The Shrewsbury and Telford Hospital NHS Trust

SaTH CQC Action Plan - Medicine

Joint Health Oversight and Scrutiny Committee (JHOSC)

10 February 2025

CQC Ratings – 2021 vs 2024 Medicine

The Shrewsbury and Telford Hospital NHS Trust

Rating for Royal Shrewsbury Hospital

		Safe	Effective	Caring	Responsive	Well-led	Overall
2021	Medical care (including older people's care)	Inadequate ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ➔➔ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021
2024	Medical care (including older people's care)	Requires Improvement ↑ May 2024	Good ↑ May 2024	Good ↑ May 2024	Requires Improvement ➔➔ May 2024	Requires Improvement ➔➔ May 2024	Requires Improvement ➔➔ May 2024

Rating for The Princess Royal Hospital

		Safe	Effective	Caring	Responsive	Well-led	Overall
2021	Medical care (including older people's care)	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Good ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021	Requires Improvement ↑ Nov 2021
2024	Medical care (including older people's care)	Requires Improvement ➔➔ May 2024	Requires Improvement ➔➔ May 2024	Good ➔➔ May 2024	Requires Improvement ➔➔ May 2024	Requires Improvement ➔➔ May 2024	Requires Improvement ➔➔ May 2024

Must and Should Do's Actions following the publication of CQC Inspection Report 2024

The Shrewsbury and Telford Hospital NHS Trust

The table shows the number of "Must" and "Should" do actions from the CQC Inspections carried out. It demonstrates that following the 2024 inspection there was a reduction in the number of "Must Do's" for Medicine from 22 to 5 (78% less), with a decrease in "Should Do's" also 26 to 17 (35% less) representing a reduction overall of 55%

	Must Do				Should Do				Total			
Core Service	2018	2021	2024	2021 vs 2024	2018	2021	2024	2021 vs 2024	2018	2021	2024	2021 vs 2024
Medical Care	18	22	5	-21	5	26	17	-8	23	48	22	**-26**

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Removal of Section 31 Condition

Getting to GOOD

Programme Management Office

Section 31 conditions – 2021 vs 2024

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Following the CQC Inspection in 2022, the CQC reviewed all the Section 31 Conditions in place across the Trust, with 1 condition remaining for Medicine (applied to both RSH and PRH)

Section 31 Condition:

The Registered Provider must devise, review and assess the effectiveness of the system, process for care planning records and provide the Care Quality Commission with a report setting out the actions taken or to be taken in relation to condition 1 above by 03 July and on the last Friday of each month.

Section 31 Condition Removal

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Following the publication of the CQC Inspection report in May 2024, we reviewed the existing conditions and submitted an application to the CQC to consider the removal of 3 of the remaining 5 conditions (see table), including the condition relating to care planning and risk assessments (Medicine).

As well as the evidence and improvements noted by the CQC during their inspection in 2023 and report in May 2024, monthly assurance data submitted as part of the Trusts monthly update to the CQC, and a supporting evidence pack was considered by the CQC by their senior management to help determine their decision.

In December 2024, the CQC agreed to remove the 3 conditions with immediate effect, leaving only two conditions relating ED on the Trusts registration.

Conditions relating to Regulated Activity : ***"Assessment or medical treatment for persons detained under the Mental Health Act" (1983)***			Proposed Action	Criteria to Apply for Removal	Date Removed
Trust Wide CYP Mental Health	Condition 1	Must not admit patients: • Patients<18 years of age who present with isolated acute mental health needs. • Do not have physical health needs that require inpatient assessment and treatment	Apply to remove	Maintenance of daily SQL reporting whereabouts of all U17 patients. Maintenance upholding of non-admitting criteria Continue to work with partner organisations to ensure patients are cared for in the most appropriate setting. Continue to report incidences to CQC for transparency	Dec 2024
Conditions relating to Regulated Activity : *"Treatment of disease, disorder and injury".*			**Proposed Action**	**Criteria to Apply for Removal**	**Date Removed**
Trust-Wide	**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**	**Apply to remove**	**Monitored via Must/Should do actions with existing and revised actions to ensure continued improvement and monitoring.** **Collate summary of compliance data (which is submitted monthly to the CQC already) and actions identified to ensure improvements to meet criteria to remove**	**Dec 2024**
Trust Wide CYP Mental Health	Condition 2	Must not admit patients: • Patients<18 years of age who present with isolated acute mental health needs. • Do not have physical health needs that require inpatient assessment and treatment	Apply to remove	Maintenance of daily SQL reporting whereabouts of all U17 patients. Maintenance upholding of non-admitting criteria Continue to work with partner organisations to ensure patients are cared for in the most appropriate setting. Continue to report incidences to CQC for transparency	Dec 2024

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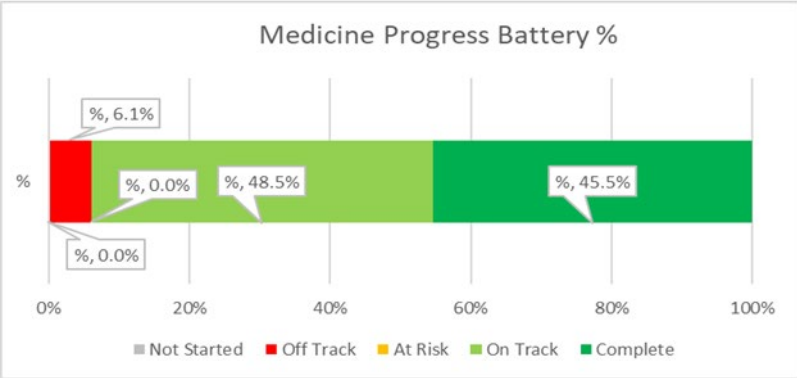
CQC Action Plan Summary and Progress

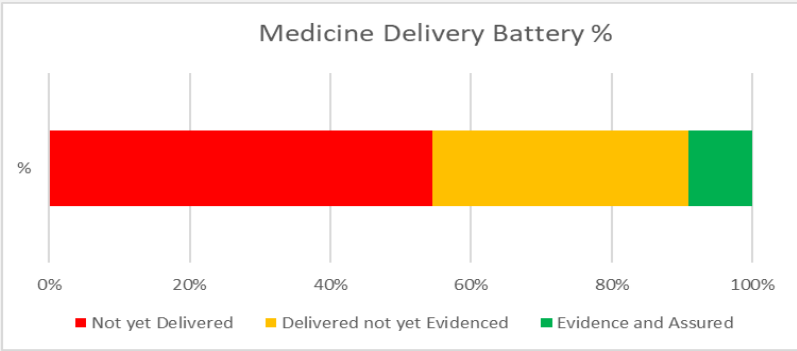
Progress

Key Data

Progress



Delivered



Summary

CQC Action Plan Deliverables

The actions aligned to the latest must do and should do's have been cross referenced and included in the Medicine Transformation workstreams

Of these Actions:

- 15 (45.5%) complete,
- 2 (6%) off track,
- 6 (48.5%) on track

Delivery

- 3 (9%) evidenced and assured,
- 12 (36%) Delivered not yet evidenced,
- 18 (55%) Not yet delivered

Progress

Actions completed in Month

- ✓ **Fluid balance** – trackers implemented; Clipboards in place to support bedside handovers. Compliance 88% in Dec – continue to monitor to go GREEN
- ✓ **Escalation wards** – substantive posts have been recruited, awaiting to start in post.
- ✓ **Escalation wards (new areas)** - SoP with equipment list to set up future areas

