the Princess Royal Hospital.

At the time of writing the Quality Account, the Trust were waiting the final CQC report. Following the publication of the CQC report an overarching improvement plan will be developed to address the 'must do' areas for improvement.

### Post CQC Inspection Activity - Overall CQC Improvement Plan Progress

The post inspection improvement plan from the Trust's November 2021 CQC inspection has progressed well and is near to completion.

The remaining outstanding improvement actions which are to be evidenced and assured, mean we can evidence that these are embedded in the clinical areas and 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" Programmes of work.

## 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 2023/24 88 national clinical audits and eight 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**%** (60/62) of the national clinical audits and 100**%** *(7/7)* 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 2023/2024.**

| *Table 1 – national clinical audits 2023/24* | | | | |
|---|---|---|---|---|
| ***Title*** | | ***Eligible*** | ***Participating*** | ***Submission rate (%) / Comment*** |
| *Adult Respiratory Audits, British Thoracic Society (BTS) | | ✓ | ✓ | All eligible cases |
| *British Association of Urological Surgeons (BAUS) Nephrostomy Audit | | x | x | Not applicable |
| *Breast and Cosmetic Implant Registry | | x | x | |
| *British Hernia Society Registry | | ✓ | ✓ | All eligible cases |
| *Case Mix Programme (CMP) – Intensive Care National Audit and Research Centre (ICNARC) | | ✓ | ✓ | All eligible cases |
| *Child Health Clinical outcome Review Programme | Testicular Torsion – National Confidential Enquiry into Peri-operative Deaths (NCEPOD) | ✓ | ✓ | 7/9 cases submitted |
| | Juvenile Idiopathic Arthritis (NCEPOD) | ✓ | ✓ | 7/7 cases submitted |
| *Cleft Registry and Audit Network (CRANE) | | × | × | Referred to specialist centre |
| *Elective surgery, National Patient Reported Outcome Measures (PROM's) Programme | | ✓ | ✓ | All eligible cases |
| Emergency Medicine Quality Improvement Projects (QIP's), Royal College of Emergency Medicine (RCEM) | *Care of Older People | ✓ | ✓ | All eligible cases |
| | **Consultant Sign-Off PRH 2021 | ✓ | ✓ | All eligible cases |
| | *Mental Health | ✓ | ✓ | All eligible cases |
| | *Time critical medications | ✓ | ✓ | Currently in progress |
| *Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies in Children and Young People | | ✓ | ✓ | All eligible cases |
| Falls and Fragility Fractures Audit programme (FFFAP) | *Fracture Liaison Service Database | ✓ | ✓ | All eligible cases |
| | *Inpatient Falls | ✓ | ✓ | All eligible cases |

| *Table 1 – national clinical audits 2023/24* | | | | |
|---|---|---|---|---|
| ***Title*** | | ***Eligible*** | ***Participating*** | ***Submission rate (%) / Comment*** |
| | *National Hip Fracture Database (NHFD) | ✓ | ✓ | All eligible cases |
| *Improving quality in Crohn's and colitis, Inflammatory Bowel Disease (IBD) registry | | ✓ | × | Unable to get MESH Access / Permission from Information Governance |
| * Learning from lives and deaths of people with a learning disability and autistic people (LeDeR) | | ✓ | ✓ | 10 deaths during 23/24 of patients with a confirmed learning disability |
| *Maternal, new-born and infant clinical outcome programme (MBRACE) | Maternal mortality confidential enquiries | ✓ | ✓ | All eligible cases |
| | Maternal mortality surveillance | ✓ | ✓ | All eligible cases |
| | Perinatal mortality and serious morbidity confidential enquiry | ✓ | ✓ | All eligible cases |
| | Perinatal Mortality Surveillance | ✓ | ✓ | All eligible cases |
| | Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity | ✓ | ✓ | All eligible cases |
| *Medical and Surgical Clinical outcome Review Programme (NCEPOD) | Community Acquired Pneumonia | ✓ | ✓ | 4/13 questionnaires returned |
| | Crohn's study | ✓ | ✓ | 84% |
| | End of Life Care | ✓ | ✓ | No data submitted, NCEPOD did not select any cases for the Trust |
| | Endometriosis | ✓ | ✓ | 6/13 questionnaires returned |
| | Epilepsy | ✓ | ✓ | 3/10 questionnaires returned |

| *Table 1 – national clinical audits 2023/24* | | | | |
|---|---|---|---|---|
| ***Title*** | | ***Eligible*** | ***Participating*** | ***Submission rate (%) / Comment*** |
| | Rehabilitation following critical illness | ✓ | ✓ | Currently in progress |
| *Mental Health Clinical Outcome Review Programme | Real-time surveillance of patient suicide | × | × | Not applicable |
| | Suicide (and homicide) by people under mental health care | × | × | Not applicable |
| | Suicide by people in contact with substance misuse services | × | × | Not applicable |
| *National Adult Diabetes Audit (NDA) | *National diabetes in patient Safety | ✓ | ✓ | All eligible cases |
| | *National Pregnancy in Diabetes Audit (NPID) | ✓ | ✓ | All eligible cases |
| | *Core Diabetes Audit | × | × | Secondary care data collection commenced April 2024 |
| | *Foot Care Audit | ✓ | ✓ | All eligible cases |
| National Asthma & COPD Audit Programme (NACAP) | *Adult Asthma Secondary Care | ✓ | × | Staff capacity |
| | *Paediatric - Children and young people asthma secondary care | ✓ | ✓ | All eligible cases |
| | *Chronic Obstructive Pulmonary Disease (COPD) Secondary Care | × | × | Not applicable |
| | *Pulmonary rehabilitation | × | × | Not applicable |
| *National Audit of Cardiac Rehabilitation | | × | × | Not applicable |
| *National Audit of Cardiovascular disease in primary care (CVD Prevent) | | × | × | Not applicable, primary care |
| *National Audit of Care at the End of Life (NACEL) | | ✓ | ✓ | Currently in progress |
| *National Audit of Dementia | | ✓ | ✓ | All eligible cases |
| *National audit of Pulmonary Hypertension | | × | × | Not applicable |
| *National Bariatric Surgery Registry | | ✓ | ✓ | All eligible cases |

| *Table 1 – national clinical audits 2023/24* | | | | |
|---|---|---|---|---|
| ***Title*** | | ***Eligible*** | ***Participating*** | ***Submission rate (%) / Comment*** |
| *National Cancer Audit Collaborating Centre (NATCAN) | National Audit of Metastatic Breast Cancer (NAoMe) | ✓ | ✓ | All eligible cases |
| | National Audit of Primary Breast Cancer (NAoPri) | ✓ | ✓ | All eligible cases |
| | National Prostate Cancer Audit (NPCA) | ✓ | ✓ | All eligible cases |
| | National Bowel Cancer Audit (NBOCA) | ✓ | ✓ | All eligible cases |
| | National Oesophago-Gastric Cancer Audit (NOGCA) | ✓ | ✓ | All eligible cases |
| | National Lung Cancer Audit (NLCA) | ✓ | ✓ | All eligible cases |
| *National Cardiac Arrest Audit (NCAA) | | ✓ | ✓ | All eligible cases |
| *National Cardiac Audit Programme (NCAP) | *Cardiac Rhythm Management (CRM) | ✓ | ✓ | Not applicable |
| | *Congenital Heart Disease (CHD) | × | × | Not applicable |
| | *Myocardial Ischaemia National Audit Project (MINAP) | ✓ | ✓ | All eligible cases |
| | *Heart Failure Audit | ✓ | ✓ | All eligible cases |
| | *National Audit of Percutaneous Coronary Interventions (PCI) | × | × | Not applicable |
| | *National Adult Cardiac Surgery Audit | × | × | Not applicable |
| | National Audit of Mitral Valve Leaflet Repairs (MVLR) | × | × | Not applicable |
| | UK transcatheter aortic valve implantation (TAVI) registry | × | × | Not applicable |
| *National child mortality database | | ✓ | ✓ | All eligible cases |

| *Table 1 – national clinical audits 2023/24* | | | | |
|---|---|---|---|---|
| ***Title*** | | ***Eligible*** | ***Participating*** | ***Submission rate (%) / Comment*** |
| *National Clinical Audit of Psychosis (NCAP) | | × | × | Not applicable |
| *National Comparative Audit of Blood Transfusion programme | *Audit of NICE Quality Standard QS138 | ✓ | ✓ | All eligible cases |
| | *2023 Bedside Transfusion Audit | ✓ | ✓ | Audit delayed, commenced March 2024 |
| *National Early Inflammatory Arthritis Audit (NEIAA) | | × | × | Not applicable |
| *National Emergency Laparotomy audit (NELA) | | ✓ | ✓ | All eligible cases |
| *National Joint Registry (NJR) | | ✓ | ✓ | 201 cases (2022/23 report) |
| *National Maternity and Perinatal Audit (NMPA) | | ✓ | ✓ | All eligible cases |
| *National Neonatal Audit Programme (NNAP) | | ✓ | ✓ | All eligible cases |
| *National Obesity Audit | | × | × | Not applicable |
| *National Ophthalmology Database | | ✓ | ✓ | All eligible cases |
| *National Paediatric Diabetes Audit (NPDA) | | ✓ | ✓ | All eligible cases |
| *National Vascular Registry | | ✓ | ✓ | All eligible cases |
| *Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry | | × | × | Primary care |
| *Paediatric intensive care (PICaNet) | | × | × | Not applicable |
| *Perinatal Mortality Review Tool (MBRRACE) | | ✓ | ✓ | All eligible cases |
| Perioperative Quality Improvement Programme | | × | × | Not notified of the audit prior to start date |
| *Prescribing Observatory for Mental Health (POMH-UK) | *Use of medicines with anti cholinergic (antimuscarinic) properties in older people's mental health services | × | × | Not applicable |
| | *Monitoring of patients prescribed lithium | × | × | Not applicable |
| *Sentinel Stroke National Audit Programme (SSNAP) | | ✓ | ✓ | All eligible cases |
| *Serious Hazards of Transfusion (SHOT): UK National haemo-vigilance scheme | | ✓ | ✓ | All eligible cases |
| *Society for Acute Medicine's Benchmarking Audit (SAMBA) | | ✓ | ✓ | All eligible cases |
| *Trauma Audit & Research Network | | ✓ | ✓ | All eligible cases (Data collection paused by TARN in June 2023) |

| *Table 1 – national clinical audits 2023/24* | | | | |
|---|---|---|---|---|
| ***Title*** | | ***Eligible*** | ***Participating*** | ***Submission rate (%) / Comment*** |
| *UK Cystic Fibrosis Registry | | × | × | Not applicable |
| *UK Renal Registry | *Acute Kidney Injury | ✓ | ✓ | All eligible cases |
| | *Chronic Kidney Disease Registry | ✓ | ✓ | All eligible cases |

*Based on information available at the time of publication.*

***Audits on HQIP commissioned NCAPOP List 2023/2024**

**** from HQIP commissioned NCAPOP list 2022/2023 – results and action plan received 2023/2024**

### Table 2: National Confidential Enquiries 2023/2024

| *Table 2 – National Confidential Enquiries 2023-24 (8)* | | | | |
|---|---|---|---|---|
| ***Title*** | | ***Eligible*** | ***Participating*** | ***Submission rate (%) / Comment*** |
| Child Health Clinical Outcome Review Programme (NCEPOD) | * Testicular Torsion – National Confidential Enquiry into Peri-operative Deaths (NCEPOD) | ✓ | ✓ | 78% |
| | * Juvenile Idiopathic Arthritis (NCEPOD) | ✓ | ✓ | 100% |
| *Medical and Surgical Clinical Outcome Review Programme (NCEPOD) | Community acquired Pneumonia | ✓ | ✓ | 31% |
| | *Crohn's disease | ✓ | ✓ | 84% |
| | *End of Life Care | ✓ | ✓ | Data submission not required - NCEPOD did not select any cases for the Trust |
| | Endometriosis | ✓ | ✓ | 46% |
| | *Epilepsy | ✓ | ✓ | 30% |

| *Table 2 – National Confidential Enquiries 2023-24 (8)* | | | | |
|---|---|---|---|---|
| ***Title*** | | ***Eligible*** | ***Participating*** | ***Submission rate (%) / Comment*** |
| | *Rehabilitation following critical illness | × | × | Not applicable |

*Based on information available at the time of publication.*

***Audits on HQIP commissioned NCAPOP List 2023/2024.**

### Table 3: Examples of actions taken following national audits

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

| *Table 3 - Examples of actions taken following National audits* | |
|---|---|
| ***Title*** | ***Action / Outcome*** |
| RCEM Pain in Children PRH 2021 v2 (4893) | • Audit results showed that initial pain scoring was carried out but not repeated. A patient pain passport has been introduced in the Emergency Department to prompt repeat pain scoring |
| National Emergency Laparotomy Audit (NELA) Dec-20 to Nov-21 - 2023 data (5390) | • The audit showed that CT reporting before surgery had declined slightly since the previous audit. The Trust is in the process of appointing NELA leads in radiology to ensure that CT reporting is timely for these patients<br>• Delays in access to Occupational Therapy were noted and a further audit is being carried out to look at reasons for delays |
| National Audit for Care at the end of life (NACEL) 2022 (5117) | • The Swan Care plan uptake is improving (68%) and the audit shows again that use of the plan improves care<br>• Recognition of dying has improved since last audit and time frame of introduction before death is in line with national benchmark |
| National Paediatric Diabetes Audit 2021/22 (4821) | • The audit showed ongoing improvement in care processes, and achievement of better than the national average in all areas |
| Bone protection in Parkinson's disease (5513) | • The audit identified a need for patient education. Lifestyle advice leaflets are in the design stage, scheduled to be rolled out by the end of 2024 |
| Dementia audit - 2022 (5301/5300) | • Trust wide staff training is now ongoing for red tray assessment (for support with meals), exemplar, observation and nutrition /hydration<br>• SaTH has moved to using the 4AT delirium assessment which is regarded as best practice |

| *Table 3 - Examples of actions taken following National audits* | |
|---|---|
| ***Title*** | ***Action / Outcome*** |
| RCEM Care of the Elderly QIP (5539) | • Going forward all patients over the age of 75 with a National Early Warning Score (NEWS2) of 4 or less will have a delirium screen completed and documented |
| Sampling and labelling for blood samples for transfusion (5174) | • Induction training is offered to all new doctors starting at SaTH in relation to safe sampling practice. Non-medical staff complete a venepuncture course which includes safe sampling practice |
| Royal College of Emergency Medicine (RCEM): Mental Health 2023 (5380) | • All underlying mental health policies for the Emergency Departments have been reviewed and updated<br>• An education programme has been agreed |
| Respiratory Support Audit, British Thoracic Society (BTS) (RSH) (5363/5362) | • SaTH performance was better than national average in a number of key areas<br>• As a unit SaTH was shown to be similarly staffed and equipped in comparison to most units in the country<br>• The respiratory clinical director is in the process of ringfencing respiratory support unit beds |
| ICNARC case mix programme – RSH 2022 (5100/5099) | • Operational managers have been made aware to escalate delayed discharges and ensure they are recorded as an incident |

*Based on information available at the time of publication.*

### Table 4: Trust Local Audits

The Trust also undertook 235 local audits, shown in table 4 below.

