The Shrewsbury and Telford Hospital NHS
NHS Trust

Quality Account 2010/11

Putting Patients First

Contents

Information about this Quality Account

Copies are available from www.sath.nhs.uk, by email (consultation@sath.nhs.uk) or in writing from:
Chief Executive's Office, The Shrewsbury and Telford Hospital NHS Trust, Princess Royal Hospital, Grainger Drive, Apley Castle, Telford TF1 6TF
Chief Executive's Office, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XQ

Our Quality Account is also available on request in large print. Please contact us at the address above or by email at consultation@sath.nhs.uk to request a large print version of the Quality Account.

Please also contact us if you would like to request a copy of our Quality Account in another community language for people in Shropshire, Telford & Wrekin and mid Wales.
A glossary is provided at the end of this document to explain the main terms and abbreviations used in our Quality Account.

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Section 1: Introduction to our Quality Account 2010/11

Section 1 of a Trust's Quality Account provides a statement on quality from the Chief Executive.

This Quality Account is probably the most important document we publish every year. It talks openly about the care we provide for our patients, describing what we do well and also where we sometimes fall down. It focuses on the reasons why I and thousands of other people have chosen to work in the NHS – to strive for safe, effective care that patients and staff can be proud of. Our job is to understand what our patients want from us, to truly listen to what they tell us about their care, their experiences about what works well and what could be better. We need to see things from their perspective.

Throughout my career I have tended to think, 'would this be good enough for my Mum?' or 'what would my Mum think about this?' Sometimes we discover that the way in which our services have been provided no longer fits what patients require from us today. Finding ways to understand how we are seen by our patients, and thinking through what this means for what we must do, is the challenge we must all set ourselves every day.

With this in mind, one of the first tasks I set myself when I joined the Trust in July 2010 was to hear from as many people as possible – patients, carers, staff, GPs, partner organisations, local representatives – about the quality of care we provide. We continue to tell ourselves that the quality of patient care is our highest priority, but is this matched by the everyday experiences of people in our wards and clinics?

Much of what I heard reminds us why so many people are rightly proud of the NHS. But, I have also heard from staff across the Trust about the help and support they need to change things for the better, and from patients about the times when we don't get things right.

There is a similar picture in this Quality Account. For example, whilst we have seen progress in stroke and Trans Iscaemic Attack (TIA) services (now, over three quarters of high risk TIA patients are scanned and treated within 24 hours compared with less than a quarter at the start of the year), there is clearly much more improvement needed for many patients needing unplanned care. Action to tackle healthcare associated infections has led to major reductions in MRSA bloodstream infections and Clostridium difficile, but we now need to bring the same vigour to prevent pressure ulcers which can be a significant source of sickness and reduced quality of life for patients. This Quality Account also sets out other issues and risks that we must address.

This year has also seen a major public consultation on changes to health services that are needed in order to tackle some significant clinical challenges faced by our hospital services. If we do not tackle these issues then there is a very real risk that our services will decline. At the end of March the Trust Board agreed that we should now develop a Full Business Case based on the consultation proposals. We will do this by the Autumn, and I am committed to working with patients and communities to address the concerns that were raised during the consultation, and to make sure that the new services are safe and appropriate for people across Shropshire, Telford & Wrekin and mid Wales.

So that we can make the improvements our patients expect and deserve, I have worked with staff to agree that the guiding principle for the Trust going forward should be **Putting Patients First**. This simple phrase reminds us to focus on what really matters for our patients, so that we can use our time, skills and other resources more wisely. But, if we are truly putting patients first then this has consequences for the way we run your health services.

One aspect of this is to make sure that this Trust is clinically-led. During 2010/11 we have changed the way our services are managed and run to give more power to frontline staff. Clinicians have been given more authority and responsibility to lead, plan and deliver patient services. This includes the appointment of clinical Centre Chiefs with the energy and drive to make the improvements that our patients tell us we need to make.

We also need to give the tools and skills to our staff, so that they can translate their enthusiasm and commitment into positive change. One way we plan to do this is through Leading Improvements in Patient Safety. This national programme builds the knowledge and abilities of hospital teams to improve patient safety. At its heart is the principle that if we get it right first time, every time, then patients will need to spend less time in hospital, their recovery will be quicker, their experience will be improved and their quality of life will be better. This in turn means that we can provide more care with the resources available to us.

Alongside this it is vital that we make sure that our plans are grounded and realistic. This includes being open to ideas, suggestions, feedback and criticism from our staff and patients. I hope that our staff will agree that I have set the right foundations for being a listening organisation. But, we need to take this further and faster in 2011/12. This will be particularly important if we are to have the financial strength that will be needed in the current economic climate to continue to maintain and improve the quality of care we provide in the year to come.

Maintaining quality services in this financial climate will be tough, and we will need the advice and inspiration of our patients and staff to make sure we keep focused on the issues that are important to you. Please do let us have your views on this Quality Account and how we can deliver the priorities for the year ahead, to help us shape the future of your health services.

Declaration

The Secretary of State has directed that the Chief Executive should be the Accountable Officer for the Trust. The responsibilities of Accountable Officers include accountability for clinical governance and hence the quality and safety of care delivered by the Trust. To the best of my knowledge and belief the Trust has properly discharged its responsibilities for the quality and safety of care, and the information presented in this Quality Account is accurate.

Adam Cairns, Chief Executive
30 June 2011

What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of the services we provide. They set out: where the Trust is doing well; where improvements in quality can be made; priorities for improvement in the coming year; and, how service users, staff and others with an interest in the Trust have been involved in determining the priorities for the coming year. They aim to enhance accountability to the public for the quality of NHS services.

This is our second statutory Quality Account. It builds on our experience from last year and the feedback we have received. We have also engaged patient and community representatives through focus groups, invited comment from our Primary Care Trusts, Local Health Board, Local Involvement Networks, Community Health Council and Health Overview and Scrutiny Committees, and engaged staff through Staff Briefings and our internal Quality News.

Our second Quality Account sets out progress to improve quality, as well as areas where significant improvement is still required. Our Quality Priorities for 2011/12, accompanied by CQUIN targets agreed in our contract with local commissioners, will support the local NHS to work together to make meaningful changes that will improve patient experience, safety and effectiveness. By focusing on important issues such as dementia, care of the older person, venous thromboembolism, pressure ulcers, falls, dignity in care and reducing waiting and access times we aim to make a big difference in areas that really matter to patients.

Our work to maintain quality, and support and develop our workforce, will need to take place against the backdrop of financial challenge and recovery facing the entire country. This includes tackling the new priorities set by the Coalition Government. It is vital that the NHS, along with all other public sector organisations, identifies and grasps opportunities for Quality, Innovation, Productivity and Prevention. This will support us to live within our means whilst meeting the changing needs and expectations of patients and communities.