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Previous Actions completed:

- ✓ Clinical peer support programme established to ensure standardised ward processes
- ✓ Oversight of metrics, deteriorating patient and quality data via regular Meetings – rolling action plan in place.
- ✓ Resus Trolley checks compliance – introduction of MyKitcheck
- ✓ Improved HCA vacancy rates – introduction of HCA apprenticeships (retention)
- ✓ Review of nursing documentation. Preparation to move to electronic (Careflow) with digital lead nurse
- ✓ Monitoring of VTE via Nursing Quality dashboard and Confirm & Challenge meetings
- ✓ Fluid Balance – focus on bedside handovers

Next steps:

- ✓ ALS/BLS –staff groups identified and multi-year trajectory in place to improve and maintain training compliance – monitor compliance (historical data entered)
- ✓ Mixed sex breaches (AMA) (off Track) – improved but still occurring
- ✓ Work to promote and highlight the importance of Dementia friendly areas

Update on Risk Assessment and Care Planning (Section 31 condition removed but completion of risk assessments including VTE remains a “Must Do”.

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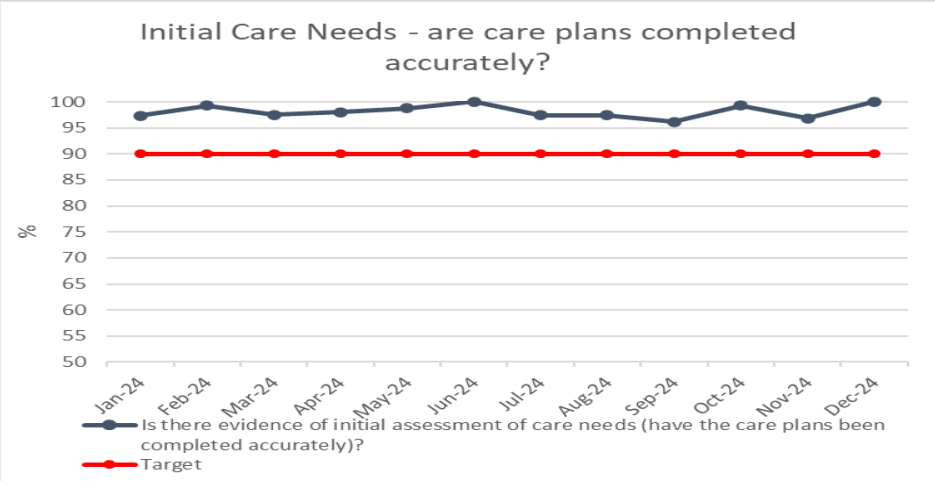
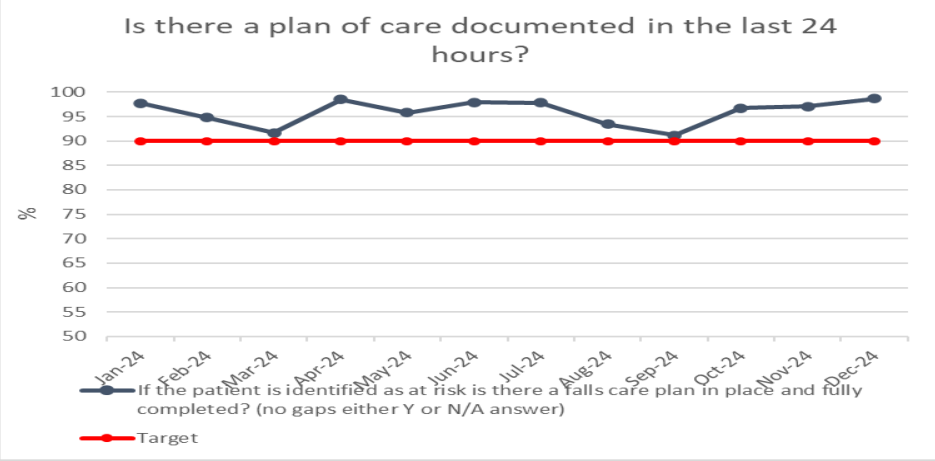




Education on nursing documentation is supported by the Quality team and knowledge in practise is monitored via a schedule of “Ask 5” audits – small question sets for specific areas of the patient care designed to ensure education is embedded and in use giving the Quality team the ability to provide on the spot education where gaps in knowledge are identified and the monthly documentation audits by the Quality Team, where written feedback is given to the individual assessed.

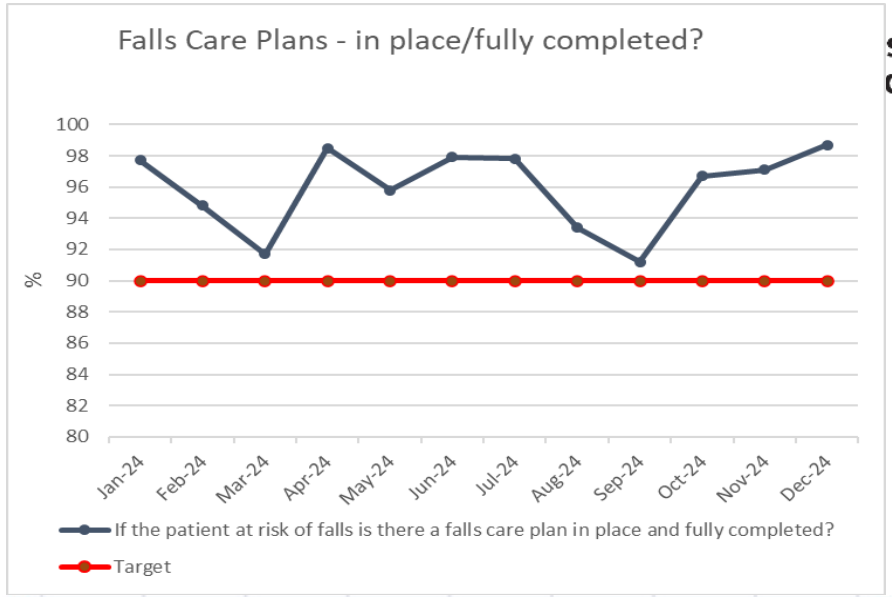
The figures demonstrate consistent and timely completion of patient care plans in addition to the standard nursing documentation and risk assessments

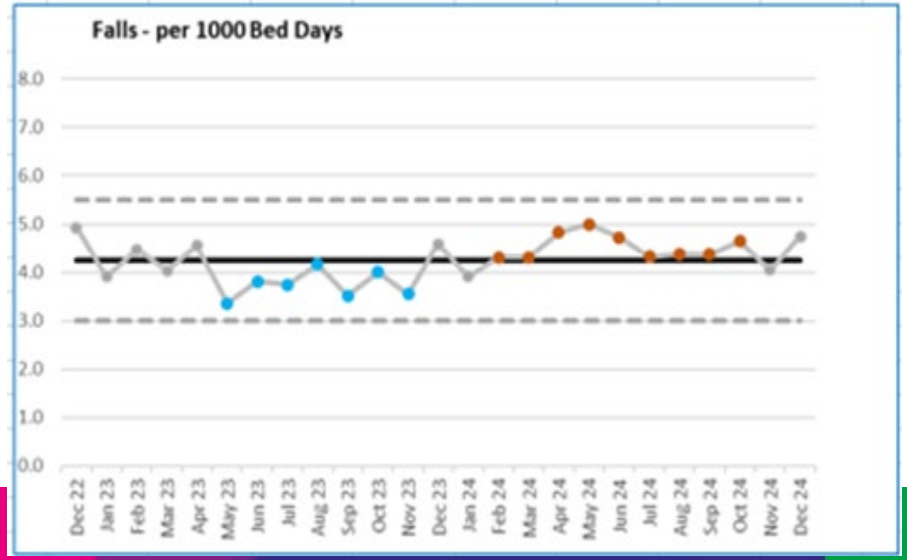
Falls

The graphs on the right demonstrate consistent compliance in completion of Falls Risk Assessments. 97% of patients had their falls risk assessment completed within 6 hours of admission in December 2024