| **TABLE 4 – Trust local audits 2023-24 (235)** | | |
|---|---|---|
| **CLINICAL SUPPORT SERVICES – PATHOLOGY** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5366 | Reporting of Thyroid Cytology Specimens and their Correlation with Thyroid Histology October 2021-September 2022 | • The audit showed good compliance with the standards, therefore thyroid FNAs will continue to be classified as proposed in the Royal College of Physicians (RCP)/British Thyroid Association guidance |
| 5496 | Punch biopsies of melanocytic lesions | • The audit identified fewer punch/incisional biopsies should be performed of melanocytic lesions on 'non-sensitive' sites. Findings are being shared and further education sessions have been delivered to address this |
| 5497 | The Influence of COVID-19 Surveillance Guidelines Changes on Urine Cytology Outcomes in Bladder Cancer Patients receiving BCG therapy | • An education session has been delivered to discuss the limitations of urine cytology post Bacillus Calmette Guérin (BCG)<br>• A consensus was reached within the cytology department on BCG-related inflammation categorization |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5498 | Cellular pathology lymphoma audit | • Awareness for the potential for wrong grading of a follicular lymphoma vs DLBCL. IT was agreed that if uncertain to have low threshold to defer grading until specialist review. Findings were discussed at the audit meeting |
| 5371 | Clostridioides difficile infection: antimicrobial prescribing - NICE NG199 | • Teaching sessions have taken place to improve patient assessment |
| **CLINICAL SUPPORT SERVICES – RADIOLOGY** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5248 | Shropshire Breast Screening Programme Client Satisfaction Survey 2022 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5358 | Ultrasound assessment of lymph node status in positive breast cancer patients | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5424 | Radiological guidance for the recognition and reporting of osteoporotic Vertebral Fragility Fractures (VFF) | • The audit results were presented to raise awareness within the radiology team of the template on PACS to use when needed<br>• An email was sent to outsourcing company to give feedback on Royal College of Radiologist (RCR) guidance |
| 5439 | Carotid artery duplex ultrasound January-March 2022 | • The report was disseminated and teaching was provided to sonographers regarding the correct application of Doppler angle and cursor placement<br>• The use of PSV ratio in addition to absolute PSV in suspected 50-70% stenosis was also discussed in the teaching session |
| 5525 | The use of PI-RADS v2.1 in pre-biopsy multi-parametric MRI - re-audit | • A review of the MRI protocol with radiographers is underway. Once the review has taken place, a lecture regarding the changes will be held |
| 5528 | Post Imaging Colorectal Cancer | • The results showed satisfactory compliance with the audit standards. A re-audit is planned in three years' time to ensure compliance is maintained |
| 5530 | An assessment of practice when performing X-rays on ITU and HDU on newly acquired mattresses with X-ray detector pouch | • It was agreed that practice will not be changed when undertaking portable X-rays in ITU and HDU with the new mattress. The imaging detector should be placed directly under the patient's back, as before and the X-ray pouch is not to be used due to the inherent risk that it poses<br>• The audit report was sent to Hillrom as they were keen to receive feedback |
| 5532 | Exploring the Impact of Radiology Taster on Junior Doctors | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5537 | CTVC audit 2023 | • The results showed satisfactory compliance with the audit standards<br>• A re-audit will be carried out to ensure compliance is maintained |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5598 | Indications of MRI prostate referral | • The indications of prostate MRI according to NICE guidelines were reviewed with consultants of urology and members of urology MDT<br>• A re-audit is planned |
| 5599 | Referrers' Awareness of Radiation Exposure and Associated Risks of Imaging | • An education session for referrers was held<br>• A re-audit is planned and will include a wider range of grades |
| 5605 | Breast MRI audit results from a GDH. Are we compliant? | • The results showed satisfactory compliance with the audit standards. A re-audit will be carried out to ensure compliance is maintained |
| 5635 | Timely Recording of X-ray Evaluations in the Emergency Department | • Reminders had been sent using a variety of platforms to affected members of staff to increase awareness of need to document findings |
| 5717 | Audit Of CT colonography reports 2022 | • The results showed satisfactory compliance with the audit standards<br>• A re-audit will be carried out to ensure compliance is maintained |
| 5718 | CT guided lung biopsy diagnostic accuracy and complication rates - re-audit | • The results showed satisfactory compliance with the audit standards. A re-audit will be carried out to ensure compliance is maintained |
| 5723 | Review of chest X-ray follow up alert compliance | • The NPSA alert was be discussed at the Radiology meeting to raise awareness |
| 5740 | Compliance with the Cauda Equina Syndrome (CES) (re-audit) | • A reminder was sent to all referring clinicians to ensure all urgent requests should document ***red flags*** for CES and must be ***clearly referred*** from A&E or inpatient ward to be reported urgently<br>• GIRFT CES Pathway has been reviewed and updated |
| 5715 | Head CT - Lens exclusion re-audit | • The results showed satisfactory compliance with the audit standards |
| 5526 | Frequency of recommendation for further action in outpatient ultrasound reports | • The results showed satisfactory compliance with the audit standards |
| 5527 | Frequency of recommendations for further action in GP-referred body CT | • The results showed satisfactory compliance with the audit standards |
| **CLINICAL SUPPORT SERVICES – THERAPY** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5251 | #NOF standards for physiotherapy | • The results showed satisfactory compliance with the audit standards |
| 5547 | Adult Critical Care Rehab Outcomes Group National Rehabilitation Survey | • A new SOP for Critical Care Therapy Service has been developed<br>• A group has been set up to improve the quality and consistency of pathway completion cross site |
| 5574 | Inpatient referral criteria audit | • A communication has been shared with the wider MDT and Trust regarding the number of inappropriate referrals |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| | | • An improvement project is underway, focused on education of medical staff on AMU at both sites<br>• A re-audit is planned |
| 5688 | Case notes and Stamp Audit - Therapies 2023 | • Registered staff have been educated on the importance of recording HCPC numbers after each entry within the notes along with their signature |
| **CORPORATE – TRUST WIDE** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5028 | Children's Emergency Department Notes | • The results showed satisfactory compliance with the audit standards |
| 5110 | Bereavement feedback questionnaire 2022-2023 | • The Palliative and End of Life Care team have implemented an action plan to ensure that all required actions are identified and implemented after each quarterly report |
| 5191 | Care after Death - Jan 2023 | • A one-minute brief was produced and shared with all ward managers and PEoLC champions in December 2023 highlighting the areas of poor compliance. The ward managers are monitoring practice and supporting improvements where required |
| 5418 | Symptom control audit | • The audit form has been simplified for the next cycle of the audit |
| 5538 | Audit of Regulation 20: Duty of candour | • The results showed satisfactory compliance with the audit standards<br>• No further action required |
| 5545 | T34 loan process audit | • Medical Engineering Services (MES) have added the equipment return date to the loan form<br>• A re-audit is planned |
| **SURGERY, ANAESTHETICS & CANCER – THEATRES, ANAESTHETICS & CRITICAL CARE** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5024 | Anaesthetic involvement in hypertensive obstetric patients (Ockenden) | • A re-audit against the local SOP has taken place |
| 5198 | Recovery - Post Operative Delivery Care | • Full monitoring for all patients using portable monitoring device during transfer has commenced. The local SOP has been updated |
| 5215 | Obstetric Anaesthetic Annual Summary Report | • The results showed satisfactory compliance with the audit standards<br>• No further action required |
| 5234 | Epidural Care and Neurological Problems 2023 | • Labour ward managers and midwives have been reminded about the blue tip and observations |
| 5317 | Women who require obstetric anaesthetic referral | • An MDT (obstetricians, midwives and anaesthetists) approach has been adopted in improving the antenatal referral system |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5318 | Difficult airway management in obstetric audit | • A reminder was sent to all anaesthetist regarding improvement of documentation and improved follow up of patients |
| 5321 | Anaesthetic management - cardiac disease in pregnancy | • Improvements to the system have been made for referring to the anaesthetic antenatal clinic for patients with cardiac disease in pregnancy |
| 5322 | Anaesthetic management in patients declining blood transfusion and blood products audit | • The process has been changed to ensure that all patients who decline blood products receive anaesthetic review<br>• An audit has taken place to review referral of patients to antenatal clinic |
| 5400 | Anaesthetics for Emergency Obstetric Cases 2023 | • The audit was presented and awareness was raised regarding documentation of consent and block height |
| 5421 | Anaesthetic management of the pregnant patient with suspected or confirmed Pre-Eclampsia/Eclampsia | • Posters to remind staff that platelet check should be done within six hours prior to regional anaesthesia were created and displayed |
| 5432 | When to call consultant anaesthetist to delivery suite/or when to inform a consultant anaesthetist | • The results showed satisfactory compliance with the audit standards<br>• No further action required |
| 5468 | Post-dural puncture headache audit | • The results showed satisfactory compliance with the audit standards<br>• No further action required |
| 5469 | Raised BMI Audit | • During presentation, all anaesthetists were reminded of the importance of fully completing the assessment |
| 5645 | Anaesthetic Involvement in Antenatal Long QT Patients | • No relevant patients identified for the reporting period. This will be reviewed again in 12 months |
| 5646 | Pruritus after Intrathecal Opioids - Audit 2022 | • During presentation, anaesthetists were reminded of the importance of the management of pruritus |
| 5694 | Anaesthetic approach to the pregnant patient with suspected or confirmed malignant hyperthermia | • No relevant patients identified for the reporting period. This will be reviewed again in 12 months |
| 5699 | Suxamethonium apnoea in pregnancy re-audit | • No relevant patients identified for the reporting period. This will be reviewed again in 12 months |
| 5700 | Anaesthetic Management of Local Anaesthetic Toxicity in Obstetric Anaesthetics | • No relevant patients identified for the reporting period. This will be reviewed again in 12 months |
| 5701 | Anaesthetic management - CPR in pregnancy re-audit | • No relevant patients identified for the reporting period. This will be reviewed again in 12 months |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5733 | Post-Anaesthesia Follow-Up Pathway Review | • Further regular audits are being carried out to review compliance with this pathway |
| 5316 | Pain scores and complications after rectus sheath catheter (RSC) insertion in anaesthetics - re-audit | • Further teaching on RSC insertion was delivered at the governance meeting and will continue in theatre |
| **SURGERY, ANAESTHETICS & CANCER – HEAD & NECK AND OPHTHALMOLOGY** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5153 | Cochlear Implant Referral Criteria Audit (CIRCA) | • Audiology have added a section in the notes template for severe-profound hearing loss patients within the hearing therapy and complex hotkey to promote and record CI discussion during appointments if appropriate<br>• The BAA service quality committee resource “it’s time to talk about cochlea implants” has been shared with Audiology staff |
| 5312 | Hearing loss in adults: assessment and management - NICE NG98 & QS185 | • The results showed satisfactory compliance with the audit standards. A re-audit is planned |
| 5352 | Casenote Audit - ENT | • Session on the importance of good documentation is included in the junior doctors’ induction |
| 5506 | Post Thryoidectomy Bleed Monitoring - re-audit | • Training video has been uploaded to the intranet<br>• Module included in junior doctor’s induction |
| 5448 | Casenotes & Stamp Audit - Ophthalmology | • The results showed satisfactory compliance with the audit standards<br>• No further action required |
| 5652 | Dilate at home (DAH) | • Single DAH clinics have been set up |
| 5488 | Emergency medicine clinician knowledge, confidence and experience of managing avulsed teeth | • An information poster has been produced and displayed to improve knowledge and training required for Junior A&E staff |
| 5552 | Orthodontic Improvement project: clinic utilisation audit | • Booking guidance for orthodontic patients has been created and shared<br>• A new receptionist has been recruited to ensure that the reception desk is always covered |
| 5704 | Paediatric clinical quality report for Auditory Brainstem Response testing (ABR) | • Monitoring will take place over the next 12 months to ensure >90% calibration target is met<br>• Implementation of new peer review form on Audit base is underway. The paediatric team were consulted to ensure that time is allocated to do this |
| 5705 | Paediatric clinical quality report for hearing aid appointments 2022 | • A comments box has been added to the assessment forms where the team can add the relevant information, to help future assessments and to ensure data collections run more smoothly |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| | | • Local paediatric speech testing processes in children and local and national guidelines on speech testing were reviewed |
| 5706 | Paediatric Clinical Quality Report for Local Hearing clinics (LHC) 2023 | • Monitoring of dashboard over next 12 months is underway to ensure >90% calibration target is met<br>• A review has taken place to look at clinic planning to accommodate increased capacity<br>• Site specific data has been shared with the paediatric team |
| 5707 | Paediatric Clinical Quality Report for Pre-School Audiology Clinic (PAC) 2022-2023 | • New outcomes have been added to Audit base so the necessary training needs can be identified and given to staff<br>• A copy of the results has been shared with the community team |
| 5708 | Paediatric patient experience 2022 | • A poster has been produced to show trends per site<br>• Monitoring of the clerical teams is on-going to make sure the texts are being sent to parents after their appointment |
| 5709 | Local Hearing Clinic Audiology Clinic Vertical Audit 2022-23 | • The results showed satisfactory compliance with the audit standards<br>• No further action required |
| 5710 | Pre-School Audiology Clinic Vertical Audit 2022-23 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5791 | Paediatric patient experience 2023-24 | • Posters showing trends per site have been displayed. Data shared with the Paediatric team and wider Audiology groups |
| 5546 | EYE PA DNA Audit | • The manager has liaised with finance and other relevant departments and the outreach clinics have now recommenced |
| 5430 | COVID-19 Delay audit | • Patients identified where harm may be possible due to delay from the COVID-19 pandemic were brought in for review on urgent appointments |
| 5429 | Telephone clinic audit | • The audit has identified the telephone clinic is successful so these have been continued |
| 5639 | Delay to treatment in orthodontics referral for dento-alveolar procedures since post COVID pandemic | • Plan to introduce tabletop MDT clinics to allow patient assessment virtually<br>• The planned new elective hub will increase capacity and improve waiting times |
| 5805 | Pre-School Audiology Clinical Quality Report 2023-24 | • Monitoring of dashboard over next 12 months is underway to ensure >90% calibration target is met<br>• A re-audit will include a minimum of 100 “complex” discharge patients to make sure the correct processes for discharge procedures have been followed |
| 5806 | Pre-School Audiology Clinic Vertical Audit 2023-24 | • The results were shared with the SMT team/ Community teams, ENT & Paediatric team<br>• A Vertical audit to be undertaken bi-annually |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5808 | LHC (School age) Audiology clinical vertical audit 2023-24 | • The results were shared with the SMT team/ Community teams, ENT & Paediatric team<br>• A vertical audit to be undertaken bi-annually |
| **SURGERY, ANAESTHETICS & CANCER – TRAUMA & ORTHOPAEDIC** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5108 | Post-operative infections in NOF patients | • Ongoing surveillance which includes all infected cases recorded on a database |
| 5242 | Compliance to ASIA spine chart for spine fractures 2022 - re-audit | • The results showed improvement since the previous audit and satisfactory compliance with the audit standards |
| 5503 | Achilles Tendon Rupture Complication Audit | • The continued audit of patient care shows improved outcomes and reduced complication rates |
| 5577 | Outpatient satisfaction survey - fracture clinic 2023 | • Information about expected waiting times is written on the notice/information board in the patient waiting area |
| 5616 | Work up for neck of femur patients by Emergency Department | • The results showed satisfactory compliance with the audit standards<br>• No further action required |
| 5617 | Work up for neck of femur patients by Emergency Department - re-audit | • The results showed satisfactory compliance with the audit standards<br>• A re-audit is planned |
| 5622 | Patient initiated follow-up (PIFU) questionnaire - second cycle | • The results showed satisfactory compliance with the audit standards<br>• A re-audit is planned |
| 5685 | Group and Save for Ankle Fracture Fixation | • The results showed satisfactory compliance with the audit standards<br>• No further action is required |
| **SURGERY, ANAESTHETICS & CANCER – SURGERY** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 4948 | Early and locally advanced breast cancer - NG101 re-audit 2021 | • The results showed satisfactory compliance with the audit standards<br>• No further action is required |
| 5397 | Review Of Re-excision after Primary Breast Conserving Operations for Cancer | • The results showed satisfactory compliance with the audit standards (results fell within the national average)<br>• To be re-audited every three years to ensure compliance is maintained |
| 5398 | National Margin Audit 2 (NMA2) | • The results showed satisfactory compliance with the audit standards (results fell within the national average)<br>• To be re-audited every three years to ensure compliance is maintained |
| 5615 | Change of practice for localisation of impalpable breast cancer | • Further audit of Magtrace against NICE guidance will be carried out to assess cost effectiveness and improve theatre utilisation. |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 4733 | Patient information following appendicectomy | • A patient leaflet has been developed and is handed out to ensure consistent advice is provided to patients |
| 4956 | One-year mortality for patients presenting to SaTH | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5356 | Obesity: identification, assessment and management of overweight and obesity in children, young people and adults - Obesity: NICE CG189 & Clinical assessment and management QS127 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5519 | Liver Shrinkage Diet in elective cholecystectomy patients with high BMI | • Liver shrinking diet advice is now provided for obese patients listed for cholecystectomy |
| 4954 | Endoscopy Unit Patient Satisfaction Questionnaire - re-audit | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5373 | Colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas - NICE CG118 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5573 | Upper GI Bleeding Audit 2022 | • GI bleed proforma and guidelines have been developed for use in ED |
| 5614 | Pancreatic Cysts | • The Trust has reviewed practice in other centres to help facilitate improvement |
| 5254 | Gallstone disease - NICE CG188 re-audit | • NICE standards were mainly adhered to. Patients who were not offered cholecystectomies were seen by a specialist surgeon and were considered unfit for surgery. Delays were noted in referral to the upper gastrointestinal (GI) team. The referral pathway is being reviewed and updated |
| 5467 | Case note audit – general surgery | • Session included in induction programme |
| 5548 | Routine preoperative tests for elective surgery (NG45) | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5370 | Case note and Stamp - urology | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5464 | Urinary Incontinence in neurological diseases (CG148) | • The Clinical Nurse Specialists have been educated on the importance of ensuring patients and relatives are involved in discussions about potential complications |
| 5662 | Urology on the day (OTD) Theatre Cancellation Audit | • To reduce rate of OTD cancellations, the SOP has been updated |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5465 | Bypass surveillance audit | • The vascular team now adds instructions in the operation note for the patient to have an ultrasound scan within six weeks<br>• A re-audit is planned |
| 4773 | Patient Information Leaflets provision as part of consenting process for Vascular surgery Operations | • The audit showed good compliance with the standards following the introduction of a patient leaflet. These will continue to be provided to patients |
| 5433 | Assessing the length of hospital stay following parathyroid operation compared to national standards | • This protocol has been successfully implemented in patients with secondary hyperparathyroidism who are deemed suitable for day case parathyroidectomy |
| 5671 | Vascular audit of surveillance imaging after endovascular aneurysm repair (EVAR) and bypass surgery re-audit | • To ensure the appropriate scan is requested instructions are now be included on the operation note |
| **SURGERY, ANAESTHETICS & CANCER – ONCOLOGY & HAEMATOLOGY** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5270 | Venetoclax with azacitidine for untreated acute myeloid leukaemia when intensive chemotherapy is unsuitable - NICE TAG765 | • The results showed satisfactory compliance with the audit standards<br>• A re-audit will be carried out to ensure compliance is maintained |
| 5420 | Myeloma: diagnosis and management - NICE NG35 | • Provision of cross-sectional imaging was reviewed and updated with the radiologists |
| 4947 | Case notes - oncology | • A teaching session was delivered to target areas for improvement |
| 5210 | Opioids in palliative care - NICE CG140 re-audit | • A staff leaflet is being written on communication and advice to be given to patients/family |
| 5238 | Hospital Palliative Care Team - patient survey | • The results showed satisfactory compliance with the audit standards<br>• No further action required |
| 5348 | Neutropenic sepsis - NICE CG151 - re-audit | • Stickers with the scoring system have been implemented to act as a prompt |
| 5471 | CT audit - 6M clinical – 347 | • A manufacturer visit to review laser stability was carried out |
| 5473 | Palliative mortality - 2yrs – 349 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5474 | QAPs satisfied through management meetings – 350 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5475 | QC - WI check for linac optics etc – 351 | • All 7 WI documents have been updated |
| 5476 | Patient satisfaction 2022 – 352 | • The results showed satisfactory compliance with the audit standards. No further action required |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5477 | Technical Test Equipment 2023-01-12 – 353 | • A request has been logged for missing calibration certificate from the calibration service |
| 5478 | Pregnancy status and laterality for treatment – 354 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5479 | 3rd check + weeklies – 355 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5480 | Chemo spill training Jan 2023 – 356 | • A new signatory list has been produced to ensure that all staff have received appropriate training |
| 5481 | Prostate treatment re- audit Jan 23 – 357 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5482 | Consent audit Jan 2023 – 358 | • The Quality Audit Protocol has been updated |
| 5483 | Concessions 2022 – 359 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5484 | Nonconformity forms review Nov - Feb – 360 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5554 | Patient ID & Accessories – 361 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5555 | Bone single # % achieved over 2022 – 362 | • The audit summary was discussed at the management meeting and safety meeting to ensure doctors aware |
| 5556 | QAP 5.1-Review – 363 | • The QAP has been updated to reflect changes needed from concession, WI 92R and breast + prostate review |
| 5557 | QAP 1.4-QA Document and Data control – 364 | • An update has included to include MPE statement.<br>• The master list of reference documents has been updated |
| 5558 | QAP 1.4-QA All quality documents should be reviewed in a timely manner – 365 | • Seven documents have been reviewed/removed |
| 5559 | Management of prostate patient side effects – 366 | • The midstream specimen of urine (MSU) protocol was reviewed and updated |
| 5560 | Recorded off-protocol treatments – 367 | • A protocol review is underway for each of the four areas, West Midland Cancer Alliance (WMCA) protocol has been adopted and a companion document produced |
| 5561 | Photon QC Results – 368 | • Brief instructions were obtained from the engineers on steering adjustments from Varian to allow steering correction when necessary<br>• A new standard plan has been created |
| 5562 | Gynae Radical Radiotherapy Audit – 369 | • Additional training on image guided radiotherapy (IGRT) has taken place |
| 5563 | IRR17 Audit – 370 | • The radon risk assessment has been given to health and safety for a review |
| 5564 | IGRT Rectum Prostate Audit – 371 | • A urology site specific group meeting took place and agreed to the introduction of this approach |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5565 | Radiotherapy On Call 2022 Audit – 372 | • CT log book reminder was sent to staff |
| 5566 | Scanning Spot Check Audit – 373 | • A repeat audit was carried out to check what is happening now. An updated WI was issued with allowance for any staff member to be able to scan and approve these documents so that it is not just band 6 rads |
| 5746 | Handover log – 374 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5747 | 3rds and weekly checks audit – 375 | • Changes have been made to the weekly checking protocol to make this check more manageable for staff while ensuring those patient groups with more complexity are still managed effectively |
| 5748 | Peer review check – 376 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5750 | Head and neck patients on treatment – 378 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5751 | Quality records – 379 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5752 | Cat 2 gaps- 380 | • The results were discussed with pre-treatment Support and tech support to increase awareness |
| 5753 | Mortality review – 3 years- 381 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5754 | Audit mapping – 382 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5755 | Brachytherapy – 383 | • The results were shared with the gynaecology consultants to improve compliance |
| 5756 | Colorectal patients fail 1st CT planning scan – 384 | • Pre-assessment will be trialled for this group of patients |
| 5757 | Lung Radiotherapy volumetric imaging - 385 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5758 | Prostate CBCT consistency audit - 386 | • A reminder was sent to radiographers to sign for images matched and to circle all aspects of image match on imaging forms, and to seek support if there are issues with matching images |
| 5759 | Head & Neck Radiotherapy volumetric imaging – 387 | • A memo was sent to staff to ensure they check the scanned documents for legibility prior to approval |
| 5760 | IMC consistency audit – 388 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5761 | Bladder CBCT consistency audit – 389 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5763 | Colorectal consistency audit - 391 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5764 | Gynae CBCT consistency audit - 392 | • A reminder was sent to radiographers to ensure they circle all aspects of image match on imaging forms and to sign for images taken even when not treated on |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5765 | Staff IGRT competency audit – 393 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5766 | KV MV SE audit – 394 | • Radiographers were reminded to check the protocols for imaging scheduling if unsure, and to record reasons for taking additional images |
| 5767 | Quality documentation audit - 395 | • A concession was completed for out-of-date documents |
| 5780 | QPA, QP, QO, management review 2023 - 396 | • A change management review is underway |
| 5781 | Training record audit – Treatment Jan 2024 - 397 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5782 | Gulmay - 398 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5783 | Drug cupboard temperature recording LA1 - 399 | • A reminder was added to the newsletter of the correct process for reporting temperature deviation |
| 5784 | Automatch feasibility for morning QA - 400 | • Automatch will not be used for morning QA as a replacement for one radiographer matching |
| 5785 | Patient feedback forms 2023 - 401 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5786 | Datix review 2023 - 402 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5787 | Concessions review 2023 - 403 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5789 | 3rd check and on treatment checks- 405 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5790 | Audit QAP + process - 406 | • The quality assurance process is being updated |
| **MEDICINE & EMERGENCY CARE – EMERGENCY CARE** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5244 | Transient loss of consciousness ('blackouts') in over 16s - NICE CG109 | • A teaching session was held on the TLOC guidelines. The TLOC standards were added to message of the week |
| 5355 | ED documentation audit 2022 | • “Perfect week” happened in November which resulted in improved triage times |
| 5417 | Prescribing in resuscitation | • The use of professional registration numbers to annotate prescriptions was highlighted in ED Board Rounds. Prescribing of oxygen in accordance with target Sp02 is now included on the ED CAS card |
| 5524 | Oxygen prescribing in the Emergency department | • Oxygen prescribing was included on the message of the week |
| 5536 | Anaphylaxis - assessment and referral (CG134 & QS119) | • Information has been provided to the treating doctors |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5636 | Age-adjusted D-dimer in patients with suspected pulmonary embolism with a low clinical probability in a district hospital | • The introduction to streamline request form in requesting CTPA is being reviewed by the radiology department |
| **MEDICINE & EMERGENCY CARE – MEDICINE** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5500 | Chest pain of recent onset: assessment and diagnosis - CG95 | • An educational poster has been produced to give a clear understanding about symptoms of sudden onset chest pain<br>• A checklist has being created to further improve compliance |
| 5505 | Bisphosphonates for treating osteoporosis - TAG 464 (zoledronate) | • Results show that majority of patients are treated with Zoledronate in accordance with guidelines<br>• Fracture liaison service has been set up for the county |
| 5221 | Dermatology minor procedures audit | • No recommendation made as no concerns identified |
| 5271 | Apremilast for treating moderate to severe plaque psoriasis - NICE TAG419 | • The results showed satisfactory compliance with the audit standards<br>• No further actions required |
| 5279 | Atopic eczema in children - CG57 & Atopic eczema in under 12s - QS44 | • Patient documentation has been updated in line with NICE guidance |
| 5280 | Secondary bacterial infection of eczema and other common skin conditions: antimicrobial prescribing - NG190 | • The results showed satisfactory compliance with the audit standards<br>• No further actions required |
| 5529 | Perioperative wound infection | • Tissue viability nurse contacted and agreed current dressing choice not suitable therefore switched to an alternative dressing. Surgical staff informed of this and to implement immediately<br>• Nursing staff have replaced all literature with new updated leaflets |
| 5171 | Diabetic foot problems: prevention and management - NICE NG19 | • Issues with foot screening were highlighted to the Community providers |
| 5405 | Hypo Box audit | • A Hypo box checklist has been updated<br>• “Think glucose” stickers have been supplied to all areas |
| 5406 | Adherence to diabetic ketoacidocis (DKA) treatment /management pathway | • A new proforma has been developed and training has been delivered in high dependency areas |
| 5407 | Think glucose compliance | • Link information to Think Glucose Champions has been shared with staff in their areas. A new referral criteria has been distributed to all wards |
| 5408 | Hypoglycaemia treatment and concordance pathway | • Hypoglycaemia management has been incorporated into mandatory trust courses to all junior doctors and nursing staff<br>• The Trust guidelines have been updated |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5409 | Maternity clinical outcomes of type 1 DM service | • There are current discussions regarding a pre-conception service, however there is still no formally commissioned pre-conception service<br>• A meeting has been requested to discuss plan for new pregnancy Hybrid Closed Loop (HCL) pump |
| 5411 | Key performance data for benchmarking and service improvement | • A new Database has been set up to ensure data is easily accessible<br>• A re-audit is planned |
| 5412 | Complex diabetes clinic outcome data | • Psychology support in diabetes clinics is being reviewed by consultants<br>• Draft contracts for patients to sign at beginning of clinic (expectations of clinic) are being drafted |
| 5413 | Patient satisfaction - services provided in insulin pump therapy | • In response to feedback received time slots have been increased to allow more time during appointments |
| 5416 | Patient satisfaction (Think Glucose) | • Trial of self-administration on SAU is planned. Insulin adjustment stickers have been devised and are currently in discussion with safe medication committee |
| 5253 | Management of acute kidney injury (AKI) in AMU - NICE NG148 & QS76 | • To increase awareness amongst staff the audit was presented at several meetings |
| 5353 | Case notes - medicine | • An education session was delivered |
| 5486 | Discharge process in SDEC re-audit | • The audit showed that compliance with the guideline has since the last audit<br>• No further actions required |
| 4837 | Improving culture negative peritonitis rate | • Improvement in the rate of culture-negative peritonitis was shown. No further actions required |
| 4933 | Renal replacement therapy and conservative management - NG107 | • The results showed satisfactory compliance with the audit standards. No further actions required |
| 5158 | PD Peritonitis re-audit | • The results showed satisfactory compliance with the audit standards<br>• No further actions required |
| 5452 | Renal Alteplase issues re-audit | • Pharmacy will explore alternative price models and supply chains for the drug |
| 5553 | Urine dip stick documentation to vital pac | • Urine dip documentation is now included in the Trust induction programme |
| 5638 | Improving the consent process in the renal department - re-audit | • Consent training is now mandatory<br>• A consent checklist has been introduced<br>• A re-audit is planned |
| 5126 | Psychological distress in lung cancer: patient self-assessment versus lung CNS clinical judgement | • Holistic needs assessment is now being carried out by the Lung Cancer Nurse Specialist (LCNS) at the point of diagnosis. LCNS now asks patients to describe distress using the distress thermometer |
| 5613 | Case notes audit - medicine | • Further education of doctors being carried out to stress the importance of completing the minimum standard for documentation. The governance lead is |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| | | working with the team to ensure chaperone details are recorded in the case notes |
| 5354 | Stable angina: management - NICE - CG126 and Stable angina - QS21 | • A letter of correspondence was sent to GPs to emphasize the importance of Lipid Management |
| 5653 | Safer Opioid Prescribing | • Posters have been produced and teaching sessions arranged. These include world health organisation (WHO) step ladder for analgesic prescription, timely co- prescription with opiates and key points of the Trust guidance |
| **WOMEN & CHILDREN'S – GYNAECOLOGY** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 4809 | UTI rates after urodynamics | • The current guidelines will be discussed in Uro-gynaecology MDT. The guideline has been updated to incorporate stricter implementation of pre-procedure prophylaxis in high risk women |
| 5169 | Casenote audit - gynaecology | • Discussion included at Induction – includes the importance of documentation, use of stamp, date and time, contemporaneous entry<br>• A re-audit is planned |
| 5359 | Fibroid Sarcoma | • Current 2 week wait pathway and multi-disciplinary review process is appropriate |
| 5435 | GATU note audit (Smears and Doctors name) | • Doctors are now prompted to check smear history and offer a smear to patients who are not up to date |
| 5609 | Colposcopy patient satisfaction survey 2023 | • Clinic 6 facilities identified as sub-standard; this has been added to the risk register<br>• A re-audit is planned |
| **WOMEN & CHILDREN'S – NEONATOLOGY** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5213 | Neonatal Hypocarbia management | • An audit of prescription of respiratory support is planned. Action has been taken to ensure blood gases are now signed to evidence review by member of the medical team |
| 5426 | Badgernet system audit for preterm birth communication - re-audit | • The neonatal team are now documenting pre-birth discussions on Maternity Badgernet<br>• The neonatal network are working towards implementation of tertiary team support for parental discussions at that level |
| 5517 | Casenote Audit - Neonatal | • The Documentation Guide has been displayed on the unit |
| 5580 | Perinatal Optimisation for Preterm Babies – caffeine, probiotics, VTV | • A review of the guideline is in progress in view of differences in nationally available recommendations |
| **WOMEN & CHILDREN'S – OBSTETRICS** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5246 | Management of third and fourth degree perineal trauma | • Procedure specific consent form for third and fourth degree tears has been designed and implemented<br>• The current service is being integrated into the post-partum haemorrhage service |
| 5286 | Care of Women in Labour on Consultant Delivery Suite | • A poster has been designed by the digital and fetal monitoring midwife highlighting “Time when Fresh eyes are due are on the board”<br>• Purple pushing pen has been introduced, this will highlight time active second stage and updates |
| 5344 | Antenatal and Postnatal Mental Health - NICE CG192 and QS115 | • The process and leaflets for referrals to the birth reflections clinic are being updated<br>• A memo was sent to community midwives reminding them to discuss mood during the postnatal period |
| 5372 | Enhanced Recovery Pathway (ERP) following Caesarean Section | • The SOP has been amended now that the ERP has been implemented |
| 5431 | Implementation of the new fetal growth surveillance pathway - initial risk assessment | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5462 | Bladder care v7.4 (009) October 2021 – March 2024 | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5463 | HIV Infection management in maternity | • This audit did not show whether women were advised how they would receive their results. Planned audit of antenatal screening guideline will provide this information<br>• Cases of non-compliance will be highlighted to the screening midwife and booking co-ordinator. |
| 5485 | Induction of labour care pathway – delays due to high activity or short staffing (Ockenden IEA 10.5) | • A framework was developed and published for women awaiting transfer to labour ward for artificial rupture of membranes (ARM)<br>• A re-audit is planned |
| 5487 | Electronic situation background assessment recommendation (SBAR) handovers in the antenatal, intrapartum and postnatal periods | • Staff have been encouraged to use SBAR in safety huddles, and ward meetings |
| 5514 | Smoking cessation in pregnancy and the postnatal period | • The guideline has been updated to reflect current guidance |
| 5571 | Concealed Pregnancy - (includes management for women who are booked elsewhere) - 027 (1) | • Referrals to Children’s Social care will only be completed if the safeguarding threshold has been met. This is in line with the Local Authority’s Safeguarding Partnership guidance. The concealed pregnancy guideline has been updated to reflect this |
| 5576 | Acute Fetal Hypoxia - re-audit | • The results showed satisfactory compliance with the audit standards. No further action required |
| 5745 | Patient Information Guideline – Maternity - 127 (1) | • Badgernet training updates now include ward support assistants and midwifery support workers |