Developing our second Quality Account has been a valuable learning experience for the Trust. We will build on this in future, and we welcome your feedback. You can do this by email to: consultation@sath.nhs.uk – please put "Quality Account" as the subject of your email. By fax to 01743 261489 – please put "Quality Account" as the subject of your fax or post to Quality Account, c/o Chief Nurse/Director of Quality & Safety, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ




Section 2: Priorities for Improvement in 2011/12 and Statements of Assurance

Section 2 of a Trust's Quality Account focuses on (a) priorities for improvement in the year ahead and (b) statements of assurance relating to the quality of services.

2.1 Priorities for Improvement in 2011/12

The section on "Priorities for Improvement" provides an opportunity to set out at least three priorities for quality improvement in the year ahead and why these have been selected. These should normally include at least one priority linked to each of the three dimensions of quality (patient experience, safety and effectiveness). This section should also demonstrate how the organisation as a whole is developing its capacity and capability to improve quality.

2.1.1 Developing our Quality Priorities for 2011/12

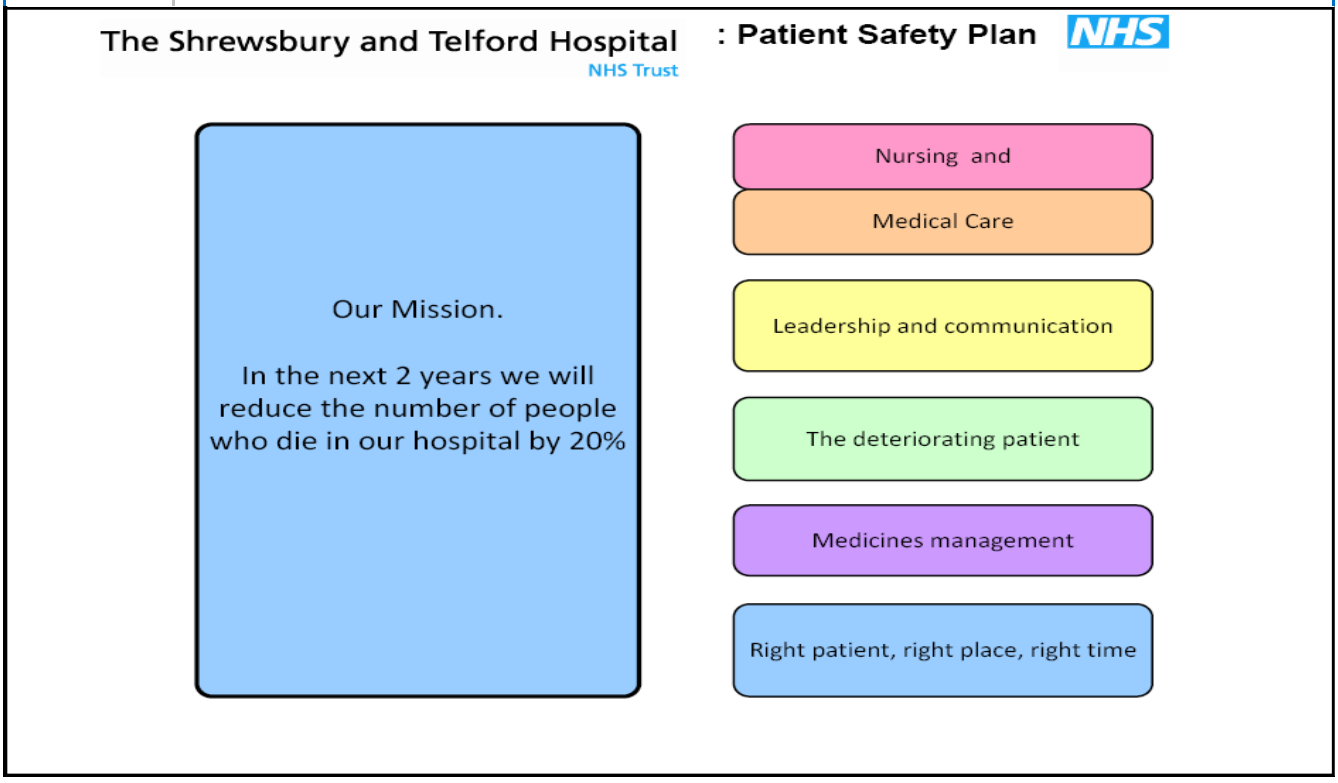
The Trust has invested significant time during 2010/11 to reviewing care delivery and to providing a baseline for the priorities established for 2011/12. The Trust has formed a formal subcommittee of the Trust Board, the Quality & Safety Committee, chaired by a Non-Executive Director of the Board. The focus of the committee has been to identify trends and themes of areas for improvement where appropriate.

We have reviewed patient feedback, our review of care delivery at the point of care (Wards and Departments) and discussed the emerging priorities with the clinical leaders (Centre Chiefs) and Ward and Department managers. We have identified the priorities listed in the table on the right in the domains of safety, patient experience and effectiveness. More information about these priorities can be found overleaf. Where we have continued with the same priorities as last year, this is because we recognise that the improvements have not been sufficient in 2010/11 and we need to improve our performance in fundamental care delivery and we are committed to do this.

Safety:	Leading Improvement in Patient Safety. Preventing avoidable pressure ulcers. Achieving year-on-year reduction in falls. Preventing venous thromboembolism.
Patient Experience:	Improving dignity in care. Improving the experience of older frail patients whilst acutely unwell. Improving the care delivered to patients with dementia or reduced capacity, to improve the patient and family experience.
Effectiveness:	Improving the nutritional status of patients. Improving patient access and waiting times. Reducing delayed discharges.

Patient Safety

Priority	**Leading Improvement In Patient Safety**
Status	**New**
Why is this a priority?	We have recognised that we need to lead a number of Improvements in Patient Safety. A small number of senior clinical staff are leading the 'LIPS' (Leading Improvement in Patient Safety) Programme which started in 2010/11. Many of our patients come into our hospitals whilst they are acutely unwell. How we safely manage their care and recognise any deterioration is key to their optimum recovery.
Where are we now?	The Trust has recognised this as a priority programme for 2011/12 and the national LIPS team will be providing a week's programme in June 2011, so that clinical teams can focus on safety improvements that they would like to make within their clinical areas. Baseline reviews of clinical notes using the International Global Trigger Tool have provided some key areas for improvements.
What are our plans for 2011/12?	The LIPS team have identified the need to prioritise the: 1. *Management of the deteriorating patient (using the modified early warning scale and VitalPac)* 2. *Medicines management* 3. *Reduce falls and pressure sores* The wider clinical teams will identify their priorities over the next 2-3 months and we will publish these areas on our web site. **What will this achieve?** Through a range of clinical teams achieving the safety improvements that they want to make within their clinical wards or departments, the Trust will see specific improvements in a number of processes along the clinical pathway for patients and in the clinical outcomes for patients. As a result we will improve the recognition of any deterioration in a patient's condition and improve the management to optimise their recovery.