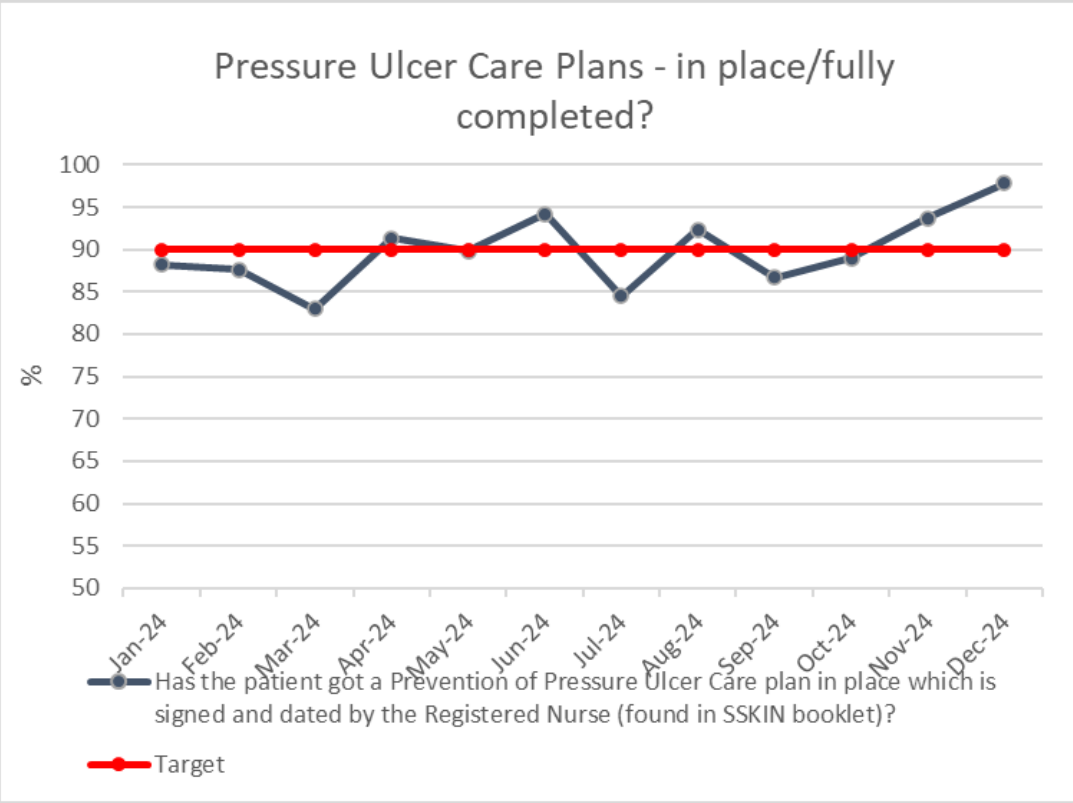
Standard/completed work:

1. Revised Falls Care Plan
2. Provision of face-to-face Falls Prevention training via HCA Induction and Preceptorship induction programmes. Also international nurses ward readiness programme. E-learning package via LMS is once only completion.
3. Enhanced Care & Support team in place providing 1:1 supervision to appropriate patients, providing supervision, activities and care.
4. Updated and improved Patient Information leaflet now in place.
5. A refresher video has been made available for watching after the face-to-face training package.
6. Falls link worker training 2 day programme across both sites. This will be offered once annually.
7. Reconditioning games continues to build on momentum, with regular events and initiatives to promote with commencement of monthly Reconditioning Group Meetings.
8. Two yearly falls training targets set for Ward Managers -achieved **94% December 2024**.
9. New beds ordered for the Trust have sensors included and training prior to roll out of new bed stock has commenced. Sensors are bed exit sensors, not falls sensors, and teams have been asked that they continue to source high-low beds for those patients who require them due to unsafe mobility.





Pressure Ulcers



The chart to the left demonstrates consistent and improved compliance in completing a TV risk assessment within 6 hours of admission and with care plan in place.

Standard/completed Work:

1. The NWSCP modules are continuing to be used by SaTH. Mandatory training compliance improved (87% for medical wards) across the Trust. Link worker programme progressing well with guest speakers arranged for the link worker meetings for this year.
2. Revised SSKIN booklets now in use, training presentation on TV intranet page for staff and the Quality Team are supporting with implementation along with the updated nursing booklet. Audits undertaken as part of quality metrics. High pressure ulcer incidence areas - the pressure ulcer prevention nurse is supporting with additional F2F training.
3. PURPOSE T risk assessment tool was implemented in September 2024

* TV November_22-A Case Study Nov 22
* TV November_22_The use of PICO on an non-healing axilla wound

Risk Assessments and Patient Centered Care –Quality Dashboard

The Shrewsbury and Telford Hospital NHS Trust

Medicine and Emergency Care

Show breakdown by area

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Total	Target	Progress
Nursing Quality Assurance Audit									
Nursing Quality Assurance - Score for all audits	92.6 (271)	92.3 (246) ▼	92.5 (256) ▲	92.4 (255) ▼	92.3 (243) ▼	93.2 (178) ▲	93	80 - 90	
Themes									
Documentation	92.8 (199)	92.2 (186) ▼	91.8 (193) ▼	92.5 (191) ▲	92.2 (181) ▼	93.4 (124) ▲	92	80 - 90	
Nutrition	90.4 (165)	85.2 (163) ▼	90.9 (168) ▲	85.6 (165) ▼	87.9 (159) ▲	87.7 (115) ▼	88	80 - 90	
Skin Integrity	88.6 (165)	89.1 (163) ▲	88.7 (168) ▼	89 (165) ▲	90.7 (159) ▲	93 (115) ▲	90	80 - 90	
Falls	93.9 (209)	93.2 (189) ▼	93.2 (200) —	92.2 (197) ▼	93.7 (187) ▲	94.7 (128) ▲	93	80 - 90	
VIP and Indwelling Devices	91.4 (165)	91 (163) ▼	88.8 (168) ▼	90.6 (165) ▲	89.8 (159) ▼	90.4 (115) ▲	90	80 - 90	
Fluid Balance	77.9 (165)	74.1 (163) ▼	81.1 (168) ▲	78.2 (165) ▼	72 (159) ▼	85.6 (115) ▲	78	80 - 90	
DoLS and Mental Health	96.8 (165)	97.2 (163) ▲	95.2 (168) ▼	92.2 (165) ▼	95.9 (159) ▲	94.7 (115) ▼	95	80 - 90	
ReSPECT and DNACPR	92.4 (165)	92.2 (163) ▼	95.4 (168) ▲	92.8 (165) ▼	96.6 (159) ▲	93 (115) ▼	94	80 - 90	
Missed Dose Audit	93.6 (165)	87.8 (163) ▼	90.7 (168) ▲	89 (165) ▼	90.9 (159) ▲	94.1 (115) ▲	91	80 - 90	