| TABLE 4 – Trust local audits 2023-24 (235) | | |
|---|---|---|
| 5507 | Newborn Blood Spot screening | • To review informed consent further, an assessment of how much digital information is being access by patients will take place<br>• Work is in progress to provide information in different formats |
| **WOMEN & CHILDREN'S – PAEDIATRICS** | | |
| **No.** | **Audit Title** | **Key actions/improvements following audit** |
| 5095 | Investigation and management of BRUE (Brief Resolved Unexplained Event) in the West Midlands | • A poster has been designed summarising the recommendations |
| 5349 | Faltering growth: recognition and management of faltering growth in children - NICE NG75 | • To improve documentation, the key findings were highlighted to junior staff |
| 5367 | Diarrhoea and vomiting in children under five - CG84 | • An education session was delivered to improve documentation of assessments and management |
| 5384 | Paediatric cervical lymphadenopathy | • Review system updated to ensure correct investigations requested<br>• A re-audit is planned |
| 5446 | Arthritis (juvenile idiopathic, systemic) - tocilizumab - TAG238 | • The results showed satisfactory compliance with the audit standards. No further action required |

## CLINICAL AUDIT OUTCOMES

The reports of 235 clinical audits were reviewed by the provider and a compliance rating against the standards audited agreed. However, 20 (8%) of these local audits demonstrated significant non-compliance with the standards audited (compared to 14% for 2022/2023). On completion of the audit, the lead auditor fills in a sign-off form with the audit conclusions, recommendations, and action plan. This includes 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 specialty 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=20)

| Table 5 – audits demonstrating significant non-compliance with standards audited (20) | | |
|---|---|---|
| **CLINICAL SUPPORT – PATHOLOGY & RADIOLOGY AND THERAPIES** | | |
| **No.** | **Audit Title** | **Recommendations - actions** |
| 5530 | An assessment of practice when performing X-rays on ITU and HDU on newly acquired mattresses with X-ray detector pouch | • It was agreed that practice will not be changed when undertaking portable X-rays in ITU and HDU with the new mattress. The imaging detector should be placed directly under the patient's back, as before and the X-ray pouch is not to be used due to the inherent risk that it poses<br>• The audit report was sent to Hillrom as they were keen to receive feedback |
| 5424 | Radiological guidance for the recognition and reporting of osteoporotic Vertebral Fragility Fractures (VFF) | • The audit results were presented to raise awareness within the radiology team of the template on PACS to use when needed<br>• An email was sent to outsourcing company to give feedback on Royal College of Radiologist (RCR) guidance |
| **SURGERY - ANAESTHETICS, THEATRES & CRITICAL CARE** | | |
| **No.** | **Audit Title** | **Recommendations - actions** |
| 5646 | Pruritus after Intrathecal Opioids - Audit 2022 | • All anaesthetists have been reminded regarding the management of pruritus in the presentation of this audit |
| 5317 | Women who require obstetric anaesthetic referral | • An MDT (obstetricians, midwives and anaesthetists) approach has been adopted in improving the antenatal referral system |
| **SURGERY - HEAD, NECK AND OPHTHALMOLOGY** | | |
| **No.** | **Audit Title** | **Recommendations - actions** |
| 5639 | Delay to treatment in orthodontics referral for dento-alveolar procedures since post COVID pandemic | • Plan to introduce tabletop MDT clinics to allow patient assessment virtually<br>• The planned new elective hub will increase capacity and improve waiting times |
| 5552 | Orthodontic Improvement project: clinic utilisation audit | • Booking guidance for orthodontic patients has been created and shared<br>• A new receptionist has been recruited to ensure that the reception desk is always covered |
| 5153 | Cochlear Implant Referral Criteria Audit (CIRCA) | • Audiology have added a section in the notes template for severe-profound hearing loss patients within the hearing therapy and complex hotkey to promote and record CI discussion during appointments if appropriate<br>• The BAA service quality committee resource "its time to talk about cochlea implants" has been shared with Audiology staff |
| **SURGERY – MSK** | | |

| Table 5 – audits demonstrating significant non-compliance with standards audited (20) | | |
|---|---|---|
| **No.** | **Audit Title** | **Recommendations - actions** |
| 5503 | Achilles Tendon Rupture Complication Audit | • The continued audit of patient care shows improved outcomes and reduced complication rates |
| **SURGERY – SURGERY** | | |
| **No.** | **Audit Title** | **Recommendations - actions** |
| 4773 | Patient Information Leaflets provision as part of consenting process for Vascular surgery Operations | • The audit showed good compliance with the standards following the introduction of a patient leaflet. These will continue to be provided to patients |
| 5671 | Vascular audit of surveillance imaging after EVAR and bypass surgery re-audit | • To ensure the appropriate scan is requested instructions are now be included on the operation note |
| **MEDICINE – EMERGENCY MEDICINE** | | |
| **No.** | **Audit Title** | **Recommendations - actions** |
| 5244 | Transient loss of consciousness ('blackouts') in over 16s - NICE CG109 | • A teaching session was held on the TLOC guidelines<br>• The TLOC standards were added to message of the week |
| 5380 | RCEM: Mental Health 2023 (RSH) | • All underlying mental health policies for the Emergency Departments have been reviewed and updated<br>• An education programme has been agreed |
| 5524 | Oxygen prescribing in the Emergency department | • Oxygen prescribing was included on the message of the week |
| 5539 | RCEM Care of the Elderly QIP | • Going forward all patients over the age of 75 with a National Early Warning Score (NEWS2) of four or less will have a delirium screen completed and documented |
| **MEDICINE** | | |
| **No.** | **Audit Title** | **Recommendations - actions** |
| 5409 | Maternity clinical outcomes of type 1 DM service | • There are current discussions regarding a pre-conception service, however there is still no formally commissioned pre-conception service<br>• A meeting has been requested to discuss plan for new pregnancy Hybrid Closed Loop (HCL) pump |
| 5412/5415 | Complex diabetes clinic outcome data and patient satisfaction survey | • Psychology support in diabetes clinics is being reviewed by consultants<br>• Draft contracts for patients to sign at beginning of clinic (expectations of clinic) are being drafted |
| 5513 | Bone protection in Parkinson's disease | • The audit identified a need for patient education. Lifestyle advice leaflets are in the design stage, scheduled to be rolled out by the end of 2024 |

| Table 5 – audits demonstrating significant non-compliance with standards audited (20) | | |
|---|---|---|
| 5553 | Urine dip stick documentation to vital-pac | • Urine dip documentation now included in the Trust induction programme |
| 5653 | Safer Opioid Prescribing | • Posters have been produced and teaching sessions arranged. These include world health organisation (WHO) step ladder for analgesic prescription, timely co- prescription with opiates and key points of the Trust guidance |
| **WOMEN & CHILDREN'S** | | |
| **No.** | **Audit Title** | **Recommendations - actions** |
| 5485 | Induction of labour care pathway – delays due to high activity or short staffing (Ockenden IEA 10.5) | • A framework was developed and published for women awaiting transfer to labour ward for artificial rupture of membranes (ARM)<br>• A re-audit is planned |

## RESEARCH AND INNOVATION

In 2023/24 we have continued to deliver the co-produced Research and Innovation (R&I) Strategy with the overarching vision to make research and innovation a fundamental part of care at SaTH. The R&I Department aims to embed research this year across the Trust, through working in collaboration with SaTH Improvement, Clinical Audit and Education, to support staff to develop their research skills, whilst also providing good quality governance around projects and studies that are delivered at SaTH. The research delivered at SaTH aims to improve the quality of care and positive experiences for patients when accessing our services, as well as strengthening the Trusts ambitions to secure University Hospital Status.

The number of patients that have been recruited to participate in research during the financial year of 2023/24 was 1,733 (for studies approved by a Research Ethics Committee and the Health Research Authority) across 55 studies covering 16 specialities across SaTH.

Some of the successful studies that have recruited well this year include within women's and children's NEO-GASTRIC study recruiting 23 babies so far, LOCI a fertility study which has been successful resulting in 11 pregnancies.

Within our generic team ASCEND PLUS is trialling a new model of recruitment out of locality with 115 patients recruited so far. SUNFLOWER – an excellent collaboration with the Research Delivery and Surgical Team, which has already been overrecruited. ADAPT – an excellent collaboration with Critical Care looking at treatment for sepsis and 67 patients have been recruited so far.

POETIC-A - SaTH won the following awards: First in Registration data (100% submission with over 100 CRFs); third in Randomisation data (99% submission with over 100 CRFs) and PROPHETIC – a commercial study.

During the 2023-24 year the Trust has successfully secured a number of grant applications through collaboration with our academic partners, including OBS-UK (a multi-site post-partum bleeding study - with the University of Cardiff, funded by the NIHR) which has allowed staff to recruit three quality improvement senior midwives to support implementation of the study national and a Breast Cancer lifestyle choices study (multi-site NIHR funded) led by breast surgeon Blossom Lake.