Patient Safety

Priority	Preventing avoidable pressure ulcers	Achieving year-on-year reductions in Falls	Preventing Venous Thromboembolism
Status	**Existing**	**Existing**	**Existing**
Why is this a priority?	We aimed to reduce the number of pressure sores which caused serious skin damage (grade 3&4 pressure sores) during 2010/11 (10% reduction) but failed to achieve this reduction. We recognise that we must improve our care to patients who are at risk of developing pressure sores whilst in hospital and will achieve this reduction in 2011/12.	We aimed to reduce the number of inpatient falls during 2010/11 (10% reduction) and whilst we reduced the overall number we did not reduce the % improvement that we had set out to achieve. Every fall is of concern to us and we recognise that we must improve our care to patients who are at risk of falling whilst in hospital. We will continue this work as a priority.	Whilst we are confident that the majority of patients who need anti-coagulants to prevent a blood clot whilst in hospital are prescribed this, we have failed to comply consistently with completing a risk assessment form required by NICE. We are required to ensure this is fully in place in 2011/12. This will ensure that we are working at the best practice level and that the appropriate medication is prescribed and administered.
Where are we now?	We have improved our documentation and risk assessments on admission and improved our recording of all grades of sores. We have developed a Multi Disciplinary Team group who are implementing the national high impact actions required to make improvements.	We have improved our documentation and risk assessments on admission and introduced other initiatives as detailed on page 31.	45% of our patient by the end of 2010/11 had a risk assessment completed. We need to be achieving at least 90%. We have developed an electronic process to capture this risk assessment and will roll this out across the Trust.
What are our plans for 2011/12?	Work with ward staff to ensure that they are able to provide the level of care that the patient needs to prevent any damage to their skin. Provide a process of audit and review to demonstrate improved care delivery. The high impact action group will work with each ward with identified challenges to make improvements. The Quality & Safety Committee of the Trust will ensure through a performance framework that improvements are made. **What will this work achieve?** The outcome of this work will be to eliminate any grade 4 pressure sore and half the number of grade 3 pressure sores across the Trust.	Trial of falls monitoring system to reduce the number of un-witnessed falls. Development of a falls management policy reflecting national best practice. Trial of new prescription sheets which include a request for review of medication for those patients who are at risk of falling or who have experienced a fall whilst in hospital. **What will this work achieve?** The outcome of this work will be to reduce by 10% the overall number of falls and reduce the number of serious injuries from falls by 50%.	The Associate Medical Director is leading the roll out of electronic risk assessment. Monthly monitoring of completed forms. Audit of Venous Thromboembolism (VTE) & Pulmanary Embolism (PE) to measure the outcome of improved risk assessment process. Audit of prescriptions against those patients who required anticoagulants. **What will this work achieve?** We will expect to achieve the national target of 90% of all patients having a completed risk assessment on admission and the required treatment prescribed or administered.

Patient Experience

Priority	Improving Dignity in Care	Improving the experience of older frail patients whilst acutely	Improving the care delivered to patients with Dementia or reduced capacity, to improve the patient and family
Status	**Existing**	**New**	**New**
Why is this a priority?	Ensuring that all patients are provided with the privacy, dignity and respect that they need whilst in hospital remains a priority to us in the Trust. This is a priority as we still need to improve some inpatient areas to ensure we maintain Same Sex Accommodation standards but also enhance the clinical area so that male/female patients do not need to travel past a bay of patients of the opposite sex to get to a bathroom or toilet.	The Ombudsman Reports nationally (into the care of the older patient) informs us that care provision can improve. Our own review into complaints and care provided for the older patient tells us that we can make improvements. Complaints profile indicates we do not always support elderly patients with their care needs leading to poor outcomes and family concerns about care. An area that we believe improvements can be made to clinical outcomes and reduce length of stay.	Nationally and locally it is recognised that care for patients with reduced mental capacity needs to improve. Patients who have reduced capacity through a learning disability or dementia or acute confusion do not consistently get the support or have the optimum experience they need whilst under our care. Patient and family complaints and reviews indicate this as a priority. Reviewing patient's notes has shown that we can make improvements in how we support patients in decisions about their care.
Where are we now?	We have reduced to a minimum the number of breaches to SSA, however there are improvements that can be made.	Clinical care is not consistently provided at a level that meets the needs of the older patient. Patient feedback (family)	Clinical care is not to the standard that we and the patients need at all times. Patient feedback (family feedback)
What are our plans for 2011/12?	We will make some changes to two clinical areas to enhance the patient environment. We will form a Patient Involvement and Engagement Board where patients and their representatives can be involved in looking at ways to improve privacy and dignity. We will gather patient stories and diaries and real time feedback to evaluate effectiveness of dignity in care. Engaging patients and families in improvements that can be made and developing and enhancing patient information. **What will this achieve?** We are confident that this work will support an improved patient evaluation of care in this area.	Focus on the full range of care improvements that will lead to safer care and a better experience. Use patient experience metrics to identify how patients perceive their care and what we could do to support them. Focus on safety and communication to improve expectations of care. Review detailed patient sensitive performance Indicators to indicate the range of improvements. **What will this achieve?** Through the safety improvements we have set out and through working with patients and their families we will be able to show improvements in the older patients outcomes and experience (audit and clinical outcomes).	To fully implement the national dementia strategy and other national guidance to outline full scope of improvements. Work with our Local Health economy organisations to make improvements across the full patient pathway. Reduce inter-hospital transfers so that we improve continuity of care Improve our support to the family and improve our written information. **What will this achieve?** We will see the evidence of better care delivery through our review of case notes. We will see an increase in patient and family information and support which will be evidenced through patient and family feedback. We will see improved patient outcomes.