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Total	Target	Progress
Medication	97.6 (165)	98.6 (163) ▲	97.3 (168) ▼	98.8 (165) ▲	97.8 (159) ▼	97.8 (115) —	98	80 - 90	
Safety/Privacy and Dignity	98.6 (209)	98.4 (189) ▼	98.5 (200) ▲	98.6 (197) ▲	97.9 (187) ▼	96.8 (128) ▼	98	80 - 90	
Dementia Screening	74.2 (165)	81.3 (163) ▲	58.7 (168) ▼	63.2 (165) ▲	72.2 (159) ▲	63.4 (115) ▼	69	80 - 90	
Patient Experience	95.2 (165)	95.8 (163)	95.8 (168)	96.7 (165)	96.1 (159)	96.4 (115)	96	80 - 90	
Care Comfort Round	94.5 (165)	92.2 (163) ▼	95.7 (168) ▲	95.4 (165) ▼	92.5 (159) ▼	95.1 (115) ▲	94	80 - 90	
Tracheostomy/CPAP Care	87.5 (165)	100 (163) ▲	91.7 (168) ▼	100 (165) ▲	100 (159) —	88.9 (115) ▼	95	80 - 90	
Palliative and End of Life Care	95.8 (165)	97.6 (163) ▲	96.7 (168) ▼	99 (165) ▲	99.1 (159) ▲	99.6 (115) ▲	98	80 - 90	
Nursing Quality Audit - Infection Prevention and Control - Score	89.7 (19)	92.4 (20) ▲	91.6 (19) ▼	91.5 (21) ▼	90.5 (17) ▼	90.9 (20) ▲	91	80 - 90	
Ward Drug Storage score	89.7 (27)	92.8 (25) ▲	93.2 (24) ▲	91 (23) ▼	93.3 (23) ▲	91.3 (22) ▼	92	80 - 90	
Controlled Drug Storage	96.3 (27)	95.5 (25) ▼	95.9 (24) ▲	96 (23) ▲	94.4 (23) ▼	95.5 (22) ▲	96	80 - 90	
Quality Governance - Score	85.5 (27)	83.8 (25) ▼	84.2 (24) ▲	82 (23) ▼	79.4 (23) ▼	79.7 (22) ▲	83	80 - 90	

- Monthly assurance checks (audits) in place to monitor compliance with completion of nursing documentation and risk assessments such as fluid balance charts, falls assessments (including bed/trolley rail assessments), care comfort chart (privacy and dignity) and IPC checks including bare below elbow (BBE) and hand hygiene.

Risk Assessments and Patient Centered Care - VTE

The Shrewsbury and Telford Hospital NHS Trust

- A review of the VTE Assessment SOP is underway
- Communications to medical colleagues to complete VTE assessments
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- A VTE section is being added to the intranet with all key information available
- VTE Assessments are now included in the medical handover
- VTE is to be included in the medical induction

Discharge planning

The Shrewsbury and Telford Hospital NHS Trust

- The Medical Transformation Programme successfully launched a Board round/ward round initiative in 2024.
- A Ward “Discharge Dashboard” has been developed so that wards have visibility of their discharge performance in real time and for the day before.
- The workstream has now been divided into 3 sub-workstreams as detailed in the next slide, to embed the ward round processes and weekend discharges processes further.
- We have seen a sustained improvement in all our metrics, now discharging more than 30% of discharged patients before 12 midday and exceeding target for simple LOS, 14 and 21 day +patients and weekend discharges.

Discharge planning

The Shrewsbury and Telford Hospital NHS Trust

Workstream 4 – Ward Processes and Improvements

T&F1 - Planning for tomorrow

Ward 27 RSH
Wards 9 and 11 PRH

- Identify tomorrows potential discharges at the afternoon huddle
- Prepare the discharge summary for tomorrows planned discharges
- Inform pharmacy of any requirements for tomorrows discharges

T&F2 - SHOP Model and afternoon huddles

Ward 28 RSH
Ward 17 PRH

- Discuss all of the key points on the checklist at board round
- Ensure all tasks from the board round are recorded with a lead allocated
- Follow the SHOP model during Ward round
- Introduction of afternoon huddles to ensure all tasks are completed or escalated

T&F3 - Weekend discharges

Ward 26 RSH
Escalation PRH

- Ensure Resident doctors identify patients and updated Careflow
- Develop a medical patient discharge sticker
- Develop guidance for medical staff on patient discharge
- Virtual Ward referrals
- Review of failed discharges on Monday

Mandatory training/appraisals – improvements/ data

The Shrewsbury and Telford Hospital NHS Trust

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Total	Target	Progress
Training									
T34 Pump Training 2 Yearly	89.9	90.1	87.42	87.73	86.56	84.76	87.75	90 - 80	
Bariatric (Baros) Bed Training Once	63.14	65.71	65.1	64.89	69.99	69.22	66.34	90 - 80	
Fire Safety Awareness 1 Yearly	88.95	88.83	88.94	91.79	90.89	89.93	89.88	90 - 80	
Fire Safety Awareness 2 Yearly	87.77	87.38	88.05	90.23	89.56	88.8	88.63	90 - 80	
Moving and Handling - Level 1 (Load Handling) 3 Yearly	84.14	85.31	85.88	89.37	89.43	88.35	87.09	90 - 80	
Infection Prevention and Control - Level 2 (Non-Medics) 1 Yearly	90.77	89.62	90.59	93.34	92.69	90.47	91.25	90 - 80	
Infection Prevention and Control - Level 1 2 Yearly	84.19	83.39	82.84	86.74	85.71	85.93	84.8	90 - 80	
Hand Hygiene 3 Yearly	85.27	84.17	83.88	84.85	84.91	83.37	84.4	90 - 80	
Moving and Handling - Level 2 (Patient Handling) 2 Yearly	87.95	88.14	87.9	89.92	89.33	87.66	88.48	90 - 80	
Resuscitation - Adult Basic Life Support (Classroom) 1 Yearly	76.82	74.74	76.06	80.57	80.87	77.56	77.76	90 - 80	

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Total	Target	Progress
Food Safety 1 Yearly	84.3	85.28	85.1	87.87	87.8	85.33	85.94	90 - 80	
Conflict Resolution 3 Yearly	94.47	94.75	95.27	95.9	95.95	95.59	95.32	90 - 80	
Equality, Diversity and Human Rights 3 Yearly	93.71	94.15	94.29	94.89	95.27	94.65	94.49	90 - 80	
Information Governance and Data Security Awareness 1 Yearly	84.04	83.75	83.05	86.56	86.02	84.17	84.6	90 - 80	
Health, Safety and Welfare 3 Yearly	94.04	94.21	94.63	95.58	96.16	95.56	95.03	90 - 80	
Preventing Radicalisation - Level 1 (BPAT) 3 Yearly	90.37	91.36	92	93.39	93.68	93.83	92.43	90 - 80	
Preventing Radicalisation - Level 3 (WRAP) 3 Yearly	92.06	92.53	92.49	93.37	93.54	93.15	92.86	85 - 80	
Safeguarding Adults - Level 1 3 Yearly	93.42	93.58	94.23	94.77	95.04	94.64	94.28	90 - 80	
Safeguarding Adults - Level 2 3 Yearly	93.12	93.37	94.4	95.46	95.45	95.09	94.48	90 - 80	
Safeguarding Adults - Level 3 3 Yearly	84.99	83.45	86.28	87.21	88.23	87.6	86.32	90 - 80	
Safeguarding Children - Level 1 3 Yearly	95	95.56	95.93	96.61	96.44	96.36	95.98	90 - 80	

Mandatory training/appraisals – improvements/ data

The Shrewsbury and Telford Hospital NHS Trust

- Training needs analysis looking at Registered nurse and unregistered healthcare professional training which is legally required and what the Trust requires the division to do. This work is ongoing at present, this training data will be adjusted to this agreed model.
- Mandatory training remains a focus this includes basic life support, patient handling and patient safety, information governance and safeguarding training.
- Review of training taken place from Jan to March 2025 to ensure all non mandatory training and non-essential training is stood down to support patient flow and staffing.