The R&I Department continues to deliver and promote access to high quality research related training and R&I is now part of the corporate induction programme, alongside being embedded with trainee doctors, consultant welcomes and associate nursing programmes. A new Research Across SaTH group has been introduced to further increase engagement in R&I throughout the Trust.

It also continues to focus on supporting patients, carers and staff to access high quality research and have been working closely with Education, Improvement and Clinical Audit teams to ensure that a culture of research, innovation and education, is embedded as part of core business at SATH.

R&I continues to be committed to patient, public engagement and involvement in research and this year have introduced two lay members to the R&I committee, alongside supporting a number of grant applications gaining the perspective of patients within different specialities including surgical, cancer and women and children's. This area continues to grow, as the team plans to introduce a patient celebration event next year, in order to thank individuals for their participation in research and also create patient research champions group to further advise on the development, design and implementation of homegrown research at SaTH.

As part of R&I's continuous improvement commitment, SaTH have received 122 completed Participant Research Experience Survey's (PRES) this year and have implemented a number of improvement projects through reviewing this feedback (this includes the patient celebration/thankyou event).

SaTH is an active contributor to a regional approach to look at research governance at an Integrated Care Systems 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. This collaboration strengthens SaTH's ability to ensure access to quality research across the wider region.

A formal memorandum of understanding has been implemented between Keele University and R&I to further support the collaboration between SaTH in terms of R&I partnership and R&I Director Will Parry-Smith has this year taken up a Professorship with the University. R&I continues to support SaTH's efforts to achieve University Hospital Status.

## DIGITAL TRANSFORMATION

The Trust's Digital Strategy outlines how we will meet the core capabilities in The Frontline Digitisation Minimum Digital Foundations (MDF), What Good Looks Like (WGLL) Framework and how we will work towards Level 5 on the HIMSS EMRAM maturity model. 2023/24 has seen significant progress towards meeting our strategic priorities and the requirements set out by NHS England.

### Digital Clinical Leadership and Engagement

Clinical leadership is essential to ensuring safe and effective implementation of new digital systems and capabilities. Our capabilities have been significantly enhanced over the past year with the introduction of certain new roles and engagement opportunities.

- Appointment of Chief Nursing Information Officer and Chief Clinical Information Officers
- Establishment of a Digital Nursing Team
- Expansion of Clinical Safety Team and Clinical Safety Officers
- Inaugural Digital Health Forum providing an opportunity for all staff to engage with the Digital Roadmap
- Over 300 change agents trained and supporting digital changes

### Upgrading our Digital Capabilities – achievements in 2023/2024

April 2024 saw the successful Go-Live for CareFlow PAS/ED/PatientFlow at the Trust. This is a significant milestone for the organisation and provides the platform for future digital developments.

| | Digital Improvements | Benefits |
|---|---|---|
|  | **VITALS (upgrade to version 4.3)** | The Adult Sepsis (NICE) module has been updated to improve usability, safety and reporting. |
|  | **NEW Patient Administration System (PAS)** | Our new patient administration system (PAS) will provide access to up-to-date information and support us to improve the quality of information that we record. |
|  | **NEW Emergency Department system** | Provision of real-time, integrated, patient management system. This will ensure patient information is more accurate and accessible to the right teams, in the right place. |
|  | **NEW electronic CAS Card** | Replacement of adult and paediatric paper CAS Cards with highly accessible and legible electronic patient records. This will support real-time access to patient information when and where the clinical teams require it. |
|  | **NEW Patient Flow System (replacement for PSAG WardVision)** | Improved access to bed capacity and discharge planning information supporting improvements to patient flow. |

| | | |
|---|---|---|
| Office 365 | **Office 365 Deployment** | 5,440 devices and 8,126 users across the organisation provided with upgraded capabilities. |

### Ambitions for 2024/2025

The Digital Roadmap is focused on delivering ongoing improvement for patient care and our clinicians. Some of the many improvements that are planned for this coming year are:

- Electronic observations for Paediatric patients
- Clinisys ICE Order Comms Results Reporting
- Ongoing CareFlow Connect and Clinical Narrative development
- Patient Engagement Portal
- Medisight Ophthalmology System

## LEARNING FROM DEATHS

The Trust remains committed to learning from the care provided to those who have died within the Trust and listening to feedback provided from those who have been bereaved. A three-stage approach to learning from deaths is utilised incorporating independent Medical Examiner Scrutiny, Mortality Screening, and formal review of care provided to adults who have died using the online Structured Judgement Review (SJR) methodology. Deaths of children are reviewed using the Child Death Overview Panel (CDOP) process and, where appropriate, the Perinatal Mortality Review Tool (PMRT).

### Summary of mortality across the Trust

During 2023-2024, there were 2,090 adult and children deaths managed by the Medical Examiner Service within the Shrewsbury and Telford Hospital NHS Trust. Of these, 1,674 were within the Medicine and Emergency Care Division, 409 were within the Surgery and Cancer Care Division and seven were within the Women and Children's Division. Inpatient deaths accounted for 81% of all deaths across the Trust, with the remaining 19% occurring within the Emergency Department, which includes deaths where a decision to admit the patient to a ward had been made. There have been a total of 13 child deaths managed by the Medical Examiner Service during 2023-24, four of which occurred when the child was an inpatient and nine of which occurred in the Emergency Department. There have been five neonatal deaths where the baby was born over 22 weeks gestation and 10 stillbirths within the Trust which were not managed by the Medical Examiner Service.

| | **2023-24** | **% of all deaths** |
|---|---|---|
| **Total deaths managed by the Medical Examiner Service** | **2090** | |
| Deaths within Medicine and Emergency Care Division | 1674 | 80.1% |
| Deaths within Surgery and Cancer Care | 409 | 19.6% |
| Deaths within Women and Children's Division | 7 | 0.3% |
| Inpatient Deaths | 1697 | 81% |
| Deaths within the Emergency Department | 393 | 19% |

In accordance with the national guidance relating to Learning from Deaths (2017), all patients who die with a confirmed learning disability or autism are reported externally to LeDeR. A mandated review of the care provided prior to the death is undertaken by clinicians within the Trust and used to inform the wider LeDeR review which is completed externally. During 2023-24, 10 patients have died with a confirmed learning disability or autism. A mandated review of care is also undertaken for all patients who die within the Trust with a serious mental illness. During 2023-24, there have been 10 patients who have died within the Trust with a serious mental illness which was confirmed by the specialist mental health team.

During 2023-2024 Learning from Deaths remained a key component of the Trust 'Getting to Good' Improvement Programme, with the Learning from Deaths team successfully delivering and evidencing all agreed milestones. Compliancy was monitored through the Trust Learning from Deaths Group and the Trust Getting to Good Operational Delivery Group. The programme of work has entered the monitoring phase in preparation for the transition into business-as-usual activity with formal project closure anticipated during 2024-25.

### Improvement work undertaken during 2023-2024

- The identification of learning opportunities arising from the review of adult deaths across the Trust using the Structured Judgement Review (SJR) methodology has significantly improved over the year, with the percentage of all deaths reviewed increasing from 3% in 2022-2023 to 17.5% for 2023-2024. This is against a recommended NHSE target of 15%.

- The SJR was completed within eight weeks of the date of death in 82% of cases during 2023-2024 which ensures learning identified is both relevant and actionable. Cases which have exceeded this timeframe, have been adversely affected by resource challenges within the Clinical Coding team which impacts the availability of notes, expected and unexpected leave within the SJR reviewing team and the need for a secondary review by specialist teams delaying final completion of the SJR.

- Recruitment to a pool of three cross divisional medical SJR Reviewers has been achieved, with each reviewer having dedicated time to complete SJRs on a weekly basis.

- Senior nursing support for SJR completion to promote a multi-disciplinary approach to mortality reviews has been available from staff employed within the temporary staffing Department.
- A review of notes management to support the increased resource for SJR completion was undertaken. The new process was adopted as 'business as usual' during the latter half of 2023-2024 and has been an essential component of the overall increase in SJR completion rates and compliancy with the eight-week time

frame detailed within the Learning from Deaths Policy.

- Following resource challenges within the Trust, specialised support has been re-established to maximise the learning opportunities arising from the mandated review of care provided to those who die with a confirmed learning disability, autism or a serious mental health illness. Quarterly feedback to the Trust Learning from Deaths Group, including learning from LeDeR reviews and wider developments within the ICS, has been provided.

- Case selection for SJR has been refined and random selection of cases introduced to promote a balanced approach to mortality review. Independence is maintained through appropriate allocation of resource.

- A programme of monthly SJR Forum meetings has been established affording SJR Reviewers the opportunity to engage with peer support and share the challenges and positives of SJR completion. Training opportunities available within this forum aim to improve and sustain the quality of SJRs.

- SJR completion has been incorporated into the Consultant appraisal process.

- The effectiveness of the weekly operational Mortality Triangulation Group, established during 2022-2023 as an integral part of the governance process around learning from deaths, has continued to mature during 2023-2024.
  The network of internal and external stakeholders within the wider Integrated Care System (ICS) has grown, affording the valuable opportunity to share positive and constructive learning whilst contributing to wider quality improvement initiatives at the earliest opportunity. Examples include collaborative working with the Deteriorating Patient Specialist Practitioners, the Medicine Safety Office, Safeguarding Team, End-of-life and Palliative Care Team, and the Fluid Balance Nurse Specialist within the Trust as well as the Patient Safety Learning from Deaths Lead from West Midlands Ambulance Service and appropriate representatives from the Shropshire, Telford and Wrekin Integrated Care Board.

- The Learning from Deaths Dashboard, which was delivered operationally during 2022-2023, has continued to develop with monthly reporting to the Trust Learning from Deaths Group including a more detailed analysis of various key performance indicators including actions arising when significant concerns have been raised by the bereaved. Data validation has been a key focus of work and the provision of ward level mortality data is in progress.

- Divisional reporting to the Trust Learning from Deaths Group using a standardised template has continued to build on work undertaken during the previous year, with an increased focus on quality improvement encouraged.

- An internal audit to review the robustness of the mortality framework and the Trust's commitment to learning from deaths has been undertaken, with a focus on the structure and effectiveness of the governance arrangements in place. An overall assurance opinion of 'substantial' was awarded. This means that the governance and control arrangements in place within the service were found to be comprehensive, robust and operating effectively and a clear organisational commitment to reviewing and learning from deaths was identified.
  One risk was identified relating to appropriate resource within the Learning from Deaths team to sustain the improvements made. The audit confirmed that learning from the external peer review of the Trust's learning from deaths arrangements undertaken by NHS England and NHS Improvement in December 2022 had been addressed.

- Active engagement with the programme of work leading to the implementation of the new Patient Safety Incident Response Framework (PSIRF) in December 2023.

- Oversight of mortality within the Women and Children's Division has been a key focus during 2023-2024, with work being undertaken to improve the validation of data and reporting of learning identified internally and from national publications including the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), through the Trust Learning from Deaths Group.

- An invited external review requested by SaTH has been completed to assist the understanding of the above average neonatal mortality for babies born within the Trust and highlighted in MBRRACE reports for deaths within 2021.

- A collaborative assurance review of the care provided to patients who died within the Emergency Department during Q3 2022-2023 has been undertaken and reported to the Board of Directors, triggered by an increase in deaths during this period. No overall failures or omissions in medical or nursing care were identified that were considered to have adversely impacted on the outcome for the patients.

- Key learning themes arising from learning from deaths processes during 2023-2024 include:
    - The impact of delays within the emergency department including ambulance offload delay and long waits for admission to a ward.

- Management of fluid balance and electrolyte imbalance, including completion of fluid balance charts and the administration of intravenous fluids.
- Medication issues including time critical medications, delay in administration of antibiotics, opiate prescribing, use of nephrotoxic drugs and the use of reversal agents for example in opioid toxicity.
- The provision and quality of end-of-life care including delayed recognition of dying, communication, use of ReSPECT forms, medication management and fast track discharge issues.
- Learning around the completion of Mental Capacity Act and Best Interest Forms.
- Nursing and medical documentation issues.
- Verification of death issues.
- Readmission and discharge issues.

### Summary of key improvement targets and actions to be taken for 2024-2025

- Sustain the improvements made during 2023-2024 relating to SJR completion

- Establish a wider multi-disciplinary team approach to SJR completion and the learning from deaths processes

- In collaboration with the Performance Team, continue to refine the Learning from Deaths Dashboard to include ward level mortality data and an enhanced dataset within the emergency department including deaths that occur in the emergency department following a decision to admit to a ward

- Continue to develop and sustain the regular programme of training and support available for SJR reviewers.

## Medical Examiner Service

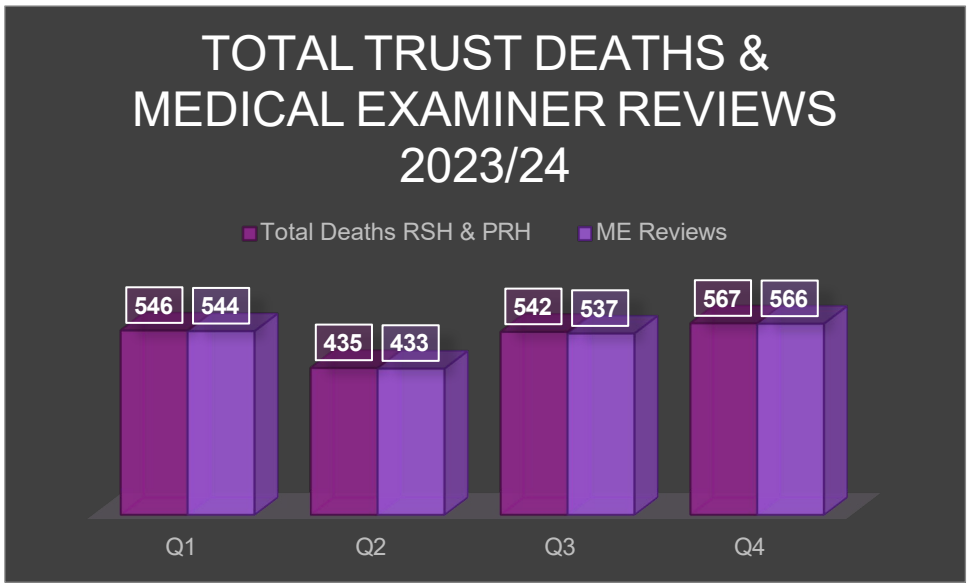
A Medical Examiner is required to review the care and treatment the patient has received during their final admission within the hospital setting and once they have held a discussion with a treating clinician, they discuss and agree an accepted cause of death.

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.

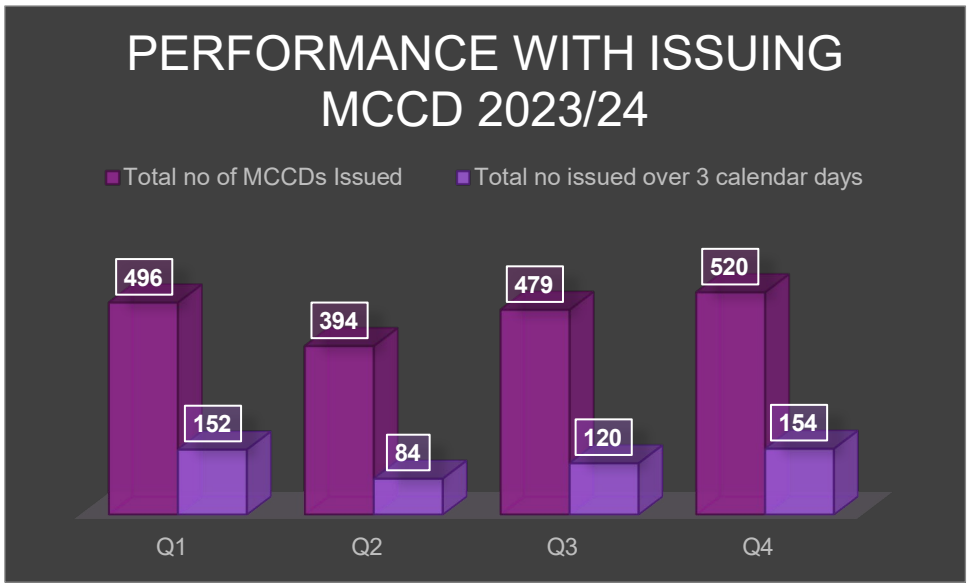
Scrutiny of the care given is also an opportunity to identify any potential learning, whether this be positive or negative, and for the Medical Examiner to identify cases where potential failings have occurred to undergo further, appropriate review, such as structured judgement review.

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, NHSE and is reported to the Trust Board. It is also monitored monthly following the development of a Medical Examiner performance dashboard, which is presented at the monthly Learning from Deaths meeting.

During 2023/24 the Medical Examiner service has undertaken reviews on 2080 deaths which is 99.5% of the total deaths that occurred in the Trust during this period.




The Medical Examiner service aims to ensure that medical certificates of cause of death (MCCD) are issued promptly to ensure relatives can register the death of their relative by the nationally agreed target of five days following the death. The service approved 1,889 MCCDs for registration throughout 2023/24 with 510 of these being over three calendar days, meaning 74% of the MCCDs were issued within the desired timeframe. This area of performance has been challenged due to the availability of doctors completing death certification due to competing clinical priorities, coupled with periods of extended bank holidays and industrial action.




The Medical Examiner service, hosted by the Trust, is extending its service to provide independent scrutiny of all deaths, not taken for investigation by a coroner, to all community providers within the STW Integrated Care System. The Medical Examiner system will become statutory from 9 September 2024.

Throughout 2023 the ME service at SaTH developed a project which has been included in the Getting to Good Programme, to enable the expansion of the service in a coordinated and robust manner. Since April 2023, the ME service has started working with several community stakeholders, including GPs, Severn Hospice, Hope House Children's Hospice, The Robert Jones and Agnes Hunt Orthopaedic Hospital, Shropshire Community Trust and the Redwoods Centre, part of the Midlands Partnership NHS Foundation Trust. A total of 229 community deaths have been reviewed by the ME service since we started working with community partners. When the ME service is statutory, no death can be registered without sign-off by either a Medical Examiner or Coroner, and so the ME service at SaTH will be responsible for reviewing an estimated additional 3,000 deaths.

Significant work has been undertaken, as part of the project, to ensure stakeholder engagement with GP practices, and non-acute health care providers to prepare the ICS for the statutory system and the death certification reforms that will be implemented because of the statutory position.

The death certification reforms will see a change to the national five-day target for registering a death. Currently the five-day target starts from the date of death. In the new system, five days will start from the date the medical examiner service authorises the MCCD and sends it to the registrar. Despite this change to the timeframe for issuing an MCCD, the ME service at SaTH does not propose changing its current target of achieving MCCDs being issued within three calendar days from the date of death and will continue with this key performance indicator. The service strives to enhance the experience that bereaved relatives experience at such a difficult time, and so keeping this performance metric in place will continue to support this.

Work has been undertaken throughout 2023/24 to define the roles and responsibilities of the Bereavement Service to ensure clear definition between the Medical Examiner and Bereavement Service is in place, to safeguard the independence of the Medical Examiner.

## COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care. Targets are based on evidence-based standards taken from the National Institute for Health and Care Excellence (NICE), Royal Colleges and other relevant national guidance. For 2023-24 11 of 17 quality indicators in the scheme were applicable to the Trust. Of these, the Trust was expected to report on 7 indicators quarterly and 1 indicator bi-annually, with data for the remaining 3 being extracted from existing national returns annually.

The CQUIN penalty (1.25% as a proportion of the fixed element of payment) for non-achievement was linked to five indicators as agreed by the Commissioners, for 2023/24. These were: CCG01, CCG02, CCG03, CCG06, CCG12.