Clinical Effectiveness

Priority	Improving the Nutritional Status of Patients	Improving Patient Access & Waiting Times	Reducing Delayed Transfers of care
Status	**New**	**Existing**	**New**
Why is this a priority?	**National** Recognition in Ombudsman report into the care of the older patient demonstrates that hospitals do not provide adequate nutritional and fluid support. **Local** We recognise that all patients need to be supported to maintain the fluids and nutritional intake whilst in hospital. This supports their recovery and outcomes.	Clinicians have highlighted this to the new Executive Team. Over 70% of our patient complaints outline that this is a significant area for improvement. We have recognised during 2010/11 that the amount of time that some patients are having to wait for appointments, treatments or procedures (some clinical specialties) is unacceptably long and has increased the clinical risks and condition of patients. In A& E our patients are having to wait too long and we need to work with the local health economy to develop and enhance support to patients.	We need to work with our local health economy partners to improve the number of delayed transfers of care from our acute environment. We record the number of delayed transfers of care every day and the numbers need to reduce for a number of reasons. 1. Improve the outcomes and experience of the patient. 2. Enable the timely admission of emergency patients into the right clinical environment. 3. Enable the staff to have the right patient in the right clinical environment to gain the best outcomes in care.
Where are we now?	We have been looking closely at the care provided to patients and we have a number of improvements that need to be made. 1. Protect all patient meal times to ensure they get the support and time to enjoy their meals and drinks. 2. For patients who need assistance with their eating and drinking, we have not always supported them as much as we could do and need to ensure a consistent approach to how we support them. 3. Drinking an adequate amount (depending on your clinical condition) is really important and we are not always able to demonstrate that we have provided adequate fluids for all patients and this needs to improve.	We have worked with the 'Intensive Support Team' to review and improve our capacity to meet the demand for these services but recognise that we have significant improvements to make in 2011/12. We have increased the number of consultants and have introduced clinical reviews of the notes of those still waiting for treatment to ensure we manage the clinical priorities. However, we recognise that we remain well short of the acceptable standards and are working with partners and GP colleagues to improve this as quickly as we can.	We have difficulty managing the number of admissions coming through our Trust and recognise the improvements that we need to make. Due to current demand for hospital beds we have too many patients who we need to move 2-3 times within the hospital to enable us to get patients who are unwell into the right clinical environment. We recognise that this is very unsettling for patients and their families and we need to improve this aspect of care.
What are our plans for 2011/12?	Each ward and clinical team will adopt the 'protected meal times' principles. Every patient who needs support to eat and drink will have a clear care plan outlining the risks and the care needed (red tray system to be fully implemented). Regular ward reviews to ensure the patients receive adequate support. **What will this work achieve?** We will see an improvement to the support given to patients to manage their nutritional status. Patients and their families will outline an improved experience, with less complaints with regard to eating and drinking.	We will be working with Centre Chiefs in each specialty to ensure that our systems and processes are robust and that clinical priorities are identified and managed. Where we still have longer waiting times in some clinical areas, we will work with our GP colleagues and patients/families to ensure that they have good written communication/support whilst waiting for treatment. Where patients have an urgent clinical condition or risk we will improve our systems to ensure these are flagged on our patient administration system. **What will this work achieve?** We will improve our systems and processes to achieve the national waiting times.	Value Stream leads and Centre Chiefs to refine and enhance the review of patients for timely and safe discharge. Improve our information for patients and their families around expected discharge dates and the planning required to support their discharge. Ensure effective 7 day planning and support to patients. Work with the LHE to support early discharge schemes in the Community. **What will this work achieve?** This work will result in a reduction in the number of delayed transfers of care.

2.1.1 Developing our Quality Priorities for 2011/12 (continued)

In discussing these priorities with our external partners they concur that these are the biggest opportunities for making progress in these three domains of quality (safety, patient experience and effectiveness).

We want to involve staff, patients and the public and communities in our work to improve the quality of the services we provide. We will be launching the process to develop a Quality Improvement Strategy during 2011/12 and would like any member of the public/local community who has either been a patient or experienced care in our hospitals to be involved.

If you would like to be involved in the workshop sessions, where we will discuss aspects of care that need to improve, we would value your contribution.

If you have any suggestions throughout the year for our quality priorities in 2012/13 or would like to be actively involved in developing our strategy to improve quality please contact us.

2.1.2 How will we increase capacity and capability for quality improvement?

A wide range of activities are taking place to increase capacity and capability for quality improvement in the Trust. Table 2.1.2a sets out some of the developments and processes currently underway.

To let us know that you would like to contribute to developing a Quality Improvement Strategy or give us your feedback, this can be sent to Quality Account, c/o Director of Quality & Safety/Chief Nurse, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ or by email to consultation@sath.nhs.uk

Table 2.1.2a

Theme	Improving capacity and capability for quality improvement
Leading Improvements in Patient Safety (LIPS)	With a team of senior clinicians having attended the national LIPS event/programme, the Trust has adopted this approach and one hundred clinical staff will start on a local LIPS programme in June 2011 to increase our capacity and capability to make and lead improvements in patient safety.
Leading Improvements in Patient Experience	We will provide training and support and the tools to enable a number of different approaches to obtaining patient/user feedback on their experiences to identify improvements to our care provision. By working with frontline and line staff, patients and patient representatives we will increase our focus and drive for improvement.
Quality Improvement Strategy	We have changed our Executive portfolios to reflect the priorities for Quality Improvement as well as the formal committees of the Trust to ensure our focus covers all areas of Improvement. The Board and senior clinicians will work with staff, patients and representatives to focus on developing a 5 year strategy on improving safety, effectiveness and patient experience and develop year on year improvements in patient outcomes in all three areas. By engaging staff and patients in the process of considering, identifying the priorities we will increase the Trust's capacity and capability for quality improvement and provide a solid approach to the priorities established in the annual Quality Account publication.
Listening into Action	We will use a structured approach to engaging staff, partners and patients/users into changes that they believe we should make. This will ensure that changes from the ward to Board are embedded to underpin the improvements we need.
Teaching and Learning Organisation	A key Foundation for SaTH is the development of the Trust as a Teaching and Learning Organisation. This incorporates a range of approaches to translating the evidence base into practice, via learning and leadership development. Priorities for the coming year will include the development and launch of Leadership and Improvement Academies. We will raise the quality of leadership at all levels of the organisation, with a focus on positive patient outcomes. We will work closely with partners to improve our clinical and leadership skills; an initial strategic partnership has been formed with 202 (Midlands) Field Hospital (the Medical Corps of the Territorial Army) which will concentrate on sharing the learning from leadership in challenging times.

2.1.3 How will we monitor progress to improve quality, including our Quality Priorities?

Safety

Across a range of safety measures we will establish "key performance indicators" which will help us to monitor progress. In many aspects of safety (i.e. falls and pressure sores) we will aim to eliminate avoidable harm. The Centre Chiefs will work with their clinical teams to make safety improvements. A monthly report will be provided to the Quality & Safety Committee and the Board, so that progress can be monitored.
We will also work with GP partners and commissioners to monitor improvements, providing reports to ensure appropriate and timely reporting.

Patient Experience

We will form a patient experience board by July 2011, which will help us to work with external partners, patient representatives, volunteers and staff to monitor a range of patient experience evaluation tools including "real time" feedback. The Centre Chiefs will work with their clinical teams to identify the actions needed to improve all aspects of the patient's experience whilst in our care and to track the implementation of change for improvement. The Quality & Safety Committee will review in details the trends and themes from patient feedback and will report to the Board on key aspects or areas that require improvement.

Effectiveness and clinical outcomes

1. The Trust is registered with the Care Quality Commission and they have developed their review of hospital standards in registered 'outcome' areas such as 'patient experience', nutrition, safeguarding.
2. Clinical audit programmes will be established across all clinical centres within the Trust to monitor the improvements in care provided to patients and to ensure that care is effective.
3. The Quality & Safety Committee will review a range of clinical effectiveness measures to identify the improvements but also any areas of care that may need further focus and improvement.

Patient Environment Action Team (PEAT) Inspections

We will continue to monitor cleanliness, food and privacy and dignity via our monthly PEAT inspection programme. Because the essence of these inspections is to look at the environment from the patient perspective we are keen to encourage patient participation and therefore welcome the support of a patient representative on these inspections.

2.2 Statements of Assurance

This section of our Quality Account confirms our commitment to review quality across all the services we deliver. This review takes into account the three dimensions of quality: patient experience, safety and effectiveness.

Mandatory statements	During 2010/11 the Shrewsbury and Telford Hospital Trust provided the full range of clinical NHS Services for which it is registered. (These are detailed in the Trust's Annual Report 2009/10 or via our web site). The Trust supported a number of reviews of its services during 2010 and 2011. These are set out in table 2.2.1a which is on page 15. As a result the Trust did not formally review any of its own services but supported the reviews and developed action plans to implement recommendations to improve the quality of care to our patients.