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Total	Target	Progress
New Early Warning Score (NEWS2) Once	94.17	92.54	92.91	93.4	94.31	93.95	93.53	90 - 80	
Blood Transfusion Theory 2 Yearly	88	87.36	86.14	87.8	87.12	87.64	87.34	90 - 80	
Blood Transfusion Collection 2 Yearly	72.95	72.02	72.66	75.71	74.63	74.67	73.75	90 - 80	
Blood Transfusion Administration Once	92.3	92.89	92.44	92.75	92.95	92.47	92.63	90 - 80	
Tissue Viability 3 Yearly	82.14	83.27	83.4	84.25	84.44	83.7	83.53	90 - 80	
ESR Latest Appraisal 1 Yearly	69.67	72.45	74.92	78.68	79.58	77.92	75.56	90 - 80	
Oliver McGowan Mandatory training	87.94	89.61	90.06	90.94	91.42	81.61	88.45	90 - 80	
Neuro obs	92.79	93.35	92.62	93.72	94.02	93.86	93.39		

Metric	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Total	Target	Progress
Safeguarding Children - Level 2 3 Yearly	94.91	95.05	95.42	96.24	96.07	96.14	95.63	90 - 80	
3836 Safeguarding Childrens Specialist Level 3	92.27	95.24	92.64	93.78	94.07	94.37	93.73	90 - 80	
3769 Safeguarding Children - Level 3 Core	92.19	92.65	92.18	92.36	91.56	91.51	92.07	90 - 80	
Mental Capacity Act and DOLS 3 Yearly	76.23	75.46	78.68	79.5	80.01	79.3	78.22	90 - 80	
Sepsis for Nurses 3 Yearly	87.36	89.46	89.55	89.66	90.09	88.78	89.15	90 - 80	
Sepsis for Healthcare Support Workers / AHPS 3 Yearly	87.8	88.83	88.73	89.37	89.83	88.86	88.9	90 - 80	
End of Life Care 3 Yearly	86.78	83.21	83.41	85.33	85.96	87.96	86.03	90 - 80	
Dementia Awareness - Tier 1 3 Yearly	91.51	92.38	93.33	96.15	96.43	95.24	94.19	90 - 80	
Dementia Awareness - Tier 2 3 Yearly	91.97	90.02	90.43	91.15	91.78	91.47	91.12	90 - 80	
Learning Disability 3 Yearly	90.73	91.9	92.16	92.94	92.58	92.95	92.2	90 - 80	
Falls Prevention 2 Yearly	93.24	93.58	94.07	94.38	94.48	94.1	93.97	90 - 80	
Falls Prevention Training (eLearning Induction)	90.52	91.5	91.95	92.07	91.86	91.86	91.63	90 - 80	

Deteriorating pt/sepsis– improvements/ data

The Shrewsbury and Telford Hospital NHS Trust

- Since starting to collect this data, we have seen slow improvements in areas but still remain below target in each of the separate areas audited. This is discussed as a part of monthly metric meetings where data is reviewed with ward managers and matrons.
- We have Sepsis and Deteriorating Patient Champions in each ward area supported by the leads for Deteriorating Patient. Meetings in place to discuss relevant themes in areas for improvement.
- Bi-monthly Deteriorating Patient Group meeting attended by matron
- The ward senior team are asked to review each deteriorating patient alongside the given targets for escalation and treatments on a daily basis. This is included in the monthly report.

Deteriorating Patient audits carried out by Wards / Matron									
Number of patients scoring over 5 or 3:1 over full calendar month	1464	2436 ▲	0 ▼	1776	1938 ▲	No data	7614	-	
Number of audits completed by area	835	811	900	867	805	732	4950	-	
Next set of Obs carried out on time	69.3 (835)	73.1 (811)	71.7 (900)	66.9 (867)	74.2 (805)	71.6 (732)	71	89 - 95	
Evidence of NEWS2 score being escalated	87.4 (835)	89.5 (811)	88.1 (900)	88.4 (867)	87.5 (805)	88.8 (732)	88	89 - 95	
Review within recommended time frame	93.2 (649)	94.9 (610)	93.8 (663)	95.1 (674)	94.5 (637)	95.1 (576)	94.4	89 - 100	
Was the patient assessed for sepsis at point of presentation (regardless if NEWS2 has been triggered) **	76.9 (52)	72.1 (61)	74.2 (66)	80.6 (62)	79.2 (77)	76.2 (42)	76.7	89 - 95	
Review by appropriate grade of clinician	97.3 (636)	97.7 (602)	97.7 (654)	98.4 (677)	98.7 (628)	96.2 (573)	97.7	89 - 100	
Is the Patient High Risk	288	262	282	279	271	231	1613	-	
Number of Patients eligible for starting sepsis 6 bundle	100	97	107	96	119	84	603	-	
% of patients who received antibiotics within 1 hour	87.2 (94)	86 (93)	87 (100)	88.4 (95)	92 (112)	85.7 (84)	87.9	89 - 95	

Staffing across Medicine wards

The Shrewsbury and Telford Hospital NHS Trust

- 9 am daily staffing meeting (Mon- Fri) to review staffing across medical wards and emergency areas across both sites. There is a review of SafeCare acuity across each of these areas - supports movement of staff to clinically at-risk areas. This meeting is attended by matrons and above and chaired by Deputy Divisional Directors of Nursing and Matrons.
- There are twice daily panel meeting to review escalation of shifts at 10 am and 4:30 pm alongside review of patients requiring additional support (Enhanced Care Support).
- There is a daily 4 pm staffing review attended by all divisions to review the staffing for night and long day.
- Essential wards are not escalating to agency to fill up to 100% but to escalate to NHSP and bank staff, Monday to Friday , additional support is provided by the ward manager and other senior nursing staff. Flow matron team support with short term absence out of hours, this is reviewed against Safe Care acuity scores on each ward. This is to support financial recovery of Trust.
- We also have Quality Matrons available on weekends between (9-5 pm) to support with short term absence escalations.
- Improvements in HCA vacancies with implementation of Apprenticeship HCA roles in February 2025 and HCA recruitment events.