Performance against the CQUIN indicators is shown for Q1-3 (Q4 and annual national return data unavailable at the time of collating the Quality Account). Targeted improvement work during the year for CQUIN07 including staff education, updated documentation and resources and review of systems and processes has resulted in an improvement in performance for CQUIN07. Review and updating of cancer pathways and increase of capacity in endoscopy has had a positive impact on performance for CQUIN04 and performance for both indicators now exceeds the CQUIN target. Updates to nursing documentation to improve performance for CQUIN12 was implemented towards the end of the year, and it is expected that the impact of this will be seen in 2024-25. As Part of wider changes to the Tissue Viability Nursing documentation related to PURPOSE T project work, in 2024/25 there will be an increased focus on education and training in relation to completion of the documentation. The training will focus on the thorough completion of the care plan preferences section. There is an expectation that they will train a minimum of 90% of staff in their area before September 2024.

| CQUIN | CQUIN Title | Target | Q1 | Q2 | Q3 | Q4 |
|---|---|---|---|---|---|---|
| CQUIN01 | Staff flu vaccinations | 75% to 80% | N/A | N/A | N/A | 49.0% |
| CQUIN02 | Supporting patients to drink, eat and mobilise after surgery | 70% to 80% | 96% | 74% | 83.00% | 87.5% |

| | | | | | | |
|---|---|---|---|---|---|---|
| CQUIN03 | Prompt switching of IV to oral antibiotics (*aiming for lower percentage*) | 40% to 60% | 10% | 5% | 11.11% | 10.64% |
| CQUIN04 | Compliance with timed diagnostic pathways for cancer services | 35% to 55% | 20% | 37.59% | 58.95% | 49.69% |
| CQUIN05 | Identification and response to frailty in emergency departments | 10% to 30% | 57% | 63% | 64.00% | 82% |
| CQUIN06 | Timely communication of changes to medicines to community pharmacists via the discharge medicines service | 0.5% to 1% | N/A | N/A | N/A | TBC awaiting national figures |
| CQUIN07 | Recording of and response to NEWS2 score for unplanned critical care admissions | 10% to 30% | 19.23% | 14.29% | 33.33% | 9.52% |
| CQUIN08 | Achievement of revascularisation standards for lower limb ischaemia | 45% to 65% | N/A | N/A | N/A | TBC Awaiting national figures |
| CQUIN09 | Not applicable (Lead Hepatitis C Centres) | N/A | N/A | N/A | N/A | N/A |
| CQUIN10 | Treatment of non-small cell lung cancer (stage 1 or 11) in line with the national optimal lung cancer pathway | 80% to 85% | 100% | 95.65% | 86.67% | 100% |
| CQUIN11 | Achieving high quality shared decision making (SDM) conversations in specific specialised pathways to support recovery | 65% to 75% | N/A | 83.43% | N/A | 79.10% |
| CQUIN12 | Assessment and documentation of pressure ulcer risk | 70% to 85% | 36% | 35.00% | 28.00% | 37% |
| CQUIN's 13 to 17 | Not applicable (Community/Mental Health) | N/A | N/A | N/A | N/A | N/A |

For 2024-25 the national CQUIN scheme has been paused. However, the Trust intends to continue to collect this important data linked to high quality patient care to measure the impact of changes made to improve performance during 2023-24.

## ENCOURAGING STAFF TO SPEAK UP

### Freedom to Speak Up

The Freedom to Speak Up (FTSU) team is made up of a FTSU Lead and one FTSU Guardian. Supporting the team are approximately 35 ambassadors whose role is to promote FTSU and signpost colleagues whose experience ranges from a variety of clinical and non-clinical backgrounds and who represent the diversity of the workforce across our Trust. The ambassadors undertake these roles on a voluntary basis in addition to their substantive posts.

The *Freedom To Speak up Vision and Strategy 2022-25* was published in October 2022 following approval by the Board of Directors with nine priorities, the focus on four of those during 2023/24:

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

- We led the 30 Voice project to highlight the lived experience of BAME colleagues and improvements in tackling racism
- Weekly discrimination meeting to ensure all reports of discrimination are dealt with robustly

**Priority 2**
Ensure FTSU processes are fit for purpose in line with best practice:

- Internal audit of all processes with associated actions undertaken.

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

- We developed the managers handbook and was one of the first trusts to mandate the FTSU online training, speak up, listen up and follow up

**Priority 4**

Alongside our cultural team, lead the civility and respect social movement:

- Over 1,000 people within the Trust have taken the Civility and Respect workshops.

During 2023/24, 217 contacts were raised to the FTSU team, a decrease of 23% on the previous year.

**FTSU concerns raised by quarter and year:**

| | Q1 | Q2 | Q3 | Q4 | Total | Increase/ Decrease | National Increase |
|---|---|---|---|---|---|---|---|
| **2023/24** | 47 | 52 | 68 | 50 | **217** | ↓ 23% | Not yet available |
| **2022/23** | 71 | 73 | 79 | 59 | **282** | ↓ 23 | ↑25% |
| **2021/22** | 100 | 113 | 90 | 66 | **369** | ↑ 21% | 0% |
| **2020/21** | 41 | 82 | 103 | 78 | **304** | ↑ 110% | 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 |

During 2023/24, 36% of the concerns brought to the attention of our FTSU teams were relating to inappropriate behaviours/attitudes; 27% of concerns were associated with systems and processes; 12% of concerns raised were regarding worker safety and wellbeing; 12% related to concerns about patient safety and 7% to bullying and harassment. All the concerns raised were escalated.

Of those speaking up, 28% were nurses and midwifery registered; 28% administrative colleagues; 10% allied health professionals 13% additional clinical services; 7% estates and ancillary; 7% medical and dental; 5% unknown or other; and 2% healthcare scientists.

During 2023/24 the new FTSU Policy was approved by the Trust Board and a Board Development Workshop held in November to consider the principles in the NHS England Board Self Reflection Tool.

The staff survey results on speaking up saw a marked improvement and we were confirmed by the National Guardian's Office as one of the most improved Trusts in the country for their staff survey results in relation to the speaking up questions.

### GUARDIANS OF SAFE WORKING

The Shrewsbury and Telford Hospital NHS Trust Guardian of Safe Working (GoSW) remains a member of, and regularly reports to the Medical Leadership Team.

### In the past year there has been a focus on:

- Supporting junior doctors in training by maintaining visibility via attendance at forums, junior doctors induction, and at drop-in sessions
- Continuing to champion safe working hours through regular meetings with key stakeholders
- Highlighting the importance of and promoting the use of a robust e-rostering software to enable visibility of safe working at all times
- Optimising the administrative processes to enable compliance with the exception reporting systems as mandated in Junior Doctor Contract
- Embedding the exception reporting process for locally employed doctors in addition to that established for post graduate doctors in training

Working in collaboration with the Director of Medical Education, the Medical 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 2023 to 31 March 2024, 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 based on average England figures, given the characteristics of the patients treated. 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 the 12-month rolling period January to December 2023 shows that the index for the SaTH is 98.59. This is below the national average and within the ‘as expected’

range. Observed deaths are comparable with expected deaths. SHMI data is published approximately four to six months behind the current month.

| SHMI | | | | |
|---|---|---|---|---|
| | **SaTH** | **National Average** | **National Highest** | **National Lowest** |
| **Jan-Dec 2023*** | 98.59 | 100 | 125.48 | 72.02 |
| **Jan-Dec 2022** | 99.82 | 100 | 121.86 | 71.17 |
| Data source – CHKS iCompare *Includes patients with a Covid-19 diagnosis who were previously excluded from SHMI | | | | |

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

The Trust regularly monitors mortality data at the Learning from Deaths Group. Over the past year in depth reviews have been conducted in the following admission conditions: acute cerebrovascular disease, anaemia and acute myocardial infarction. An extraordinary review has been completed and presented to the Trust Board of Directors exploring the high mortality in the emergency departments across the Trust during Quarter 3 and into Quarter 4 2022/2023.

## Percentage of deaths coded at either diagnosis or specialty 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.

## The percentage of patients re-admitted to hospital within 28 days of discharge

The data in the table below describes the percentage of patients readmitted to hospital within 28 days of being discharged.

| | SaTH 2023/24 | National Highest | National Lowest |
|---|---|---|---|
| **0-15** | 15.96% | 23.09% | 0.89% |
| **16 and over** | 8.25% | 14.34% | 2.58% |

**Data Source:** CHKS, less than or equal to 15, greater than or equal to 16

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's responsiveness to the inpatients' personal needs

The results for 2022 Inpatient Survey which were published in 2023 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 8.0 for the care and treatment section, meaning it is rated as "about the same" as other Trusts (figure 2).

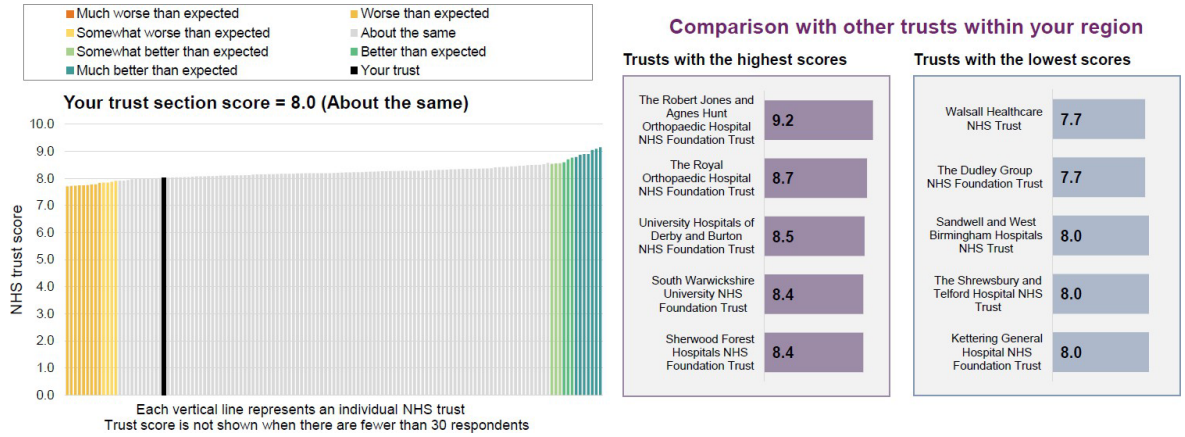



*Figure 2 – Overarching Care and Treatment Section Scoring and Benchmark Position* (National NHS Adult Inpatient *Survey, 2022)*

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. In addition to the overarching benchmark position, questions within the section can be measured individually providing greater detail (figure 3).

## Question scores

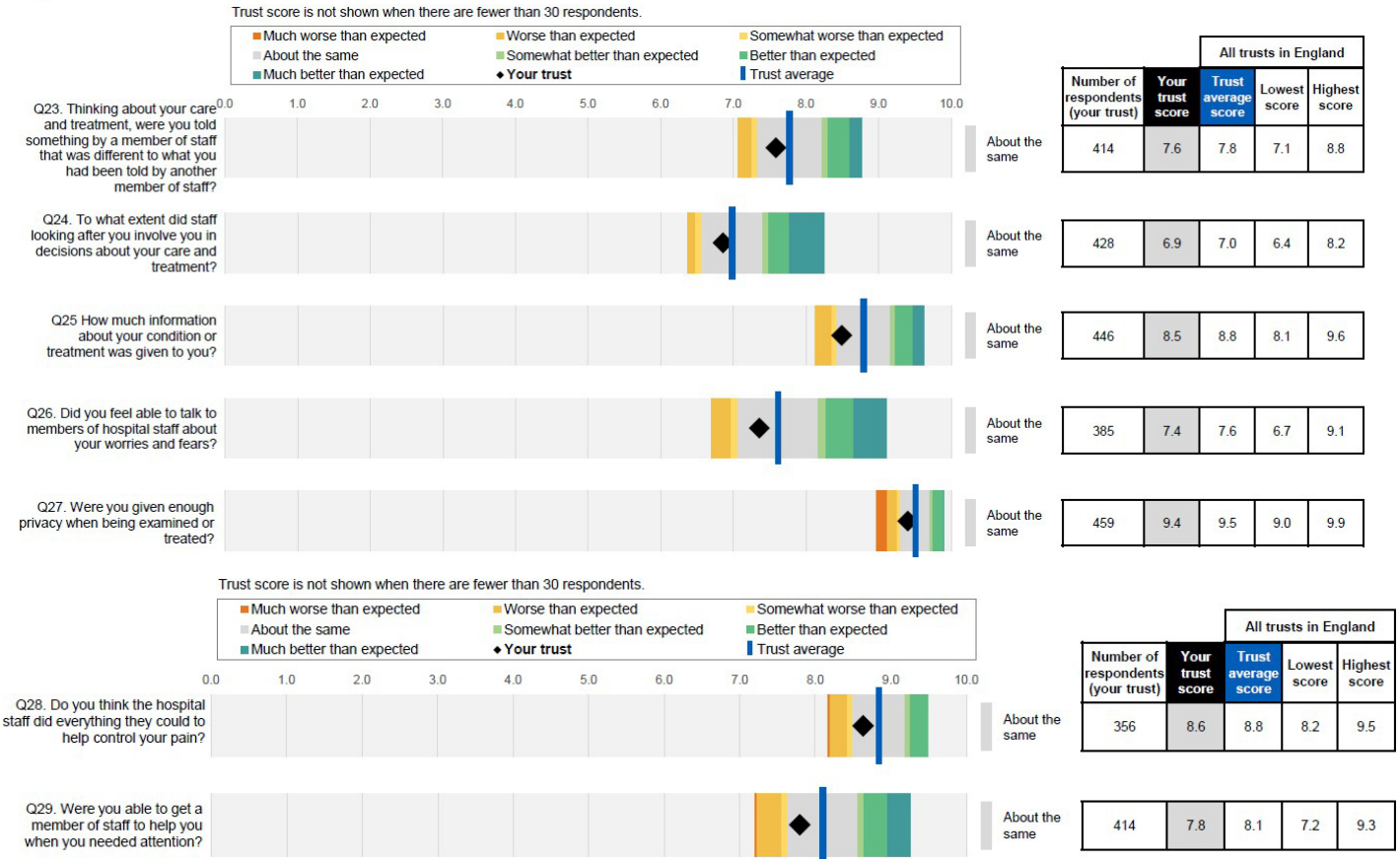
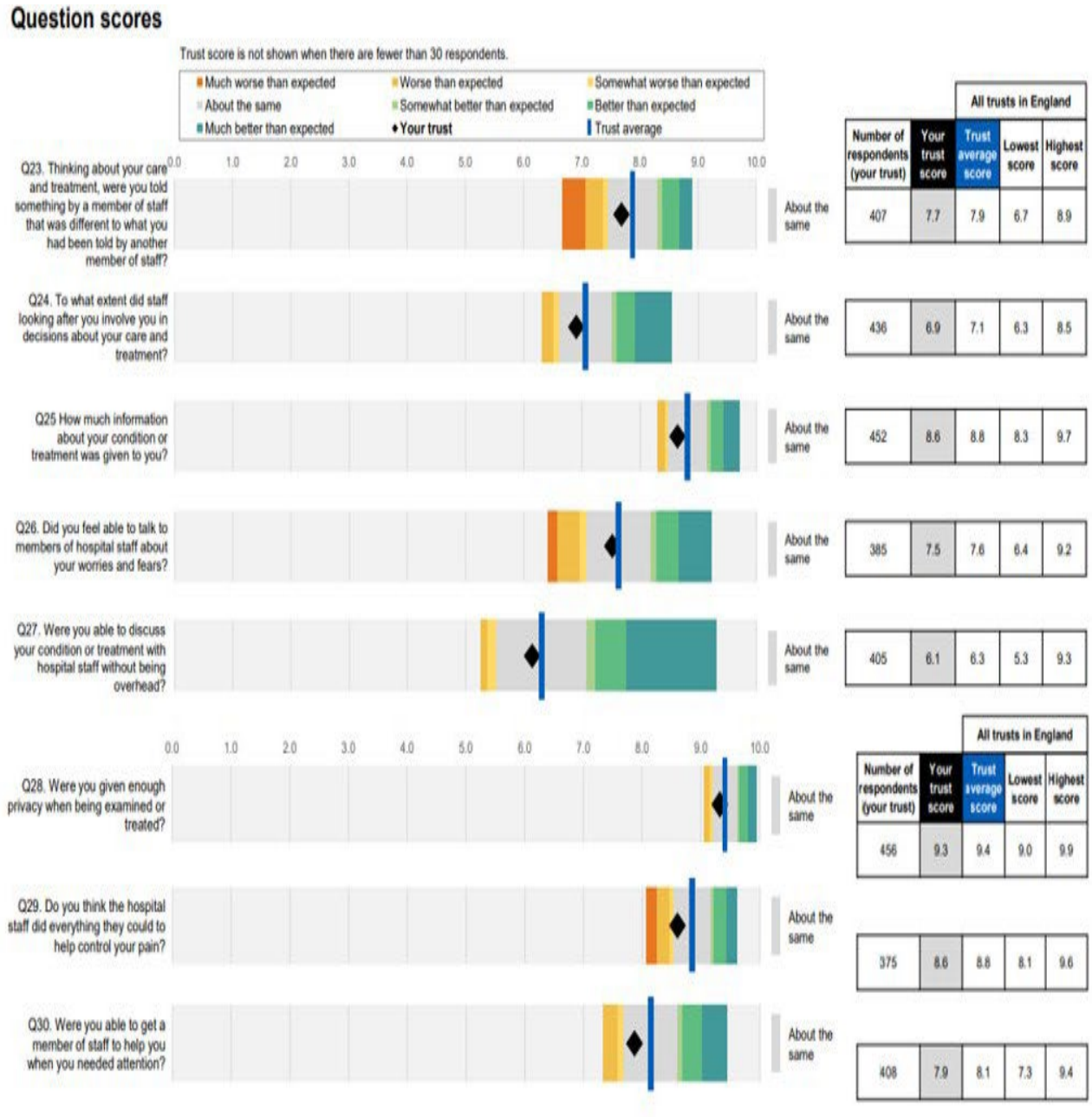






*Figure 3 – Breakdown of Care and Treatment Section Scoring* (National NHS Adult Inpatient *Survey, 2022)*

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




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

## 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.

Whilst national reporting of the response rate ceased from 1 April 2020, the Trust has continued to monitor response rate by Wards and Departments 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 have been higher during quarters one to three in 2023/2024 in comparison to the previous year in inpatient areas at 18.6% (an increase of 1.6%), and in A&E at 1.48% (an increase of 0.61%), however response rates were lower in Maternity (birth only) at 3.9% (a reduction of 2.1%). 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.

A pilot of 'Short Message Service' (SMS) texting for gaining feedback from people accessing the Emergency Departments commenced in the third quarter 2023/24. In quarter two 110 FFT responses were received, however, this increased to 1,443 in quarter three, through a combination of SMS (1,369) and completion of FFT cards (74). Whilst the response rate within the Emergency Departments is below the target, an increase in responses has been demonstrated each month since the introduction of SMS (figure 4) resulting in a small increase in overall Trust reporting for Inpatient and Emergency Department responses (figure 5).