2.2.1 Review of Services

The categories of services provided by the Shrewsbury and Telford Hospital NHS Trust are:

- Daycases
- Elective care
- Emergency care, including A&E services
- Maternity care
- Outpatients
- Direct access diagnostics

These services support us to deliver the regulated activities for which we are registered with the Care Quality Commission from April 2010 (see 2.2.5):

- Treatment of disease disorder or injury
- Surgical procedures
- Diagnostic and screening procedures

In 2010/11 our services were provided in three clinical Divisions. In 2011/12 this will move to clinical centres led by senior clinicians known as Centre Chiefs.

2010/11	
Division 1 focused on unplanned care services, including:	Emergency services (including Accident and Emergency, Medical Assessment Units) and Trauma & Orthopaedics Critical Care (including intensive care units, anaesthetics & pain management, renal services, cardiology services) General Medicine
Division 2 focused on planned care services, including:	Women & Children's services (including obstetrics & gynaecology) General surgery Cancer, oncology and haematology services
Division 3 provided a range of clinical support services, including:	Imaging Therapies Sterile Services Theatres Pathology Pharmacy Medical Engineering Scheduling

The majority of our services are provided at the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury. We also provide services from other locations, including midwife-led maternity units in Bridgnorth, Ludlow and Oswestry and consultant outreach clinics in the Community hospitals in Shropshire and mid Wales.

We review the quality of our services in a variety of ways. Examples from 2010/11 are set out in Table 2.2.1a.

Table 2.2.1a

Trust Wide NHS Litigation authority (NHSLA) Inspections	✓	The NHSLA introduced the CNST (Clinical Negligence Scheme for Trusts) Clinical Risk Management Standards in 2000. All member organisations were required to be assessed against these standards. The Trust was successfully assessed at Level 2 of the NHSLA Risk Management Standards in December 2008 and has maintained this level throughout 20010/11.
Trust Wide Inspections by the Care Quality Commission (CQC)	**Minor Concerns**	Outcome 4 & 13 (September 2010) – Care provision and staffing. Minor concerns were highlighted and an action plan put in place and implemented. Outcome 1 & 5 (March 2011) patient involvement in care and nutrition. Immediate actions taken and full action plan implemented when report received in May 2011.
Trust Wide Environmental Health Review	✓	5 star food hygiene rating awarded to both sites
Trust Wide (NPSA) - environmental reviews	✓	Formal annual assessment undertaken across both sites by the patient environmental action team on a range of cleanliness and patient related standards
Medical Engineering Services	✓	The auditor reviewed the organisation's position against ISO 9001:2008 and ongoing ISO 13485:2008 Medical Devices Materials. Continued certification to both standards was recommended and the Trust achieved the highest level of performance across all areas assessed. This is the twelfth consecutive annual external audit without a non-compliance.
Trust Wide Reconfiguration – Keeping it in the County	✓	Published document outlining clinical services that required consultation on a reconfiguration process to ensure that the quality of our services improved in identified areas. **www.ournhsinshropshireandtelford.nhs.uk**
Trust Wide Pharmacy	✓	The Medicines and Healthcare products Regulatory Agency carried out an unannounced inspection in March and found no areas of major concern.
Maternity	✓	The NHSLA introduced the CNST (Clinical Negligence Scheme for Trusts) Maternity Risk Management Standards in 2000 The Trust was successfully assessed at Level 1 of the CNST Standards in June 2010.
Midwifery	✓	The Local Supervising Authority carried out their annual review of Midwifery services in March 2011 and issued a positive report.
Laboratory Services	✓	Clinical Pathology Accreditation (CPA) visits took place during the year. The Trust laboratories received full accreditation.
Laboratory Services	✓	The Health and Safety Executive reviewed the microbiology laboratories. A few minor recommendations were made; all of which have been implemented.
Mortuary	✓	The Human Tissue Authority (HTA) assessed standards in the Mortuary. The establishment was found to meet the majority of the HTA standards across the four areas of: consent; governance and quality; premises, facilities and equipment and disposal. Some shortfalls were identified in relation to consent; governance and quality and premises facilities and equipment. The action plan to rectify the minor issues was completed by May 11. A number of examples of strengths or good practice were included in the report.

Table 2.2.1a (cont)

ISO Review of Apley Ward (Private ward)	✓	The auditor reviewed the ward's position against ISO 9001/2008 – Provision of nursing care and support services to private patients including Out Patients Department. Continued certification to the standard was recommended. Apley ward has participated in this external audit for the past ten years.
West Midlands Quality Review of Acute Stroke, Transischemic attack, vascular and critical care services	✘	West Midlands Quality Review Service Stroke (acute phase) and TIA, Vascular, Critical Care reviewed care across the Health Economy and made a number of recommendations for improvement. The West Midlands Quality review raised a number of concerns which are key to the plans to centralise acute services which has been the subject of a public consultation during 2011.
Health and Safety Executive Review Princess Royal Hospital	✓	The Health and Safety Executive carried out a management audit at PRH in March 2011. The review was largely positive with one improvement notice issued about workplace transport.
2011/12 Annual Cancer Peer Review	✘	No immediate risks were raised. A number of areas of good practice were identified within a number of teams; one stop fast track lung clinic, patient information, well established clinical protocols, good leadership. Serious concerns were identified which predominantly related to lack of Consultant resource; Histopathology, Radiology, Oncology, Onco-plastic Surgeon which have already been resolved with additional appointments being progressed.
Hospital Standardised Mortality Rate (HSMR)	✘	Nationally published data – a summary of the work being progressed in this area is outlined on page number 40 & 41
Intensive Support Team review of waiting and access times	✘	Access/waiting times reported nationally Internal review supported by Intensive support team Actions from the review form part of the ongoing improvements highlighted earlier in the priorities established for 2011/12.
Internal clinical assurance reviews	✓	December-March (ongoing)– ward reviews/visits by Chief Nurse and Lead Nurses/ Matrons Ward assurance reports reported formally to Quality and Safety Committee Outline and key finding, have set the priorities for improvement.
Quality & Safety Committee	✓	Formal sub committee of the Board formed in November 2010. Committee members undertake monthly Patient Safety walkabouts – to observe care and talk to patients and staff. The Committee listens to "Patient Stories" – to reflect positive and negative experiences of patients who have been in our care. Balanced Score Card – approach to outline review
Hygiene and Compliance Audits	✓	Annual review of cleanliness compliance assessed against the National Standards of Cleanliness and PEAT

✓ Performed Well

✘ Requires Further Improvement

2.2.2 Participation in Clinical Audit

This section of our Quality Account provides information about our participation in clinical audit. Clinical audit is "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery." Participation in national clinical audits, national confidential enquiries and local clinical audits provide an important opportunity to stimulate quality improvement within individual organisations and across the NHS as a whole.