Escalation areas – criteria and mitigation

The Shrewsbury and Telford Hospital NHS Trust

- Escalation beds are in place on Ward 11 x 1, Ward 28 x 4. These additional beds are supported by the substantive workforce in these areas.
- Review of Hospital full policy taken place in December 2024 with new areas identified for “next patient” additional spaces on wards to support the flow of patients through the trust (Medical wards: PRH 6, 7, 9, 10, 11, 16 and AMU; RSH: 26, 27, 28).
- There is a medical escalation criteria for patient allocation, this criteria has been shared across the site team and admission areas to ensure patients are allocated correctly.
- At the Princess Royal Hospital we have a medical escalation 25 bedded ward, it has been staffed by substantive registered nurses and unregistered nurses from PRH medical wards. This ensures we have staff that are familiar with hospital guidance and policies on each shift giving a safer level of care and a consistent approach. Substantive staff recruited for Band 5 and Band 2.

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Appendix 1
CQC Action Plan - Medicine

Summary Area for Improvement	Action Numb	Priority	Site	Action Details	Updates	Measures/evidence of success	Progress Stat	Delivery Status	Delivery Deadlin
The service must ensure all staff complete mandatory and legally required training and medical staff complete safeguarding children's level 3 training in line with trust targets.	MD001.1	Must Do	RSH	Actions to address training compliance (trajectories for improvement) will be scoped and included in MedTP Workstream 1.	Compliance Dec 24 - areas less than 85% -Adult BLS. Childrens Safeguarding Level 3 = 79% (level 2 = 95%) Staff maybe pulled from training to cover staffing shortfalls (reviewed daily). Length of appraisal improved - easier to complete. All wards have a trajectory in place	Compliance monitored/challenged via PRM and Corporate nursing Confirm & Challenge - target 90% for all elements except IG = 95% and PREVENT = 85%	On Track	Not yet Delivered	Mar-25
The trust must ensure that all risk assessments, with particular attention to venous thromboembolism risk assessments are completed in line with trust policy, to reduce the risk of harm to patients.	Md007.1	Must Do	PRH	**VTE assessments**	Review of Board Round checklists VTE - direct admissions focus - included on Dashboards for oversight at NMQ Actions to address are being led by Medicine Clinical Governance lead: Communications to medical colleagues Trust committee for VTE - terms of reference being agreed Training/education on induction Collate baseline data on VTE compliance (looking at national audit data collection methods available)- VTE audit once actions embedded	Achieving the target in Medicine of 95% consistently for minimum 3 months consecutively AMBER - minutes of VTE committee Communications Training/induction resources Compliance audit - GREEN	On Track	Not yet Delivered	Mar-25
	Md007.2	Must Do	PRH	Establish a clinical peer support programme to sustain delivery of standardised ward processes	Support rotas and comms for support rota submitted	**Amber - Support Rota; Amber Comms for support rota - received** Green - Monitoring below: Det pt response; VTE completion improvement; Dementia and ReSPECT completion	Complete	Delivered not yet Evidenced	Sep-24
	Md007.3	Must Do	PRH	Continue to complete NMQ audits and monitor via NMQ Meetings, exception reports and dashboard	Fluid balance - bedside handovers - refocus to ensure fluid balances are handed over and updated routinely (inc. charts at handover). trracker and clipboardss in place Dementia - new tool in place - compliance improving Nutrition - support from Quality team - improved to 91% (usually amber)(MUST score completion improved) Tissue V - focused work on ward 27 and areas with increases in incidents Focused support from QM's where identified	Improved NMQ audit results Exemplar Assessments Reduction in themed incidents Reduction in complaints Improved FFT data	**Complete**	Delivered not yet Evidenced	Mar-25
	Md007.4	Must Do	PRH	Confirm & Challenge Meetings - focused divisional meetings to agree themes and actions (monitored via action log = AMBER) VTE to be added for oversight	This is now included on dashboard and governance meetings - no further action from a Confirm & challenge perspective.	Ensure all metrics are reviewed as part of NMQ meetings	**Complete**	**Evidence and Assured**	Jul-24
The trust must ensure they adhere to the policies in place around mixed sex breaches.	Md008.1	Must Do	PRH	Confirm & Challenge meetings to incorporate rolling "action log" and where themes identified, specialists support will be brought into monthly meetings to discuss actions to improve	Most breaches occurring on AMA and SDEC where bedded overnight with footfall through the next day. Wards (stroke cardio) when pts need a step down bed. Breaches are included on NMQ Dashboard for oversight and discussion. Ward breaches improving	Mixed sex breach report	**off track**	**Not yet Delivered**	Jul-24
	Md008.2	Must Do	PRH	Actions taken to date	Review of reporting against national guidance (i.e seated patients - may result in increase. Single Sex policy followed by CSMs but capacity results in longer waits in admission areas.	Improved numbers of breaches - number not defined	**off track**	**Not yet Delivered**	Sep-24