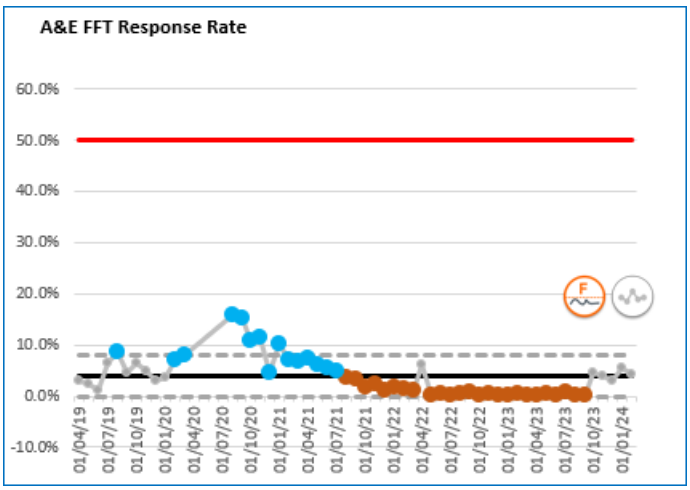



*Figure 4 – Friends and Family A&E Response Rate by Month*

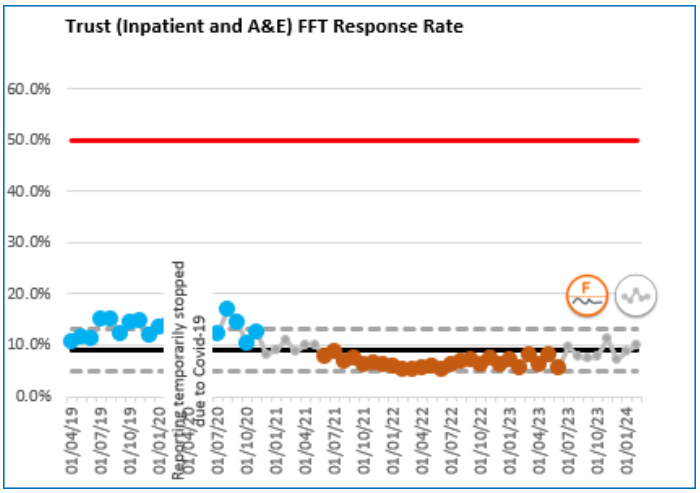
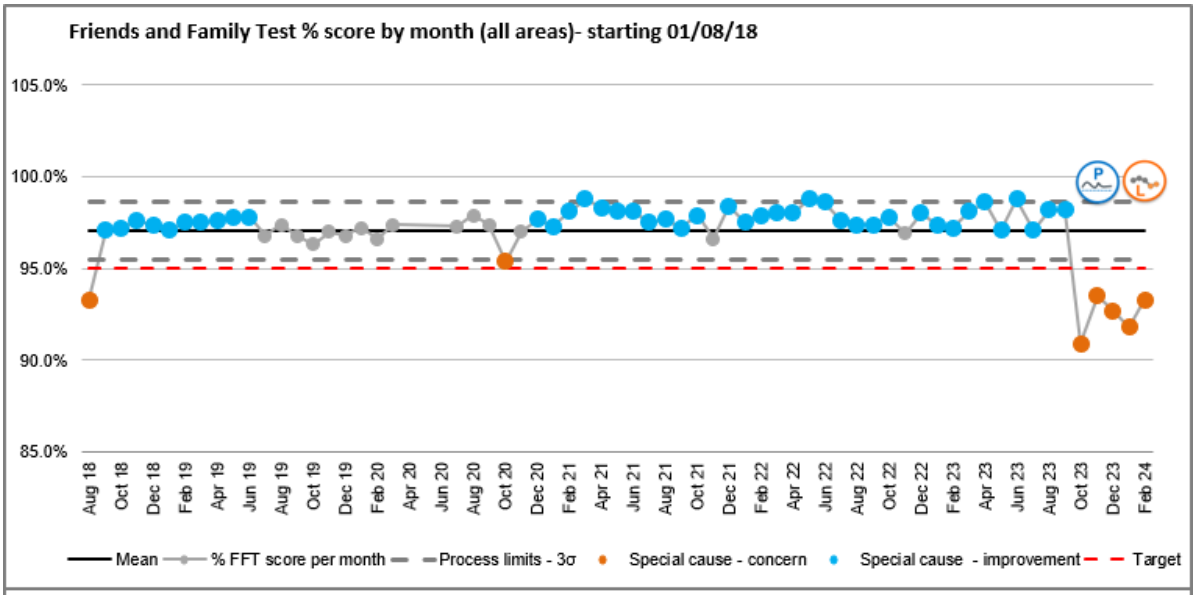



*Figure 5 – Friends and Family Trust Response Rate by Month*

The Trust continued to perform well, with the monthly FFT score above the national target of 95% throughout the first and second quarter 2023/2024. During quarter three the percentage of respondents across the Trust rating their overall experience as 'very good' or 'good' (figure

*Figure 6 – Friends and Family Test Overall Satisfaction Score by Month*

6) reduced to 92.4%. A six-month SMS FFT pilot commenced within the Emergency Departments (EDs) on 9 October 2023. The pilot has increased FFT response rates in patients discharged from the EDs, however, there is a possibility that the heightened reporting from the EDs may have affected the overall satisfaction response rate for the Trust during the third quarter. This is evident as the percentage of patients satisfied with their overall experience within the ED service during this period is lower than across Inpatient, Maternity and Outpatient areas.



## 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**

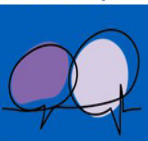
Embargo Lifted, Half day workshops to share results with Divisions. Workshops to be opened by CEO and Facilitated by Director of People and OD.

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.

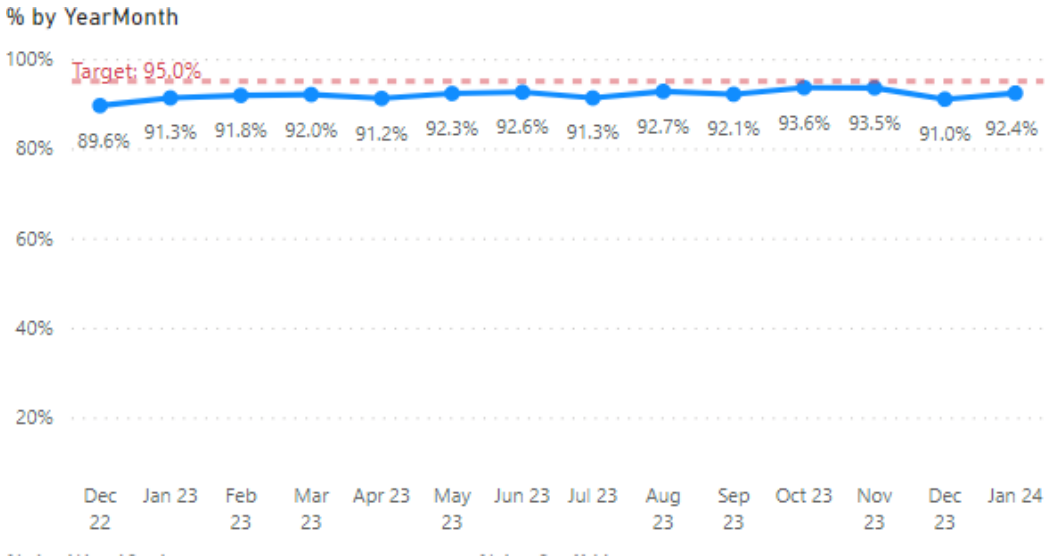
**Continuous Improvement Loop**

## Venous Thromboembolism (VTE)

A venous thromboembolism is a blood clot that forms in a vein. Prior to COVID the Department of Health required all Trusts to submit their performance data around the assessment of patients who are admitted for their risk of having a VTE. This was to try to reduce preventable deaths that occur following a VTE while in hospital. This performance data submission was paused during COVID but as a Trust we still collected the performance data for VTE against the national target (95%).

There has been national notification that this VTE Risk Assessment Data Collection will be reinstated, and the first data collection will commence in July 2024.

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




The Trust performance for VTE has been consistently under the 95% target for the financial year of 2023-2024. This has been due to the intense pressure within the system and the overwhelming numbers of patients coming into the Trust. Observation reinforces that we need cultural changes of a collective responsibility for all basic assessments including VTE as part of a multi-disciplinary approach to preventing harm. The Medical Director, in collaboration with the Director of Nursing proposes to include VTE assessment performance in the Exemplar Ward Programme to reinforce the importance of this work and to improve the overall performance of VTE assessment completion.

## 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. In previous years data produced by NRLS was used to provide comparison nationally, however the National Reporting database changed in September 2023 to Learning From Patient Safety Events (LFPSE), with approximately 50% of organisations now reporting to LFPSE therefore comparator data is not available for 2023/24.

The number and the rate of Patient Safety Incidents reported within the Trust 2023/24, up to October 2023 when the change to LFPSE occurred, and the number and percentage of Patient Safety Incidents that resulted in severe harm or death, are identified below:

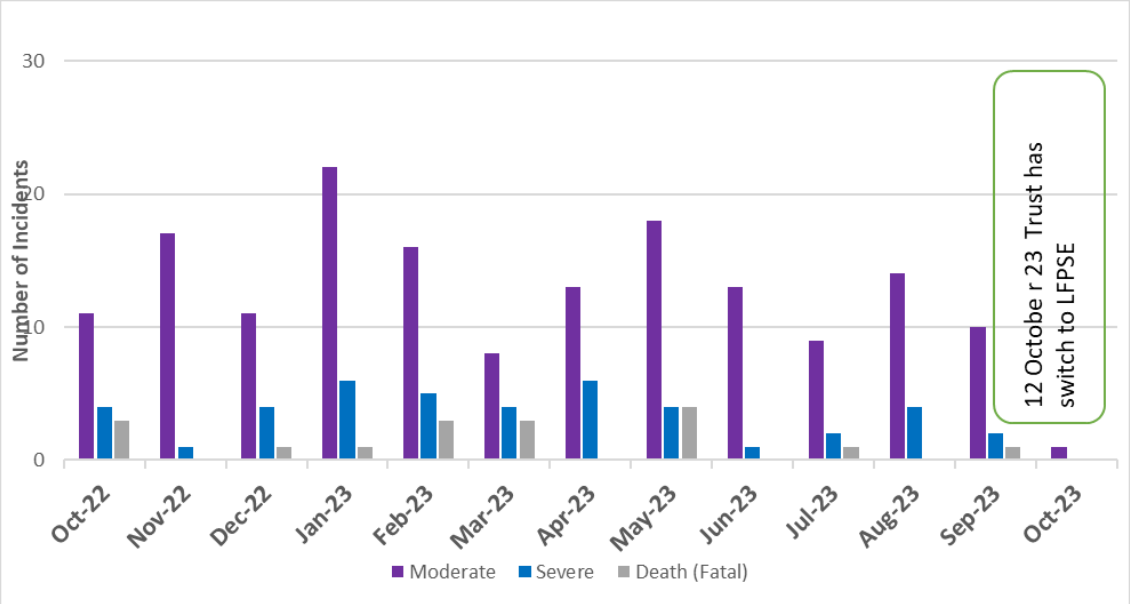
| Domain | | | | |
|---|---|---|---|---|
| | **SATH 2023/2024** | **SATH 2022/23** | **SATH 2021/22** | **SATH 2020/21** |
| Number of Patient Safety Incidents | 18,212 | 20,456 | 18,000 | 13,011 |
| Rate of Patient Safety incidents per 1,000 bed days | 61.35 | 70.35 | 74.75 | 65.06 |
| Severe harm or death | 52 | 79 | 56 | 35 |
| Percentage of Patient Safety Incidents which resulted in severe harm or death | 0.29% | 0.39% | 0.31% | 0.27% |
| Rate of Severe/death incidents per 1,000 bed days | 0.18 | 0.27 | 0.23 | 0.16 |

Note: In September 2023 NHS England paused the annual publishing of comparator data whilst future publication, in line with the current introduction of the Learn from Patient Safety Events (LFPSE) service to replace the NRLS is transitioned. NHS England LFPSE is not ready yet to produce any meaningful reports as some of the Trust have just only started transition.

The above data for 2023/24 should therefore be used with caution as they are sourced by combining NRLS data, pre October 2023 and LFPSE data, October 2023.

SaTH continues to be a high reporter of incidents which may represent a positive reporting culture. Important to note that SATH have not seen any reduction in incident reporting since the transition to the new LFPSE reporting system, which is positive.

The graph below identifies the number of incidents reported per month alongside the number resulting in moderate and severe harm, during 2023/24, up to end of October 2023 when the change to LFPSE occurred.




## Rate of Clostridioides difficile

Clostridioides difficile (C.difficile) is a bacterium found in the gut which can cause diarrhoea after antibiotics. The Clostridioides difficile rate per 100,000 bed days for 2023/24 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.

Q1 2023/24 – 31.8 per 100,000 bed days (22/69,175 x 100,000)

Q2 2023/24 – 29.6 per 100,000 bed days (20/67,389 x 100,000)

Q3 2023/24 – 46.2 per 100,000 bed days (33/71,436 x 100,000)

Q4 2023/24 – 30.2 per 100,000 bed days (22/72,686 x 100,000)

Year Total 2023/24 – 34.5 per 100,000 bed days (97/280,686 x 100,000)

SaTH considers this data to be as described for the following reasons: Every case is scrutinised using a Root Cause Analysis (RCA)/PSIRF Process to determine whether the case was linked with an issue in the quality of care provided to patients. Common themes remaining similar to previous years: Antibiotics usage, timely obtaining of stool samples and isolation continue. The Trust continues to provide 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

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 2023/24 was no more than 32 cases of Clostridium Difficile, there were 97 cases in total meaning the Trust did not achieve its target this year. The Trust is undertaking a review of current processes with the support of NHSE which will hopefully operationalise the C diff action plan to get 'buy-in' from all staff and involve doctors more and have sustainable actions.

## 2.4 Looking forward: Our Priorities for Quality Improvement 2024/25

The quality priorities for 2024/25 are based on the Quality Strategy and key workstreams which we want to continue to develop or implement in 2024/2025. The quality priorities for 2024/25 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 2024/2025

### 1. SAFE:

| Learning from Events and Safety Culture | Measurement |
|---|---|
| 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. | • Embedding of PSRIF-Governance IROG, RALIG<br>• Safety Conference<br>• Shared learning<br>• Safety Triangulation Group<br>• Safety Huddle Safety boards |
| **Deteriorating Patient** | **Measurement** |
| Fragility- Cognition Screening /Delirium | • By March 2025, 75 % of patients will receive a screening for Delirium/Cognition by a doctor.<br>• Monthly Audits for compliance<br>• Learning from complaints and patient stories<br>• Dementia conference |

| | |
|---|---|
| Ensure (early) Recognition, Escalation and Response processes are in place to support timely intervention for Adults, Pregnant Adults, Children and Young People (CYP) at risk of deterioration and sepsis | • Data – consistent and reliable use of early warning scores (NEWS2, PEWS, MEOWS) for recognising deterioration<br>• Evidence of consistent reliable use of escalation protocols informed by track and trigger tools and national guidance, CQUIN07 data<br>Monitor - projects developing systems and processes for documentation clinical management e.g. TEP, Respect forms |
| **Inpatient falls** | **Measurement** |
| To continue to sustain the reduction of inpatient falls<br><br>Reduce the level of harm caused from falls. | • Development of a reconditioning dashboard to triangulate quality measures<br>• Number of falls<br>• Number of falls with harm per 1,000 bed days<br>• Patient experience data<br>• Learning identified through PSIRF<br>• The Energise project on Ward 27 June 2024 |
| **Omitted doses of time critical medication** | **Measurement** |
| Improved understanding of omitted doses of time critical medication within the organisation.<br><br>Reporting of all omitted doses of medication onto incident reporting system.<br><br>Reduce the number of omitted doses of time critical medication. | • Consistent and appropriate investigation and learning following reported incidents of omitted doses<br>• Implementation of the prevention of omitted doses of medication clinical guideline aimed at supporting clinical teams to reduce omitted doses and required actions following omission<br>• Successful implementation of EPMA<br>• Compliance data/continual audit to monitor |
| **Radiology – timely reporting** | Measurement |
| Ensure improved patient experience in our Trust, reducing waiting times, timely decision making and intervention by addressing the timeliness of Radiology reporting. | • A working group will be developed to formulate an action plan that includes audits and engagement/focus groups |

| | |
|---|---|
| | to better understand the issues that result in radiology reporting issues and to identify and implement improvements<br>• A reporting review in Radiology and improvements |

## 2. EFFECTIVE:

| Right care, right place, right time | Measurement |
|---|---|
| Ensure improved patient experience in our Emergency Departments.<br><br>Reducing waiting times, timely decision making and intervention.<br><br>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. | • Activity Data<br>• Reduction in incidents relating to these themes<br>• Performance data<br>• Audits – SOPs and National Standards<br>• Triage performance<br>• Reduction in incidents relating to these themes<br>• Links to Emergency Transformation Programme/MED Transformation Programme<br>• GIRFT recommendations<br>• Number of discharges < 10am, 12 midday<br>• Reduction in number of patients with no criteria to reside<br>• Discharge process audits/Roll out Criteria Led Discharge |
| Best Clinical Outcomes | Measurement |
| Address and improve care with people with diabetes through close working with system partners.<br><br>Diabetic foot clinic – improving foot care for people with diabetes.<br><br>Ensuring quick access to a multi-disciplinary foot team for people with acute foot problems.<br><br>Improving in-patient foot assessments and care to prevent iatrogenic harm, with new assessment documentation, preventative care and staff | • Establishment of commissioning agreement for diabetic services with ICB<br>• Evidence of meetings of system clinical advisory group<br>• Reduction in hospital admissions with primary diagnosis of complication of diabetes<br>• Reduction in amputations of people with diabetes<br>• Development of OPAT service for suitable patients with diabetes associated infections |

| | |
|---|---|
| education.<br><br>To provide inpatient foot reviews with a view to using OPAT for reduced hospital stay. | • Evidence of MDT educational programme for secondary, community and primary care Training compliance<br>• Audit compliance |

## 3. PATIENT EXPERIENCE

| Learning from Experience | Measurement |
|---|---|
| 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<br>• Functioning speciality PACE panels<br>• All wards to have a "You said, we did" Quality Boards<br>• Improve our ratings in the national staff survey<br>• Improve complaint response performance |
| Mental Health Training<br><br>Quality Standards and demonstrate NICE Guidance compliance for: Violence and aggression; short-term management in mental health, health (NG10) and self-harm; assessment, management and preventing recurrence (NG225). | • Staff training figures<br>• Restrictive Interventions audit- Governance Safeguarding Operational groups and Committees |
| **Learning Disabilities and /or Autism** | **Measurement** |
| Improve the care and experience for patients with Learning Disabilities and/or Autism | • Oliver McGowan training figures T 1 and T2<br>• PACE panel<br>• Patient Passports |

## 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 | April 2023– Sept 2023 (Old Rules) | Oct 2023 – March 2024 (New Rules) |
|---|---|---|
| Total Patients Waiting Over 62 Days to begin cancer treatment (% referral to treatment time – national target 85%) | 45.6% | 53% |
| Proportion of patient meeting the faster Cancer diagnosis standard (National target 75%) | 65.5% | 74.3% |

## 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.

Within 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 2023/2024 the Trust received 16 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/2023/004/MHRA | Recall of Emerade 500 micrograms and Emerade 300 micrograms auto-injectors, due to the potential for device failure | 09/05/2023 | 12/05/2023 | 11/05/2023 | Closed |
| NatPSA/2023/005/MHRA | Removal of Philips Health Systems V60 and V60 Plus ventilators from service – potential unexpected shutdown leading to complete loss of ventilation | 18/05/2023 | 30/09/2023 | 18/05/2023 | Closed |
| NatPSA/2023/006/DHSC | Shortage of Pyridostigmine 60mg tablets (short term to 12/06/2023) | 24/05/2023 | 26/05/2023 | 26/05/2023 | Closed |
| NatPSA/2023/007/MHRA | Potential risk of underdosing with calcium gluconate in severe hyperkalaemia | 27/06/2023 | 01/12/2023 | 30/11/2023 | Closed |
| NatPSA/2023/008/DHSC | Shortage of GLP-1 receptor agonists | 18/07/2023 | 18/10/2023 | 24/08/2023 | Closed |
| NatPSA/2023/009/OHID | Potent synthetic opioids implicated in heroin overdoses and deaths | 26/07/2023 | 04/08/2023 | 03/08/2023 | Closed |
| NatPSA/2023/010/MHRA | Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls | 31/08/2023 | 01/03/2024 | 22/02/2024 | Closed |

| | | | | | |
|---|---|---|---|---|---|
| NatPSA/2023/011/DHSC | Shortage of methylphenidate prolonged-release capsules and tablets, lisdexamfetamine capsules, and guanfacine prolonged-release tablets. | 27/09/2023 | 11/10/2023 | 05/10/2023 | Closed |
| NatPSA/2023/012/DHSC | Shortage of verteporfin 15mg powder for solution for injection | 28/09/2023 | 20/10/2023 | 05/10/2023 | Closed |
| NatPSA/2023/013/MHRA | Valproate: organisations to prepare for new regulatory measures for oversight of prescribing to new patients and existing female patients | 28/11/2023 | 31/01/2024 | 31/01/2024 | Closed |
| NatPSA/2023/014/NHSPS | Identified safety risks with the Euroking maternity information system | 07/12/2023 | 07/06/2024 | 26/03/2024 | Closed |
| NatPSA/2023/015/UKHSA | Potential contamination of some carbomer containing lubricating eye products with Burkholderia cenocepacia - measures to reduce patient risk | 07/12/2023 | 17/12/2023 | 16/12/2023 | Closed |
| NatPSA/2023/016/DHSC | Potential for inappropriate dosing of insulin when switching insulin degludec (Tresiba) products | 08/12/2023 | 22/12/2023 | 21/12/2023 | Closed |
| NatPSA/2024/001/DHSC | Shortage of GLP-1 receptor agonists (GLP-1 RA) update | 03/01/2024 | 28/03/2024 | 26/03/2024 | Closed |
| NatPSA-2024-002-NHSPS | Transition to NRFit connectors for intrathecal and epidural procedures, and delivery of regional blocks | 31/01/2024 | 31/01/2025 | Expected closure within deadline | Open |

| | | | | | |
|---|---|---|---|---|---|
| NatPSA/2024/003/DHSC/MVA | Shortage of salbutamol 2.5mg/2.5ml and 5mg/2.5ml nebuliser liquid unit dose vials | 26/02/2024 | 08/03/2024 | 08/03/2024 | 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.