Mandatory statements	***Clinical Audit Information for Quality Accounts 2010 to 2011*** ***Clinical Audits*** During 1st April 2010 to 31st March 2011, 69 national clinical audits and 5 National Confidential Enquiries were undertaken which covered NHS services that the Shrewsbury and Telford Hospital NHS Trust provides. ***Section 2.2.2a*** During that period the Shrewsbury and Telford Hospital NHS Trust participated in 51/69 [74%] of the national clinical audits and 5/5 [100%] National Confidential Enquiries in which it was eligible to participate. ***Section 2.2.2b*** The national clinical audits and national confidential enquiries in which the Shrewsbury and Telford Hospital NHS Trust was eligible to participate during 1st April 2010 to 31st March 2011 was 74 and can be accessed at: ***www.sath.nhs.uk/services/audit/*** ***Section 2.2.2c*** The national clinical audits and national confidential enquiries in which the Shrewsbury and Telford Hospital NHS Trust participated between 1st April 2010 and 31st March 2011 can be accessed at ***www.sath.nhs.uk/services/audit/*** ***Section 2.2.2d*** The national clinical audits and national confidential enquiries in which the Shrewsbury and Telford Hospital NHS Trust participated, and for which data collection was completed during 1st April 2010 and 31st March 2011 are listed, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. This can be accessed on our website: ***www.sath.nhs.uk/services/audit/*** ***Section 2.2.2e*** The reports of 14 national audits were reviewed by the provider during 1st April 2010 and 31st March 2011. ***Section 2.2.2f*** The following are examples of actions that The Shrewsbury and Telford Hospital NHS Trust has taken and also intends to take to improve the quality of healthcare provided, as a result of participation in national audits. • Participation in the national acute kidney injury audit has resulted in the Trust creating new guidelines for better management of patients with this condition. • Comparison with other Trusts in the national dementia audit identified the need for a care pathway for this group of patients. This is now being developed to ensure that patients receive the most appropriate care throughout their hospital stay.

Mandatory statements	• The results of the national stroke audit showed the need for more timely treatment and faster admission to the specialist stroke ward. The Trust has now introduced increased cover for thrombolysis (treatment for stroke), and direct admission to the stroke ward for appropriate patients. A complete table of all actions that The Shrewsbury and Telford Hospital NHS Trust intends to take to improve the quality of healthcare provided, as a result of participation in national audits can be accessed at: ***www.sath.nhs.uk/services/audit/*** ***Section 2.2.2g*** The reports of 95 local clinical audits were reviewed by the provider during 1st April 2010 and 31st March 2011 ***Section 2.2.2h*** ***The following are examples of actions that have arisen following local audits during the reporting period.*** • Audit of Venous Thromboembolism assessment and prophylaxis (assessment and treatment to prevent blood clots) in gynaecology showed a need for improvement in this area. Awareness was raised and further training carried out. A recent re-audit has shown a significant improvement with 100% of patients now assessed and treated appropriately. • Evaluation of the tinnitus service, using a patient survey showed a decrease in the benefit of the counselling programme on patients. A designated technician will now be identified to lead service improvements within this area. • Audit of use of Green Light Laser as an effective treatment for urinary outflow obstruction patients against NICE (National Institute for Clinical Excellence) guidance showed that this new treatment is effective, resulting in no blood loss, no need for a catheter, and decreased length of stay. • The X-ray department carried out an audit to monitor the cleanliness of ultrasound probes, which should be cleaned between patients to reduce the spread of infection. A piece of equipment tested how many bacterial cells were found. The results showed that all equipment tested was found to be clean. • An audit of the prevention of peri-operative hypothermia has led to the development of new guidelines for use in the Trust. • Work for the national "Think Glucose campaign", carried out at the Trust, identified that diabetic patients are unhappy with being unable to access their own medication whilst in hospital. A trial is currently under way on one of the wards using key pad lockers to allow patients access to their own medication. If this is successful it will be rolled out across the Trust. A full list of the actions that The Shrewsbury and Telford Hospital NHS Trust intends to take to improve the quality of healthcare provided can be accessed at ***www.sath.nhs.uk/services/audit/***

2.2.3 Participation in Clinical Research

This section of our Quality Account describes our participation in clinical research. Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. Participation in clinical research has benefits for individual organisations and their patients, as well as for the NHS as a whole.

Mandatory statements	The number of patients receiving NHS services provided or sub-contracted by SATH in 2010/11 who were recruited during that period to participate in research approved by a research ethics committee was 1109.

Participation in clinical research demonstrates SATH's commitment to improving the quality of care we offer and to make our contribution to wider health improvements. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

How have we done?

The Trust works closely with the West Midlands North Comprehensive Local Research Network and the Topic Specific Networks to promote a robust research culture. We have been successful in increasing the number of national portfolio studies open to recruitment. The spread across the different specialties has increased and the balance between simple non interventional and complex Randomised Controlled Trials (RCTs) has been maintained.

The Trust has been highly successful in increasing the number of specialties involved in research:

A full list of recruiting studies is available from the Trust website *http://www.sath.nhs.uk/services/Research_and_Development/default.aspx*

Development of the workforce has been an essential part of the growth process. A Clinical Trials department has been established to provide Local Investigators with support from trained research nurses, allied health professionals and research support staff.

What we will do in the coming year

Work will continue to identify and overcome blocks to research so that the national target of an average of 30 days to Trust approval and 30 days from approval to first patient recruited can be met.
Further studies are planned to increase opportunities for patients and thus recruitment numbers. Where appropriate, studies will be opened at both sites.

Where trials are adopted by more than 1 specialty they have been assigned to the specialty of the Principal Investigator.

Specialty	Total no of studies 2009/10	Recruitment 2009/10	Total no of studies 2010/11	Recruitment 2010/11
Cancer	30	231	35	501
Cardiovascular	4	84	4	30
Gastro-Intestinal	2	6	6	112
Stroke	1	1	3	33
Respiratory	0	0	4	23
Reproductive Health	3	1611	4	258
Medicines for Children	1	4	5	13
Renal	0	0	2	8
Mental health	1	1	1	74
Other	2	5	3	57

2.2.4 Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

This section of our Quality Account describes how the Commissioning for Quality and Innovation (CQUIN) payment framework is used locally. The CQUIN payment framework aims to support a shift within the NHS to ensure that quality is the organising principle for all NHS services. It provides a means by which the payments made to providers of NHS services depends on the achievements of locally agreed quality and innovation goals. For NHS acute trusts, 0.5% of the contract value was dependent on CQUIN targets in 2009/10. This increases to 1.5% in 2010/11.

Mandatory statements	A proportion of The Shrewsbury and Telford Hospital NHS Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between The Shrewsbury and Telford Hospital NHS Trust and any person or body they entered into contract, agreement or arrangement within England for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html. During 2010/11 1.5% of our contract values with PCTs in England were based on achievement of 10 CQUIN goals. These are summarised in table 2.2.4a.