The trust must ensure they continue to work on meeting their referral to treatment targets for all pathways.	Md009.1	Must Do	PRH	Actions to address RTT targets (trajectories for improvement) will be scoped and included in MedTP Workstream 1. Monitored via weekly meetings and PRM	Reviewing standardised referral processes (electronic) for Rep/cardio. Improve utilisation of the Advice and Guideline line - attend GP Federation meetings to promote	RTT targets achieved for all specialisms	On Track	Not yet Delivered	Mar-25
The trust must ensure all staff complete mandatory and legally required training and receive an appraisal.	Md010.1	Must Do	PRH	Continue oversight via Divisional Governance and Confirm and Challenge meetings	Appraisal rate - 80% (was 70% in July) - ongoing talks with Education to minimise lag with data being input onto LMS. Length of appraisal improved - easier to complete. All wards have a trajectory in place	Compliance monitored/challenged via PRM and Corporate nursing Confirm & Challenge - target 90% for all elements except IG = 95%	On Track	Not yet Delivered	Mar-25
The service should ensure records are completed consistently to assess and mitigate individual patient safety risks.	SD010.1	should Do	RSH	Actions to address completion (and re-assessments) MedTP Workstream 1 2. Continue to complete NMQ audits	Fluid balance - bedside handovers - refocus to ensure fluid balances are handed over and updated routinely (inc. charts at handover). Dementia - new tool in place - compliance improving Nutrition - support from Quality team - improved to 91% (usually amber)(MUST score completion improved) Tissue V - focused work on ward 27 and areas with increases in incidents Focused support from QM's where identified	Improved NMQ audit results Exemplar Assessments Reduction in themed incidents Reduction in complaints Improved FFT data AMBER Admission booklet Audit data	Complete	Delivered not yet Evidenced	Mar-25
	SD010.2	should Do	RSH	Confirm & Challenge Meetings - focused divisional meetings to agree themes and actions Confirm & Challenge meetings to incorporate rolling "action log" and where themes identified, specialists support will be brought into monthly meetings to discuss actions to improve	Action log in place and reviewed each monthly meeting MIAA auditing quality metric audits, meetings and actions to identify good practise and suggest improvements. Survey on audits and meetings to send out to ward managers and matrons	Improved NMQ audit results Exemplar Assessments Reduction in themed incidents Reduction in complaints Improved FFT data	Complete	Delivered not yet Evidenced	Oct-24
The service should ensure that deteriorating patients are consistently identified and escalated in line with trust policy.	SD011.1	should Do	RSH	Continue to complete audits Deteriorating patient action plan - to be incorporated into overarching Fundamentals in Care action plan and overseen via DPG New clinical lead for Deteriorating Patient and Sepsis is new Deputy Medical Director TEP form trial will help address this as not all patients will then need escalating as clear parameters will be set	Looking at tolerance built into Vitals system. Want to reduce to 10%. Take to QOC. FB sop reviewed to highlight need for monitoring in deteriorating patients. Additional actions identified: Monitoring of late obs audit data - complete ; Sepsis policy review Transfer Patient policy Review - complete ; Recognition - SHOP model (poster) Deteriorating Patient Group - re-launch with updated TOR (ToR and Minutes) - complete Escalation - audit SBAR -- in progress ; Escalation - stickers - complete Compliance in escalation appropriately = 86% in Dec	Improved compliance in escalation compliance and delivery of sepsis 6 bundle reduction in incidents	On Track	Not yet Delivered	Mar-25
	SD011.2	should Do	RSH	Confirm & Challenge Meetings - focused divisional meetings to agree themes and actions Confirm & Challenge meetings to incorporate rolling "action log" and where themes identified, specialists support will be brought	Action log in place. continued oversight of compliance - review of audits, frequency and number to be agreed with parallel peer audit to focus on education. DPG will now meet quarterly. Divisional level oversight needed at med clinical governance. Det pt has 6 workstreams in place repoprtiong into programme group that metss	Improved compliance in escalation compliance and delivery of sepsis 6 bundle reduction in incidents	Complete	Delivered not yet Evidenced	Aug-24
	SD011.3	should Do	RSH	TEP form trial will help address as not all patients will then need escalating as clear parameters will be set	TEP trial paused, one of the workstreams as part of Programme Group for Det Pt, led by a respiratory consultant. Escalated to Deputy Medical Director to help progress	Improved compliance in escalation compliance and delivery of sepsis 6 bundle reduction in incidents	On Track	Not yet Delivered	Jun-25
	SD011.4	should Do	RSH	Education will be offered in completing audits where there are discrepancies in ward own audits vs validations and hence educating on the correct processes so that this can be fed down to clinical staff	Work from specialist team to ensure consistency provided to wards. Support via peer audits, specialist teams providing education where discrepency in outomes from ward vs peer. Rota for support in place.	Improved compliance in escalation compliance and delivery of sepsis 6 bundle reduction in incidents	On Track	Not yet Delivered	Jun-25
The trust should ensure checks on resus trolley are recorded as per policy.	SD012.1	should Do	RSH	Monitored via NMQ audits and Confirm and Challenge. Resus Team to oversee improvements via new system	Resus trolley checks = 100% . "MyKitCheck" - monitor by ward with data overseen by Resus team - Ward manager gets email - central option being looked at - looking into what solution centrally	Improved NMQ audit results Exemplar Assessments	Complete	Delivered not yet Evidenced	Mar-25
The trust should ensure nursing and health care assistant staffing levels are as planned.	Sd013.1	should Do	RSH	MedTP workstream 2 - Staff Continue development and use of Safer Staffing nursing tool (acuity) to determine correct staffing levels HCA Academy	Monitor staffing report (AMBER evidence); levels monitored via staffing morning meeting. Safe staffing levels vs acuity monitored via SafeCare (GREEN evidence) Monitor reduced in HCA Vacancies (Workforce) - GREEN evidence - HCA recruitment event 1st Feb 25 - HCA aprentices starting in Feb - improving vacancy position. Provide 2 weeks training for new HCA's. Apprentices have ongoing support and training Safecare ensuring safe to move from (to) being introduced at 4pm meetingsx	Staffing/fill rates on dashboard	Complete	Delivered not yet Evidenced	Mar-25
The trust should ensure there is consistent leadership and staffing on the escalation wards.	Sd014.1	should Do	RSH	MedTP workstream 2 - Staff Ward 21 is no longer being used as an escalation ward Review of processes and staffing as part escalation processes will be included in the MedTP work stream 1 Existing/substantive staff are moved from other areas to support	Matron appointed Recruitment in substantive posts completed - waiting to start	Monitoring via Divisional governance Rosters Gather Dashboard Substantive to agency ratio	Complete	Delivered not yet Evidenced	Mar-25

The trust should ensure wards are appropriately equipped to meet patient's needs.	Sd015.1	should Do	RSH	MedTP Workstream 1 - Clinical Quality, Outcomes & Co-ordination of Care Work is progressing on producing a standard list of equipment required for escalation areas - where to retrieve/locate, in order to ensure areas can be safely opened	Equipment list and SOP to be distributed - budget for additional equipment to be identified.	Checklist in place - spot audit against checklist when escalation areas in use	Complete	Delivered not yet Evidenced	Mar-25
The service must ensure the storage of medicines within wards are stored.	SD016.1	should Do	RSH	**ECTP workstream 1** **Fundamentals in Care project will support divisional actions corporately.** Nurse in Charge checklist Discuss via daily safety huddles	Ward drug storage score = 92%, Controlled drug storage = 96% Review of pharmacy audit data to evaluate gaps to move to Green review data from Set 23 with now to see if improving (Pharmacy audits)	NMQ Audit showing compliance over 90% consistently Exemplar assessments Pharmacy audits	Complete	Delivered not yet Evidenced	Mar-25
The trust should ensure advanced life support and immediate life support training is captured on the trust learning management system.	SD017.1	should Do	RSH	Work is ongoing to ensure the audience for those requiring Advance Life support training are capture on the LMS system and a % compliance can be provided. Audience has now been defined and training needs are being aligned.	Train the trainer put in place SEMTRaG update: Historical data has been uploaded to LMS. Defined audience. Training in place to meet 4 year trajectory.	Compliance figures will be available and in line with Trust target of 90%	On Track	Not yet Delivered	Mar-25
The trust should ensure waiting times from referral to treatment and arrangements to admit, treat and discharge patients are in line national standards.	Sd018.1	should Do	RSH	Actions to address RTT targets (trajectories for improvement) will be scoped and included in MedTP Workstream 1. Monitored via weekly meetings and PRM	Workshop w/c 09/09/24 - trajectories to be shared	RTT targets achieved for all specialisms	On Track	Not yet Delivered	Mar-25
The trust should ensure the store cupboard for clean equipment is moved from the dirty utility room in the discharge lounge.	SD019.1	should Do	RSH	This was addressed at the time of the inspection and moved accordingly. Assurance this has been maintained to be obtained to sign-off	Complete	Assurance visit to ensure maintained	Complete	Evidence and Assured	May-24
The trust should ensure the governance system in place is effectively supporting all aspects of safe, quality care.	Sd048.1	should Do	PRH	Actions to address triangulation of performance targets and actions to be will be scoped and included in MedTP Workstream 1 Continue to complete NMQ audits Confirm & Challenge Meetings - focused divisional meetings to	Action log in place Minutes from governance meetings to evidence oversight	Improved compliance with NMQ audit and Exemplar assessments	Complete	Evidence and Assured	Mar-25
The trust should ensure that patients are screened and treated for sepsis in line with recommended guidance and trust policy.	SD049.1	should Do	PRH	MedTP Workstream 1 - Clinical Quality, Outcomes & Co-ordination of Care Actions to address improvement in elements of sepsis screening and treatment to be scoped and included in MedTP Workstream 1 - this will be included in divisional reports via DPG Continue to complete sepsis audits Confirm & Challenge meetings to incorporate rolling "action log" and where themes identified, specialists support will be brought into monthly meetings to discuss actions to improve	Looking at tolerance built into Vitals system. Want to reduce to 10%. Take to QOC. FB sop reviewed to highlight need for monitoring in deteriorating patients. Additional actions identified: Monitoring of late obs audit data - complete Sepsis policy review Transfer Patient policy Review - complete Recognition - SHOP model (poster) Deteriorating Patient Group - re-launch with updated TOR (ToR and Minutes) - complete Escalation - audit SBAR -- in progress Escalation - stickers - complete Compliance in escalation appropriately = 86% in Dec	Improvement in compliance in sepsis treatment and outcomes Reduction in incidents Reduction in complaints	On Track	Not yet Delivered	Mar-25
	SD049.2	should Do	PRH	TEP form trial will help address this as not all patients will then need escalating as clear parameters will be set	DPG re-launch and review of Tor in Sept.Oct wth updated action plan with support from PMO November 24 - TEP trial stopped, one of the workstreams as part of Prograame Group for Det Pt, led by a respiratory consultant. HOW ARE THE DIVISION ASSURED THEY ARRE SCREENING PATIENTS?	Det pt audts - green evidence	On Track	Not yet Delivered	
	SD049.3	should Do	PRH	Education will be offered in completing audits where there are discrepancies in ward own audits vs validations and hence educating on the correct processes so that this can be fed down to clinical staff	DPG re-launch and review of Tor with updated action plan with support from Peer audits - support via peer audits, Specialist teams providing education where discreprency in outomes from ward vs peer.	Det pt audts - green evidence	On Track	Not yet Delivered	