The Serious Incident Framework ended within SATH on 31 November 2023 and was replaced with the new Patient Safety Incident Review Framework (PSIRF).

Review, Action and Learning from the Incidents Group (RALIG) is now well embedded and is Chaired by the Medical Director and Director of Nursing. This multidisciplinary group meets weekly to review incidents that have been escalated by the Incident Review Oversight Group (IROG) and make the decisions in relation to the level of learning response required.

Up to the end of November 2023, the end of the Serious Incident Framework, the Trust had reported 72 serious incidents for the year 2023/2024.

## Never Events 2023/24

Never Events are serious, largely preventable PSIs that should not occur if the available preventative measures have been implemented. In 2023/2024 SaTH had one incident which met the definition of a Never Event. Thorough investigations are undertaken for Never Events and robust action plans are developed to prevent similar occurrence.

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

| **Never Event** | | | |
|---|---|---|---|
| **SATH 2023/24** | **National Average 2023/24** | **Best Performing Trust 2023/24** | **Worst Performing Trust 2023/24** |

| | | | |
|---|---|---|---|
| 1 | 2.3 | 1 | 9 |

| Date | Description of Never Events 2023/24 at SATH |
|---|---|
| June 2023 | Wrong Site Surgery - Dermatology |

Learning from this Never Events in 2023/2024 included:

- Improvement work to ensure all booking documentation is accurately completed
- Explicit description in describing any lesions to be removed, particularly where there are multiple lesions

## National Inpatient Survey

The National NHS Adult Inpatient Survey (2022) was undertaken between January and April 2023 and included patients meeting the eligibility criteria who were discharged from the Trust in November 2022. 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 40%, which was 1% above the 2021 Trust response rate and comparable to the national average (40%). Of the completed responses, 88% relate to urgent/emergency admissions and 12% 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 are displayed in figure 7.

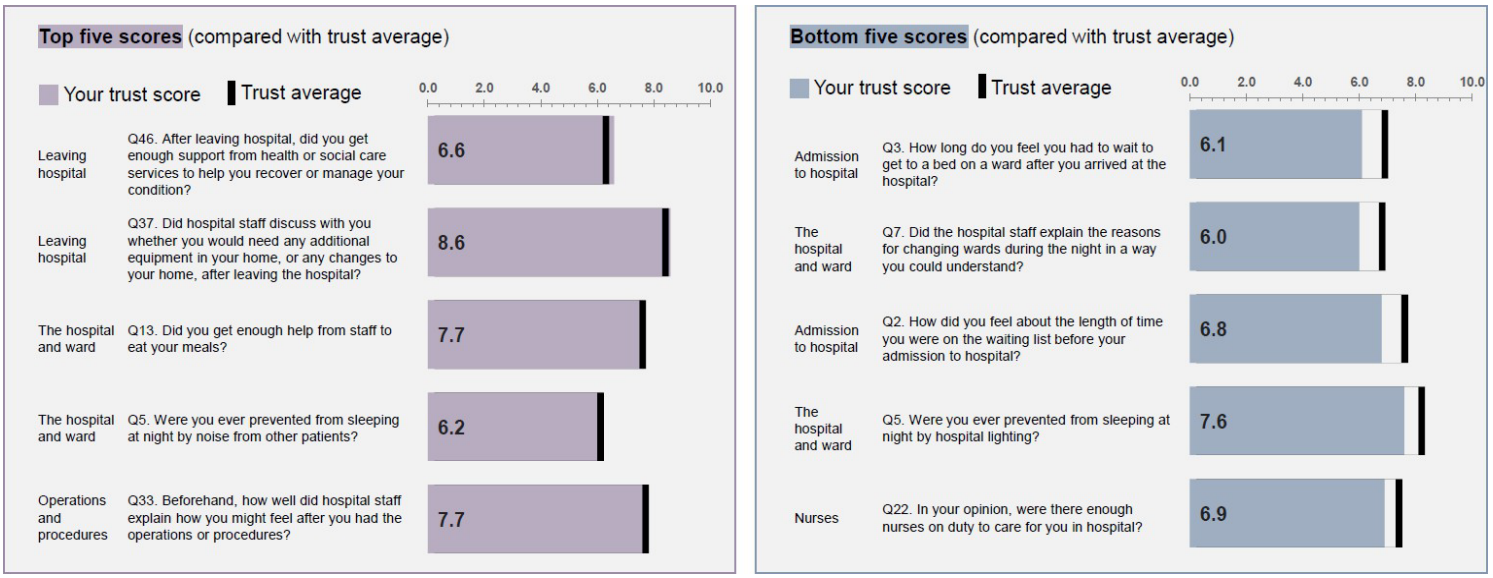



*Figure 7 – Top 5 and Bottom 5 Ranking Scores Compared with Trust Average (*National NHS Adult Inpatient *Survey, 2022)*

Following the Adult Inpatient Survey 2022 being published the subsequent actions have been taken:

- Results have been shared with Specialist Patient Experience Groups to inform improvement work that will feed into an overarching action plan
- Measures to reduce waiting times for a bed such as the Next Patient initiative, Test of Change Week, MADE events and establishment of Sub-acute Wards have been introduced to support work being driven by the ED Transformation Project
- An acute medical floor and Acute Medical Facilitators have been established at RSH to support flow and access to timely treatment
- An external company has been commissioned to undertake an audit on flow and emergency pathways
- Pharmaceutical vending machines are being introduced to support access to frequently dispensed medication and discharge medicines

- An Integrated Discharge Team has been established and are working with Therapy Teams on a range of projects to improve referral to assessment. Discharge Assessors attend morning board rounds to support the discharge process, escalating potential barriers when encountered
- A number of steps have been taken to increase awareness of carers across the Trust and the role of the Hospital Carers Link Workers. Co-development of a carers discharge checklist to support carers as the person they care for leaves hospital
- Health literacy awareness training is being delivered across a range of staff groups including junior Doctors, focusing upon chunk and check methodology

## National Maternity Survey

The NHS National Survey of Women's Experiences of Maternity Services (2023) was undertaken with patients meeting the eligibility criteria who were aged 16 years or older, who had a live birth during February 2023. The Trust had a response rate of 51%, which was 5% above the 2022 Trust response rate and above the national average (41%).

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.

The Trust performed 'about the same' as other Trusts for the majority (50) of questions and scored 'worse than expected' for one question. The Trust scored 'much better' than most Trusts for one question, 'better' in one question, and 'somewhat better' than most Trusts for one question. These include:

Worse than expected:
- Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?

Somewhat better than expected:
- Thinking about your antenatal care, were you treated with respect and dignity?

Better than expected:
- Before you were induced, were you given appropriate information and advice on the benefits associated with an induced labour?

Much better than expected:
- Before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?

In summary, the 2023 findings are very positive, indicating that overall the Trust performed 'Much Better' than other Trusts in one of the eight sections relating to 'labour and birth'.

The Trust's performance rated favourably to other Trusts for three questions, with results showing the Trust performed "Much Better" than other Trusts in one of the 54 individual

questions, “better” than other Trusts in one of the 54 individual questions and “somewhat better” than other Trusts in one of the 54 individual questions.

When comparing the Trust’s 2023 results to the previous 2022 results, there was a significant improvement in two key areas: involving people in decisions about their antenatal care and treating people with dignity and respect during their pregnancy.

Whilst the Trust’s performance showed a statistically significant decline for five questions it is important to note that the scores for these questions remained “about the same” as those for other Trusts. These will be key areas of focus for improvement by the maternity leadership team. As part of next steps, and in-line with the NHS Resolutions Clinical Negligence Scheme for Trust’s Maternity Incentive Scheme, (CNST MIS), a gap analysis will be undertaken by the Maternity and Neonatal Voices Partnership (MNVP) on the qualitative data underpinning the free text element of the survey to ensure we have a co-produced action plan that addresses our service user feedback with a specific focus on feeding and increasing awareness of postnatal mental health support.

## 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. Eight Speciality Patient Experience Groups feed into the PaCE Panel, providing insight and assurance into actions being taken at a local level to seek and respond to patient feedback to inform learning and shape improvements.

The Trust Independent Complaints Review Group consists of external independent reviewers aiming to provide objective, impartial, and constructive insight into complaint handling. A structured and practical approach is adopted in reviewing each case, founded on incorporating best practices aligned to complaint standards, and good communication to support and inform the complainant. The Group is Chaired by a patient partner, providing assurance that the process is transparent, and actively seeking to learn and improve the service in response to feedback. Findings from each of the complaints reviewed and discussed are captured in an action log. Themes are fed back to the Complaints Team, the Corporate Patient Experience Group, and reported in the quarterly PALS, Complaints and Patient Experience Report, providing additional transparency and governance of the process.

Digital stories can be a powerful tool, providing insight of personal experiences of care within our Trust which can help to improve understanding and learning. The Trust recognises the value of learning from people with lived experience and capturing feedback digitally enables their story to be shared wider across the Trust. A number of patient stories are shared through the appropriate channels within training sessions, meetings, Divisions; and, externally via the Board of Directors meeting, to increase awareness and promote learning as a result of feedback.

## Maternity improvements

### Saving Babies Lives Care Bundle v3 (SBLCBv3)

The SBLCBv3 was published in May 2023. The Trust was required to achieve a minimum of 50% for all six elements, and at least 70% overall by 30 November 2023 in order to meet the requirements of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS). Additionally, all providers were required to work towards full implementation of all six elements by 31 March 2024.

The table below confirms the Trusts position as of 31 March 2024; The Trust is currently the only provider in the Midlands to have achieved all six elements of the bundle. In keeping with the validation process, the Trust's position was externally verified at the quarterly review meeting chaired by the ICS prior to uploading to the NHS Futures platform.

| Intervention Elements | Description | Element Progress Status (Self assessment) | % of Interventions Fully Implemented (Self assessment) | Element Progress Status (LMNS Validated) | % of Interventions Fully Implemented (LMNS Validated) | NHS Resolution Maternity Incentive Scheme |
|---|---|---|---|---|---|---|
| Element 1 | Smoking in pregnancy | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 2 | Fetal growth restriction | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 3 | Reduced fetal movements | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 4 | Fetal monitoring in labour | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 5 | Preterm birth | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| Element 6 | Diabetes | Fully implemented | 100% | Fully implemented | 100% | CNST Met |
| All Elements | TOTAL | Fully implemented | 100% | Fully implemented | 100% | CNST Met |

### Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 5 (CNST MIS)

The Trust is a member of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS), which is regulated by NHS Resolution (NHSR) and is designed to support the delivery of safer maternity care. The scheme incentivises 10 maternity safety actions. Trusts that can demonstrate they have achieved all 10 safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

The Trust declared compliance against all 10 safety actions, with the evidence repository reviewed by Mr Simon Mehigan who is the Trust link for NHS England's Maternity Safety Support Programme prior to submission of the Board Declaration. NHS Resolution has since confirmed our position and the Trust is waiting for the funds to be allocated, with final confirmation of the sum awarded outstanding.

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

### Implementing recommendations of the Independent review of maternity services

The Independent Review of Maternity Services at the Trust, chaired by Mrs Donna Ockenden, examined cases arising mainly between 2000 and 2019, involving 1,486 families and the review of 1,592 clinical incidents.

The first Ockenden report[1] was published in December 2020, and was followed by the final report[2], which was published in March 2022. These reports highlighted significant failings in maternity care at the Trust.

The Review found repeated failures in the quality of care and governance, as well as failures of external bodies to monitor the care provided effectively. These failures included there not being enough suitably experienced staff, a lack of ongoing training, a lack of investigation and governance at the Trust, and a culture of not involving or listening to the families involved.

The Chief Executive gave an unreserved apology to the women and families affected by the review, along with the commitment to implement all the actions arising from the Review, which was later reiterated by the Board of Directors on 15 April 2022.

We owe it to those families we failed, and to those we care for today and in the future, to continue to make improvements, so that we are delivering the best possible care for the communities that we serve.

The combined reports included 210 actions; 93 'Local Actions for Learning' to be implemented solely by the Trust, and 117 'Immediate and Essential Actions' for implementation of all providers of maternity care in England.

Based on a rigorous assurance validation process, progress with delivering the actions at 12 March 2024, is, as follows (rounded percentages):

- 178/210 (85%) have been delivered fully, and evidenced and assured as working as they should be
- 10/210 (5%) actions are on track to be delivered within their expected timeframes
- 12/210 (6%) actions are at risk, comprising:
    - 11 actions that require substantive funding, which are the subject of a business case that is being considered currently

[1] Ockenden Review (December 2020), Emerging Findings and Recommendations from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust.

[2] Ockenden Review (March 2022), findings Conclusions and Essential Actions from the Independent Review of Maternity Services at Shrewsbury and Telford NHS Trust; Our Final Report

    - One action is delayed for logistical reasons, but it is anticipated this will be delivered later during 2024
- 10/210 (5%) actions are de-scoped. This means they are outside of the Trust's control to deliver, and they are dependent upon the actions of third parties, such as NHS England or the Care Quality Commission. These continue to be reviewed with the respective agencies.

The Ockenden Report Assurance Committee (ORAC), a committee of the Board of Directors, held its first meeting in March 2021, and will complete its work in April 2024, whereupon the Maternity Transformation Assurance Committee (MTAC) will undertake the on-going review of action delivery and sustainability. MTAC meets monthly and is chaired by the director of nursing. MTAC will continue to report on progress to the Quality, Safety and Assurance Committee (QSAC), which is a committee of the Board of Directors.

A new Integrated Maternity Report is now in place and will continue to report on progress against actions from the Independent Maternity Review to the Board of Directors each time it meets in public. In addition, this report consolidates relevant maternity matters into one report, and includes progress in relation to The Clinical Negligence Scheme for Trusts (CNST, which manages all clinical negligence claims against member NHS bodies), and the Three- year Delivery Plan for Maternity Services.

By 1 February 2024, the Trust had declared compliance with year five of the Clinical Negligence Scheme for Trusts safety actions, and delivered fully on all elements of the Saving Babies Lives Care Bundle (version Three) by the end of March 2024.

The CQC maternity survey 2023 results were overall positive for the Trust and its service users. There are some areas of improvement required and the Trust is working alongside the Maternity and Neonatal Voices Partnership to address these.

The achievement of all these safety initiatives will assist the Trust to mitigate the maternity risks highlighted within this Annual Governance Statement and Annual Report. Also, notwithstanding the improvements made, there is still further work to do to continue to improve and assure the care and services we deliver to women and families.

Finally, West Mercia Police continues to investigate allegations of poor maternity care at the Trust. The independent police investigation will explore whether there is evidence to support a criminal case against the Trust or any individuals involved. The Trust continues to co-operate fully with the investigation.

## Maternity Quality Priorities 2024/25

- Continue to deliver the outstanding Ockenden actions as part of the Maternity Transformation Plan
- Deliver NHS Resolutions Maternity (and perinatal) Incentive Scheme Year 6
- Work towards full implementation of the single delivery plan (incorporating the maternity and neonatal three-year plan and the Quality and Equity Strategy)
- Continue to increase the workforce and developing future leaders
- Introduction of advanced clinical practitioners (ACPs) into maternity

## Infection prevention and control

## COVID-19

In 2023/24 there were a total of 1,238 positive results reported from samples sent from SaTH.

| Month | Number of positive isolates |
|---|---|
| Apr-23 | 241 |
| May-23 | 136 |
| Jun-23 | 27 |
| Jul-23 | 59 |
| Aug-23 | 86 |
| Sep-23 | 141 |
| Oct-23 | 96 |
| Nov-23 | 56 |
| Dec-23 | 107 |
| Jan-24 | 145 |
| Feb-24 | 55 |
| Mar-24 | 89 |

The Trust reported 65 outbreaks COVID-19 in 23/24

| Month | Number of outbreaks |
|---|---|
| Apr-23 | 6 |
| May-23 | 6 |
| Jun-23 | 4 |
| Jul-23 | 5 |
| Aug-23 | 3 |
| Sep-23 | 12 |
| Oct-23 | 3 |
| Nov-23 | 5 |

| | |
|---|---|
| Dec-23 | 4 |
| Jan-24 | 9 |
| Feb-24 | 1 |
| Mar-24 | 7 |

The reoccurring themes from outbreaks have been:

- Inappropriate PPE use, including inappropriate masks
- Lack of/ delay in isolation
- Poor communication from admission area regarding suspicion of COVID or having taken a test from a patient before transfer
- Ventilation poor in ward areas

## Changes in Guidance

- In May 2023, staff were no longer advised to test themselves by lateral flow routinely, asymptomatic patients were not to be tested routinely for COVID and COVID testing in hospital was to be conducted primarily by a lateral flow device rather than PCR

- Briefly contacts were not flagged (except in Oncology and Haematology), this was restarted following an increase in cases

- In June 2023, the requirement for universal masking in most clinical areas was removed

- In October 2023, masking was reintroduced in high risk clinical areas as directed by “Mask Wearing and Outbreak Management” letter from NHSE

- In March 2024, universal masking was stopped in all clinical areas.

The Trust COVID/Flu/RSV risk assessment is regularly reviewed and updated in line with new guidance and changing clinical picture of the illness.