Table 2.2.4a

No	CQUIN Goal	Achievement
1	Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE). 90% of admitted patients to have a VTE assessment in Q4	Partially met
2	Improve responsiveness to personal needs of patients. Maintain or improve upon 2009/10 survey results (66.3)	Met
3	Failure to administer prescribed medications as a result of non-availability of medicines. Maintain or reduce level of omitted drugs from the 11.2% baseline	Met
4	Reduction in falls of patients admitted to hospital Q2 4% reduction in the number of falls Q3 7% reduction in the number of falls Q4 10% reduction in the number of falls	Partially met
5	Compliance with Think Glucose Guidance Audit of evidence of Trust working in line with Think Glucose principles	Met
6	Tissue Viability (pressure ulcers) Admitted patients assessed within 6hrs Patients at risk to have preventative/ treatment actions documented Reporting of grade 3 or 4 ulcers Reporting deterioration of grade 2+ ulcers	Partially met
7	Smoking – Brief Intervention (outpatient setting) Delivering a brief intervention to more than 80% of smokers who wish to quit	Partially met
8	Admission to Stroke Unit within 4 hours of arrival at hospital (usually A&E) for confirmed stroke Q1 >23% of patients to be admitted to a stroke ward within 4hrs Q2 >29% of patients to be admitted to a stroke ward within 4hrs Q3 .33% of patients to be admitted to a stroke ward within 4hrs Q4 >38% of patients to be admitted to a stroke ward within 4hrs	Met
9	Alcohol identification and brief interventions for people admitted to hospital with alcohol related condition Composite measure around training, delivery of brief intervention and monitoring.	Partially met
10	End of Life Care – Number of patients who had followed the supportive care pathway for at least 3 days or the duration of their admission if less than 3 days Q4 60% of appropriate patients to be on the Liverpool Care Pathway	Met

There were goals relating to renal dialysis and neonatal care for our contract with Specialised Services, summarised in table 2.2.4b below. Further details are available on http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

Table 2.2.4b

No	CQUIN Goal	Achievement (Trust Data)
1	Reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE). 90% of admitted patients to have a VTE assessment in Q4	Partially met
2	Improve responsiveness to personal needs of patients Maintain or improve upon 2009/10 survey results (66.3)	Met
3	Annual report	Met
4	Access to renal home therapies 16% of renal patients to be on home therapies	Partially met
5	Neonatal 81% of patients able to discuss care with a senior clinician 72% of babies offered breast milk	Partially met

During 2011/12 1.5% of our contract values with PCTs in England will be based on achievement of 9 CQUIN goals. As in 2010/11, VTE and Improving Responsiveness to personal needs of patients will remain national CQUIN goals. Local CQUIN goals are currently under discussion for inclusion in the 2011/12 contract. These are summarised in table 2.2.4c.

Table 2.2.4c

No	CQUIN Goal
1	Reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE)
2	Improve responsiveness to personal needs of patients
3	Reduction in falls of patients admitted to hospital
4	Tissue Viability (pressure ulcers)
5	End of Life Care
6	Development of a pharmaceutical care plan for 'at risk' patients
7	Maternity
8	Discharge planning
9	Nutritional screening or improve nutritional intake of 'at risk' patients

There are goals relating to renal dialysis and neonatal care for our contract with Specialised Services, summarised in table 2.2.4d below. Further details are available on http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

Table 2.2.4d

No	CQUIN Goal
1	Reduce avoidable death, disability and chronic ill health from Venous Thromboembolism (VTE)
2	Improve responsiveness to personal needs of patients
3	Access to renal home therapies
4	Access to organs for transplantation
5	Neonatal Specific Avoiding preventable blindness Improving neonatal pathways

2.2.5 Registration with the Care Quality Commission

CQC Responsive Review

This section of our Quality Account describes our registration with the Care Quality Commission (CQC), as well as any reviews they have undertaken of our services (either periodic reviews or special reviews). From 1 April 2010 all providers of NHS services are required to register with the Care Quality Commission. Registration provides us with a "licence to operate" to provide NHS services. To be registered, NHS Trusts must show that they are meeting essential standards of quality and safety. Compliance with these standards is monitored on an ongoing basis by the Care Quality Commission.

Mandatory statements	The Shrewsbury and Telford Hospital NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Care Quality Commission has not taken any enforcement action against Shrewsbury and Telford Hospital NHS Trust during 2010-2011 and the Trust is not subject to periodic review by the Care Quality Commission

The Trust has participated in a responsive review by the Care Quality Commission related to the following areas during 2010. The overall judgment of the CQC is that they had minor concerns in four outcome areas – (see above)
The CQC judged the Trust compliant with outcomes in five additional areas.

Outcome	CQC judgement
4: Care and welfare of people who use services	Minor concern
9: Management of medicines	Compliant
11: Safety, availability and suitability of equipment	Compliant
13: Staffing	Minor concern
16: Assessing and monitoring the quality of service provision	Compliant
17: Complaints	Compliant
21: Records	Compliant
1: Dignity in Care	Minor Concerns
5: Nutrition	Minor Concerns

The CQC concluded that people who use services were receiving the right care, at the right time, from the right people. However, they found some inconsistencies in the planning and delivery of care, particularly around the prevention and management of pressure sores. The Trust was already aware of this problem and has developed a plan of work to improve prevention and management of pressure sores (see page 32 &33 of the Quality Account).

The CQC also judged that there were areas within the Trust where there is not a sufficient number of qualified and experienced staff in post to meet the needs of the service. This related particularly to staffing in the maternity unit. Again, the Trust was aware of this issue and is in the process of recruiting additional medical and midwifery staffing in obstetrics and gynaecology. A wider staffing review was undertaken in 2010/11 and increases where required were put into the ward budgets.

CQC visit - dignity and nutrition standards
The CQC carried out an inspection in March 2011 as part of a national review. The inspection reviewed standards relating to dignity in care and nutrition. Verbal feedback at the time of the inspection identified a number of improvements that needed to be made, which were acted on. The report was received in draft form by the Trust in May 2011 and published in June 2011(this report can be accessed by visiting the CQC web site www.cqc.org.uk

In summary for Outcome 1 & 5, CQC commented that;
Outcome 1– Dignity in Care

"Privacy is respected and care provided is dignified for the majority of the people most of the time. Most people are involved in making decisions about their care but this is not consistent. People unable to make their own decisions are not treated equally because they do not always receive proper assessments".

Outcome 5 –Nutrition

"People receive an assessment of their nutritional state and if necessary assistance is requested from dietary specialists. People are offered choice but this is not always the option they actually receive. Staff know which people need assistance to eat their meal and provide this help in a respectful and sensitive way. People are not always given enough time to eat without interruption which may impact on their enjoyment of meal times."

The Trust had recognised these areas for improvement and the priorities for 2011/12 reflect these areas which were agreed with Clinical leaders in the Spring 2011.

An action plan has been formed based on the recommendations to ensure the progress required is fully implemented.