The trust should continue to work on the completion and quality of care records.	Sd050.1	should Do	PRH	MedTP Workstream 1 - Clinical Quality, Outcomes & Co-ordination of Care Actions to address triangulation of completionn of care records scoped and included in MedTP Workstream 1	Evidencef intial assessment of care needs and completion of care plans = 97% NMQ audit - dashboard = AMBER evidence Nursing documentation update Medical documentation audit to be undertaken to understand gaps	Improved FFT results Compliance in NMQ/Exemplar audits	Complete	Delivered not yet Evidenced	Mar-25
	Sd050.2	should Do	PRH	Exemplar questions to be reviewed to include additional questions to oversee completion. Fundamentals in Care project will look at potential improvements in documentation/mechanisms to record and communicate patients needs and preferences. Continue to complete NMQ audits	Work with Josh Pagden - intro of electronic pts records (inpatients) - preparing for next project - nursing assessments starting work with Chief NursingInfo officer, in prep for the next electronic documetation prject for nursing assessment. Compliance in completing assessments continue via NMQ. Exemplar review from jan - March 25		Complete	Delivered not yet Evidenced	Apr 25 - exmplar monitor adherence to standardspopst implementation
The trust should continue to use the audit data to drive improvements for patient care and treatment.	Sd051.1	should Do	PRH	MedTP Workstream 1 - Clinical Quality, Outcomes & Co-ordination of Care Actions to address triangulation of performance targets and actions to be will be scoped and included in MedTP Workstream 1 Continue to complete NMQ audits Confirm & Challenge Meetings - focused divisional meetings to agree themes and actions Confirm & Challenge meetings to incorporate rolling "action log" and where themes identified, specialists support will be brought into monthly meetings to discuss actions to improve	The following will be continued/progrressed to continue oversight: CQUIN data - deteriorating patient; ; Annual Medical audit plan; Exception reports (NMQ audits via Confirm & Challenge) Exemplar data; Dashboards Using data from patients BI - ward patient flow dashboard as part of ward round. Used to give picture of hospital activity - hitting targets. Giving bigger picture - bench marks. Discussion at MUEC Mtg October - what is new in division to use data for improvement - further work to support launch of electronic flow boards in ward areas.	Improved compliance with NMQ audit and Exemplar assessments	On Track	Not yet Delivered	Mar-25
The trust should continue to work with partner organisations to improve discharges.	SD052.1	should Do	PRH	ECTP will be part of a the planned system wide UEC improvement plan looking at flow, discharges and alternative provision. **MedTP also has workstream 4** to look at Ward Processes and Improvements (Flow through medicine wards, early discharge, LOS etc)	An electronic flag in Careflow (Patient Flow)e. Capacity and flow programme has focused workstreams on Transport (reducing delays), Discharge Lounge (increasing productivity, earlier discharges, expectations), site management, Deconditioning and Virtual Ward (increase utilisation) Frailty (wkstrm 3) - Advice and Guidance line extended to WMAS The simple LoS has reduced by 2 days and the average time the over 75's are spending in the Emergency Department has reduced by 2 hours since the opening of FAU. Extended service hours. Electronic Flow Board was been developed and soft launched; Frailty dashboard implemented to monitor LoS etc. Task and Finish groups for Weekend Discharges, SHOP Model & Afternoon Huddles Planning for Tomorrow Supported input commenced Prioritise pathology tests for patients planned to be discharged earlier in the day to ensure that bloods can be reviewed on ward rounds - sticker to flag in notes created Next Steps - Review outcomes of the supported improvement work relating to Weekend Discharges and SHOP model & Afternoon Huddles; Clinic Hot Slots – Recommendations contained in final report will be evaluated to determine any next steps	Improved number/proportion of discharges early in the day Reduction of delays in transfer from ED to ward base Improved 4 hr target in ED	On Track	Not yet Delivered	Mar-25
The service should continue to improve the care provided to patients living with dementia which includes improving the environment.	SD053.1	should Do	PRH	MedTP Workstream 1 - Clinical Quality, Outcomes & Co-ordination of Care This will be reviewed as part of the Fundamentals in Care project and aligned with the work of the Dementia Steering Group and the Hospital Transformation Group Cognitive screening assessment changing throughout the trust. 4AT assessment now taking place in ED, Medicine directorate are rolling out 6CIT. Surgery, women and children to follow with 6 CIT	6 CiT rolled out in Medicine replacing AMT ED using 4 AT as a delirium screening tool and on Orthopaedic wards using 4AT also in #NoF; Dementia lead drafting a briefing paper and liaising with Divisions to highlight requirements and higglighting what needs to be in place to best support patients	Improvement in Dementia audit results	On Track	Not yet Delivered	Mar-25
The service should ensure all patients are able to discuss any concerns with staff.	SD054.1	should Do	PRH	MedTP workstream 2 - Staff	Promote PALS leaflet and accessibility - new leaflet in distribution. Monitor complaint themes. New leaflet being given to patient in additional bed spaces to improve communications. Patient stories being brought to weekly meeting via PE - relevant to medical wards. Matrons and ward managers attend complaint meetings. Less complaints year on year and response time improving - 57 overdue as of Jan 25. Details of complaints shared with teams for learning opportunities	Exemplar results Monitor complaints - response times and number received + PALS contacts	On Track	Not yet Delivered	Mar-25

Acronyms

The Shrewsbury and Telford Hospital NHS Trust

Acronym	Definition	Acronym	Definition
SoP	Standard Operating Procedure	**SHOP**	S – Sick H – Homes O – Others P - Plans
HCA	Health Care Assistant	**NHSP**	NHS Professionals
VTE	Venous thromboembolism	**PURPOSE T Risk Assessment**	Pressure Ulcer Risk Primary or Secondary Evaluation Tool)
ALS/BLS	Advanced Life Support/Basic Life Support	**TV Risk Assessment**	Tissue Viability?
AMA	Acute Medical Assessment	**NWSCP**	National Wound Care Strategy Programme
LMS	Learning Management System	**SSKIN**	S-Surface S-Skin Inspection K – Keep Moving I – Incontinence N – Nutrition and Hydration