## Measles

Measles is an acute, highly infectious viral illness that is comparatively rare in the UK following the introduction of the Measles, Mumps and Rubella vaccine in 1988. However, if vaccine coverages fall below 90% the risk increases for community circulation and outbreaks. There is now evidence of this occurring in the UK due to the disruption of the COVID-19 crisis and anti-vax sentiment in certain communities. Measles is, in most cases, a self-limiting condition; symptoms usually resolving over the course of about a week.

Measles remains a potentially highly dangerous disease in hospitals due to its highly infectious nature and the risk to immune-compromised patients. The incubation

period is
between 7-18 days but may be prolonged to 21 days in the immunosuppressed. A prodromal phase of 2-4 days starts with a fever, conjunctivitis, cough, and coryza. During this prodrome

Koplik spots may be seen on the buccal mucosa in around 70% of cases. Measles cases are highly infectious from the beginning of this prodromal phase to four days after the appearance of the rash. The rash is non-itchy and consists of red or brown blotches which often coalesce. It usually starts behind the ears and spreads downwards over the face, neck and body, lasting 5-6 days. Other symptoms may include diarrhoea, vomiting and abdominal pain. Rare severe sequalae of Measles include otitis media, pneumonia, and encephalitis. Severe diarrhoea can sometimes lead to dehydration and electrolyte disturbance.

### Transmission

The virus is transmitted via respiratory droplets that become airborne during coughing or sneezing, or via direct contact with respiratory secretions and, less commonly, by articles freshly soiled with nose and throat secretions. Spending more than 15 minutes in direct contact with someone infected with measles is sufficient to transmit the virus (UK HSA 2014).

### Incubation period

The incubation period is between 7-18 days (average 10- 12 days) after exposure.

Period of infectivity four days before the onset of rash until four days after the onset of the rash in otherwise healthy individuals and for the duration of the illness in immune compromised patients. A patient with measles should avoid contact with unvaccinated young children, susceptible pregnant women, and immunocompromised persons during the contagious period (specifically until four days after onset or rash).

### Exposure

Patients/staff who have had face-to face contact of any length of time or in the same room for longer than 15 minutes are classed as having been exposed. Refer to policy for prevention of MMR in healthcare workers. Signs should be placed in waiting areas of Emergency Departments advising patients with a rash to report to reception so that they can be promptly isolated. Receptionists should be made aware that any patients with rash and fever, or who are unwell and have a link to confirmed case of measles are potentially infectious. These patients should not be in the waiting room. Appropriate measures for triage and isolation in health care settings are essential to avoid prolonged exposure to suspected measles cases in waiting areas. In a recent series of cases associated with transmission in health care settings, five of the seven secondary cases were in the same room as the index case for 2.5

-4 hours.

## Case definitions:

### *Confirmed Case*

A suspected case with a typical presentation and either: positive serology or oral fluid test for measles immunoglobulin (IgM) in the absence of recent vaccination ***or*** isolation of measles virus RNA from any clinical sample.

### *Probable Case*

A case classified as likely by an experienced member of the unit staff based on the clinical and epidemiological features: being clinically typical, epidemiologically linked to other confirmed or likely cases, or epidemiologically likely based on age (older child or adult), vaccination status, membership or contact with a travelling community or other high risk unvaccinated group, recent travel, or having a current outbreak in the area.

### *Possible Case*

A case classified as unlikely by an experienced member of the unit staff based on the clinical or epidemiological features: being clinically atypical (e.g. mild illness, with minimal symptoms other than a rash; or fever goes when rash appears (and case rapidly feels better and returns to normal); or epidemiologically unlikely based on vaccination status, age, initial laboratory findings, absence of contact with other cases, absence of confirmed cases in the area, and no travel history.

## Persons most at risk of measles infection

Anyone who is exposed to measles, during the infectious period and has not had measles in the past, or has not received two doses of MMR vaccine, is at risk of measles infection. Susceptible, pregnant women and infants are particularly at risk. Immunocompromised contacts are at increased risk.

## Vaccination history

Known immunity (of staff) - staff known to have received their MMR vaccination and/or immunity confirmed during staff induction through Occupational Health are deemed to have known immunity. Health Care Workers with satisfactory evidence of protection can continue to work normally but should be advised to report to Occupational Health Department, if they develop a fever or symptoms of measles in the next 18 days. Satisfactory evidence of protection includes documentation of having received two or more doses of measles containing vaccine and/or a positive measles antibody test (IgG).

## Actions/process we have taken in 2023/24

- Internal/external meetings to include ICB/HPA/UKHSA/Trust
- Flow chart development for:
    - Patient presenting or referred with typical erythematous rash and fever
    - Out of hours confirmed Measles case (Adult)
    - Out of hours confirmed Measles case (paediatric)
- Trust wide risk assessment developed by Health & Safety/IPC Team
- Communication strategy
- Rapid response meeting with Public Health
- Establish vaccination status of our workforce

## Section 4: Statements from External Organisations

**Healthwatch Telford & Wrekin**

**Review and Feedback – Shrewsbury and Telford Hospital NHS Trust (SaTH) Quality Account April 2023 – March 2024**

# Healthwatch Shropshire response to the SaTH Quality Account 2023-24

Healthwatch Shropshire (HWS) welcomes the opportunity to comment on the Quality Account. The feedback we received during this period predominantly concerned quality of treatment, 67% of which was positive, the kindness and caring of staff (70% positive), communication (74% negative) and waiting times (68% negative). Overall, we heard from 246 people, their feedback raised more negative aspects to their experiences (56%) than positive aspects (44%). During this period we also heard from patients during our Enter & View visits to:

- Acute Medical Floor, RSH - Enter and View visit report | Healthwatch Shropshire
- Ward 29 AOTU Royal Shrewsbury Hospital - Enter & View visit report | Healthwatch Shropshire
- Ward 28 Frailty, Royal Shrewsbury Hospital - Enter & View visit report | Healthwatch Shropshire

## Priorities for Quality Improvement 2023-24

**It should be noted that the Quality Account 2022 – 23 listed 9 priorities for 2023 – 24. Eight have been reported in this Quality Account 2023 – 24, with one of those having been changed, Priority 4, please see below.**

**The missing priority is 'Address and improve care with people with diabetes through close working with system partners.' We were keen to see the outcome of this work and hoped it might address some of the issues we raised in our October 2023 report Diabetes Care and Support in Shropshire. There is no explanation given for the exclusion of this priority.**

### Priorities

1. **Learning from events and developing a safety culture**

HWS is pleased to see that the Trust has achieved all 3 of the goals set out under this priority and importantly the staff survey has seen an increase in 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 although these measures remain below the national average for Acute Trusts.

## 2. The Deteriorating Patient

We are pleased to see the progress that has been made in developing the dashboard and implementing the training programme. It is unclear how the trust has performed against its target of embedding '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' and how the progress that has been made has affected patient care. We look forward to hearing how the action plan helps the improvement strategy.

## 3. Falls

The progress in this area is very welcome and we are very pleased to see the downward trend of falls per 1000 bed days.

## 4. 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.

**It should be noted that in the Quality Account 2022-23, Priority 4 was to 'Ensure improved patient experience in our Emergency Departments, reducing waiting times, timely decision making and intervention.' We were pleased to see this as a focus and had hoped it would address some of the findings in our report, Calling for an ambulance in an emergency | Healthwatch Shropshire. This priority has not been reported and not explanation offered for its exclusion. It's inclusion as a priority for 2024 – 25 is noted.**

## 5. Right Care. Right Place.

The improvement in the capacity of the discharge lounges and the consequent freeing up of beds for incoming patients is welcomed but some indication of quality of the patient experience would be helpful, the small amount of feedback from 14 patients, we have received around discharge has been entirely negative.

Much of our feedback around the public's experience of the Emergency Department continues to include negative feedback about waiting times so the improvements in waiting times shown with the increased use of the Same Day Emergency Care facilities is welcomed and we look forward to the implementation of the action plan to further improve access.

## 6. Learning from Experience

We are pleased to see that the trust has achieved 4 out of 5 goals in this area. It is useful to see some examples of the learning the Trust has taken from complaints. It would be helpful to see what level of increase in complaints there has been and, as it is a reflection of increased activity, how the rate per 1000 patients compares with previous years.

We welcome the continued focus on the 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" and the acknowledgement that although the ratings have increased the Trust has the second lowest score out of 122 comparator trusts.

It is disappointing to see the deterioration of the proportion of complaints responded to within the initial agreed timescales (from 59% to 50%). We provide the Independent Health Complaints Advocacy Service for Shropshire and frequently hear about the impact it has on patients and their families when deadlines are not met. We look forward to seeing the impact of the new streamlined

processes and how they will improve the timeliness of responses.

### 7. Vulnerable Patients

The improvement in Safeguarding Training compliance is welcomed. As is the planned launch of the Learning Disability Charter and the focus on meeting the needs of patients with Learning Difficulties and autism.

In the 2022-23 Quality Account it was reported that the level of dementia screening of patients aged over 75 fell from just under 70% to around 50%. In this Quality Account it highlights that an improvement has not been achieved this year however it is unclear what the screening rates were during the year. Also, in the 2022-23 Quality Account there was a commitment '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." This commitment is repeated in this Quality Account with no indication if any progress has been made.

The work of the Dementia Team with those people that are recognised with dementia is to be commended but the screening deficiencies mean that there may be many vulnerable people not getting the care and support they need. Patient experience we have received and shared with the Trust highlights the issues and impact on patient care that can occur where patients are not identified.

We are pleased to see the partial achievement in improving Patient Led Assessments of Care Environment (PLACE) scores relating to dementia-friendly environments but it would be helpful to understand where the improvements were made and by how much. The scores for both hospitals are well below the national average.

We are pleased to see that audits of the application of the Mental Health Act have demonstrated positive results, some indication of what these are would be helpful.

8. **Palliative and End of Life Care (PEoLC)**

The development and use of the PEoLC Strategy is to be welcomed and we look forward to seeing the improvements in care this helps to achieve. Similarly with the commitment to continue to promote the Care after Death training to improve care.

# Statement of Assurance from the Board

## CQC Improvement Plan

The Trust is to be commended on the progress it has made during the year and its improvement in the overall rating from 'inadequate' to 'requires improvement'.

## 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. The examples of resultant actions and outcomes helps to give an understanding of this process.

## Research and Innovation

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

## Digital Transformation

The commitment to digital transformation is underlined by the introduction of new roles. Some scenarios of how patient care will be affected would help with public understanding of the benefits of the new systems.

### Learning from Deaths

Although some are quite vague it is helpful to see the key themes arising from learning from death processes during the year.

### Medical Examiner Service

The aim to support bereaved relatives at the time of death by keeping the current 3-day target of issuing Medical Certificates of Cause of Death, despite the changes to the target at the national level is welcomed.

### Commissioning for Quality and Innovation (CQUIN)

The improvement in the CQUIN 4 linked to 'compliance with timed diagnostic pathways for cancer services' is especially pleasing to see. The work plan to improve CQUIN 12, 'Assessment and documentation of pressure ulcer risk', is welcomed.

### Encouraging Staff to Speak Up

It is encouraging that the combination of a significant decrease in the number of concerns raised with Freedom to Speak Up (FTSU) Guardians and a rise in staff confidence that they feel safe speaking up and that the organisation would address their concerns, as shown in the NHS staff survey, indicates that staff have fewer concerns.

### Guardian of Safe Working (GSW)

The continued focus on supporting Junior Doctors with respect to their safe working hours is welcomed.

## Core Quality Account Indicators

### Summary Hospital-level Mortality Indicator (SHMI)

It is reassuring to see that the SHMI data places the number of deaths 'as expected' and that the Trust carries out in depth reviews but it would be helpful to see some indication of the outcomes of those reviews.

### Percentage of deaths coded at either diagnosis or specialty level

This section does not seem to have been updated since the 2022 – 23 Quality Account. It the 2022 - 23 Quality Account it showed a general improvement over the previous 5 years in the proportion of patients who died receiving palliative care. However, it was still below the national average for non-specialist acute Trusts.

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

The narrative in this section does not seem to have been updated from last year.

The Trust stated in the Quality Account 2022 – 23 that Improving discharge planning processes for patients would be a key priory for 2023/24 so the reported results are disappointing.

Looking at the historical data supplied in the Quality Account 2022 – 23 it is evident that the Trust readmission rate for adults has risen this year but is below the rate for the previous 4 years.

The increase for under 16s to the highest level for 6 years is very disappointing. As with last year 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 2022 Patient Survey show that the Trust score has improved and places the Trust 'about the same' as other Trusts.

The actions put in place following the survey are welcomed and we look forward to hearing about their effectiveness.

## Friends and Family Test

We are pleased to see the Trust's commitment to improving the FFT response rate. We would be interested to know if the Emergency Department response by text pilot will be expanded to cover other areas particularly those with low response rates such as Maternity.

## Percentage of staff who would recommend the Trust to a friend or family needing care

This section is listed in the contents, and appears in previous Quality Accounts, but there is no reporting here apart from a diagram outlining the 'Staff Survey Continuous Improvement Timeline'.

The 2023 NHS Staff Survey shows an increase in the percentage of staff who agreed with the statement 'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation' from 39.27% in 2022 to 45.03% in 2023. However, this still means the Trust is the second worst performing out of 122 Acute & Acute Community NHS Trusts.

## Venous Thromboembolism (VTE)

The acknowledgement from the Medical Director and Director of Nursing that cultural changes are needed to establish a collective responsibility for all basic assessments including VTE as part of a multi-disciplinary approach to preventing harm is noted. We hope the changes in the Exemplar Ward Programme achieve the required increase in VTE assessment.

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

The decline in reported patient safety incidents, including those that resulted in severe harm or death, coupled with the increase in staff confidence in reporting concerns around clinical care, as reported in the NHS Staff Survey 2023, is encouraging.

## Rate of Clostridium Difficile

After a significant rise in the number of cases last year, from 12.6 per 100,000 bed days in 2021-22 to 20.63 in 2022-23, it is disappointing to see a further rise to 34.5 per 100,000 bed days, three times the set target, 97 cases against a target of 32. We hope that the involvement of NHS England will help the Trust to reduce the number of cases.

## Waiting Times

The improvement in the percentage of patients waiting for cancer treatment and diagnosis is encouraging to see but it would be helpful to see an indication of how the Trust is planning to

increase the number of patients being treated within 62 days of referral from 53% to try and meet the national target of 85%. We have heard from patients about the distress they and their families face during this period of uncertainty.

## Other Quality Information

### 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 number of serious incidents reported under the Serious Incident Framework (in place until the end of November 2023) was slightly higher than the same period in the previous year (as reported in the Quality Account 2022-23), 72 April – November 2023 compared to 69 in April – November 2022. This however could reflect a greater staff confidence in reporting.

### Never Events

We are pleased to see the fall in Never Events from 3 in 2022-23 to 1 in 2023-24.

### Learning from Patient Experience

We are pleased to attend the Patient and Carer Experience (PaCE) Panel while also having regular meetings with the Trust to share the feedback we receive from patients, family and friends about their experiences.

### National Maternity Survey

It is noted that the Trust performs about the same or better than other Trusts. We are pleased to see the involvement of the Maternity and Neonatal Voices Partnership (MNVP) in co-producing the action plan to address service user feedback and the areas indicated where there was a decline in the scores.

### 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. The full implementation of the Saving Babies Lives Care Bundle v3 is to be congratulated.

### Infection Prevention and Control

It is useful to see the reoccurring themes from the COVID outbreaks during the year but some indication of steps taken to address the themes would be helpful. The actions taken to address the issue of patients with suspected or confirmed measles is noted.

## Priorities for Quality Improvement 2024 - 25

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 Radiology is welcomed, patients have shared their anxieties and frustrations around delays in radiology reporting with us.

We look forward to working collaboratively with the Trust in the coming year to improve patient experience.

## ICB comments

***SaTH Quality Account Statement from Shropshire Telford and Wrekin ICB 2023/24***

Our Ref: VW

**Re: Quality Account 1 April 2023 - 31 March 2024**

NHS Shropshire Telford and Wrekin Integrated Care Board (the ICB) are pleased to have the opportunity to review the Shrewsbury and Telford NHS Trust (SaTH) Quality Account for 2023/24. SaTH has collaborated with partners in the integrated care system (ICS) as we continue to develop, to address the needs of the population and improve the quality of healthcare services within it.

It is the ICBs view that the account accurately identifies the priorities for 2023/2024 and reflects some of the improvement work and achievements shared in the quality account for this period. This account demonstrates an awareness of the areas that have been challenging and notes areas for further improvement.

This quality account demonstrates evidence of self-assessment progress against these priorities and acknowledgement of where there is still more to do. Dementia care is one such area and the account references the areas for improvement and the training and plans to help to improve this for 2024/2025. The ICB acknowledges the quality priorities for 2024/25 and look forward to working collaboratively with SaTH and the integrated care system to adopt a systems-based approach to learning responses which will provide more insight into the systems and processes that can be improved. The methodology recently adopted at divisional level demonstrate how change is embedded; this is a robust process which demonstrates a culture of wanting to do the right thing and provides greater assurance.

A significant patient safety initiative has been the introduction of the Patient Safety and Incident Response Framework (PSIRF). The Trust formally adopted PSIRF on the 30th November 2023 transitioning away from the Serious Incident Framework. The key aims of PSIRF will provide a considered and proportionate response to patient safety incidents with compassionate engagement and involvement of those affected by these incidents and we look forward to seeing the outputs in terms of safety and organisational culture. There is evidence of a balance of learning from good practice and learning from adverse incidents. The ICB was pleased to see that the Learning from Deaths work was shared in the report as this is a collaborative group that has continued to strengthen over the 12-month period referenced in the account.

Maternity services and the progress with the independent maternity review is outlined in the quality account. This is supported by an unreserved apology and with a determination to continue to improve which has been acknowledged in the most recent CQC report May 2024. The maternity team are working closely with the hospital transformation team and the ICS to look at continuously improving services for the local population and for the teams providing the services.

The ICB recognises that Urgent and Emergency Care (UEC) functions in the Trust are often under extreme pressure and the quality account highlights the concerns regarding delays in ambulance off loads and the delays for patients being transferred to a ward. The Trust is continuing to work with the ICS and NHS England to reduce the delays and improve the patient journey.

We note the planned new elective hub which will increase capacity and improve waiting times, particularly for treatment in orthodontics referral for dento-alveolar procedures. The quality account demonstrates improving with cancer treatment waiting times, however this remains below the national target and teams are working collaboratively with the cancer alliance to remedy this. The ICB are aware that waiting times for a number of specialties in relation to inpatient and outpatient procedures, are longer than the National Targets and SaTH are working to address this. The quality account also acknowledges the National Audit Programme undertaken in 2023/24 and the participation in clinical research, which includes cancer studies.

It is pleasing to see the response from staff in the National NHS Staff survey results in relation to speaking up, which saw improvement. SaTH were confirmed by the National Guardian's Office as one of the most improved Trusts in the country for their staff survey results in relation to the speaking up questions. It was noted that SaTH led the 30 Voice project to highlight the lived experience of BAME colleagues and improvements in tackling

racism. Continued improvements in the percentages of staff responding positively to the relevant safety culture elements included in the staff survey was also highlighted.

In conclusion, the ICB views the 2023/4 Quality Account as an accurate picture of the challenges the Trust faces and evidence of improvements in key quality and safety measures. There is focus on the core values outlined in the account and a clear vision to continue the improvement journey. 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.

Yours sincerely

Vanessa Whatley
Chief Nursing Officer
NHS STW

# The Shrewsbury and Telford Hospital
**NHS Trust**

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 ☐<br>Quite useful ☐<br>Not very useful ☐<br>Not useful at all ☐ |
| **Did you find the context?** | Too simplistic ☐<br>About right ☐<br>Too complicated ☐ |
| **Is the presentation of data clearly labelled?** | Yes completely ☐<br>Yes, to some extent ☐<br>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?** | |

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