2.2.6 Data Quality

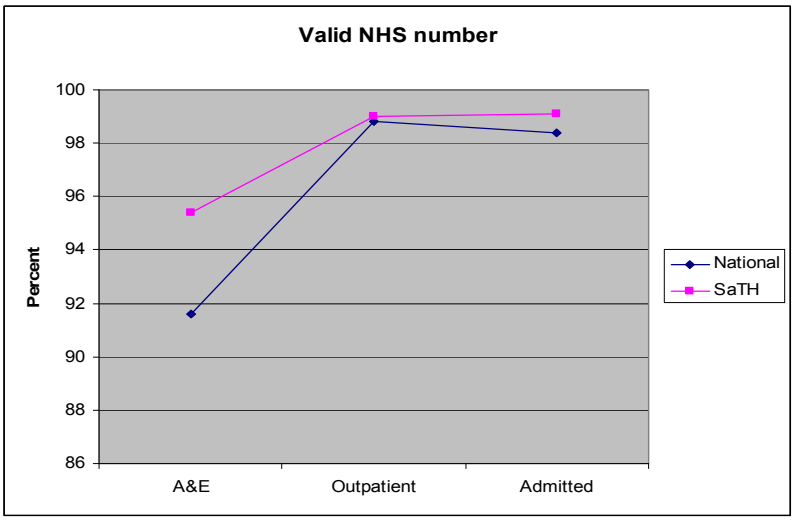
This section of our Quality Account provides information about data quality. Good quality information underpins the delivery of effective patient care and is essential if improvements in quality of care are to be made.

Mandatory statements

SaTH has submitted records to the Secondary Uses Service, during the current financial year (2010/11) for inclusion in the Hospital Episode Statistics and these are included in the latest published data.

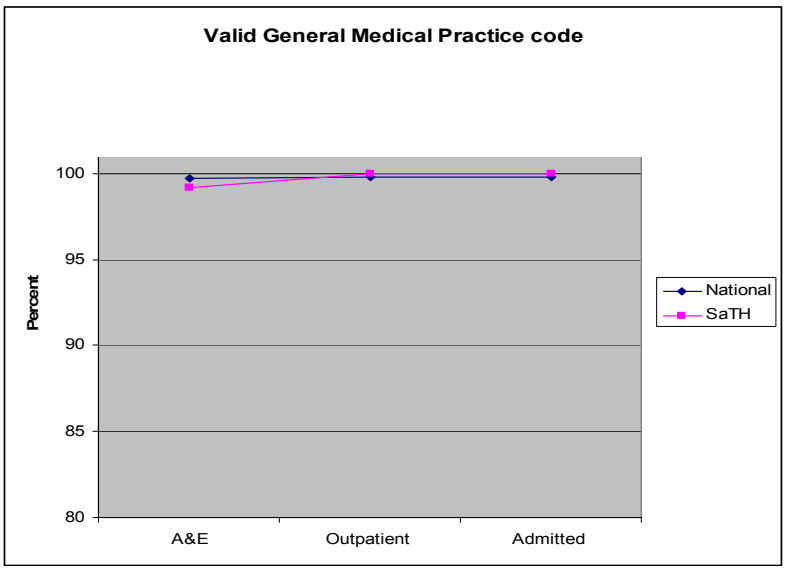
The percentage of records in the published data (Based on Apr-Jan 10/11 SUS data at the Month 10 inclusion date) which included the patient's valid NHS number was:

99.1% for Admitted patient care
99% for Outpatient care
95.4% for Accident and Emergency care



Which included the patient's valid General Medical Practice Code was:

100% for Admitted patient care
100% for Out patient care
99.2% for Accident and Emergency care



This information is from the National SUS Data Quality Dashboard, it compares average national percentages with Trust percentages. This means that we are slightly below average in capturing NHS numbers in A&E.

Current improvement and assurance initiatives in the Trust include:

A number of new Data Quality Policy and Procedures documents have been approved. These include:

Implementation of a Trust Data Quality Policy

This policy is intended to cover all types of patient information recorded within the Trust, with particular emphasis on the main computer based system, Sema Helix PAS and the data extracted from them for analysis for corporate management and reporting purposes. It covers primarily data relating to service users and the delivery of care but is also relevant to other related data including financial management, service management, performance and contract management, corporate governance and communications.

This Policy sets boundaries within which action will take place and reflects the Trust's philosophy towards raising standards generally and in particular towards improving techniques for collecting, storing and communicating data.

Data Quality Audit Procedure and Review of Accuracy of Recorded Information

This procedure document details the responsibilities of the Trust and staff within our organisation to comply with the Information Governance Standard requirement 506.

2.2.6 Data Quality: Clinical Coding

Mandatory statements	SaTH was not subject to the Payment by Results clinical coding audit during 2010-2011.

The next PbR Audit will take place in the summer of 2011. Dates have yet to be confirmed.

2.2.7 Information Governance Toolkit attainment levels (to be updated after April 11)

The Shrewsbury and Telford Hospital NHS Trust's Information Governance Assessment Report overall score for 2010/11 was 72% and was graded "not satisfactory". The mandatory requirement is for all NHS organisations to achieve level 2 compliance in all 45 requirements otherwise a 'not satisfactory' score is awarded. The Trust is compliant with 43/45 standards.

The two requirements scored at level one are:

8-324
Pseudonymised and/or anonymised data is used for all secondary purposes. Currently this is not technically possible throughout most of the NHS. The Trust is working with other organisations to identify ways to fulfil this requirement.

8-505
This requirement is scored by using the results from a 'clinical coding audit'. This was carried out in early March and the accuracy did not meet the requirement to achieve a level 2. All 22 key standards were achieved which positively affect the Statement of Internal Control (SIC).

The attainment levels assessed within the toolkit provide an overall measure of the quality data systems, standards and processes within an organisation.

The Information Governance (IG) Framework is concerned with establishing leadership, ownership, control and achieving cultural change. IG is the term used to describe the principles, processes, legal and ethical responsibilities for managing and handling information. IG is essential for the lawful and ethical use of patient information both for the benefit of the individual to whom the information relates and for the public good.

The IG Toolkit (IGTT) is a self-assessment tool that sets out the requirements and standards that NHS organisations need to achieve to ensure it fulfils its obligations to ensure that information is handled legally, securely, efficiently and effectively. The purpose of the assessment is to enable organisations to measure their compliance against the law and central guidance and to see whether information is handled correctly and protected from unauthorised access, loss, damage and destruction. Where partial or non-compliance is revealed, organisations must take appropriate measures to improve.

The ultimate aim is to demonstrate that the organisation can be trusted to maintain the confidentiality and security of personal information. This in turn increases public confidence that 'the NHS' and its partners can be trusted with personal data. Final submission assessment scores reported by organisations are used by the Care Quality Commission to risk assess outcomes. The baseline submission for October 2011 was 50%, with the end of March 2011 position outlined in the box below.

Initiative	Level achieved 2011	Grade
Information Governance Management	86%	satisfactory
Confidentiality and Data Protection Assurance	70%	satisfactory
Information Security Assurance	66%	Not satisfactory
Clinical Information Assurance	86%	Satisfactory
Secondary Use Assurance	70%	Not satisfactory
Corporate Information Assurance	66%	satisfactory
March 31st 2011 - Overall score 72% (Not satisfactory)		

Section 3: Review of Quality Performance in 2010/11

Section 3 of a Trust's Quality Account sets out a review of quality performance during the previous year. It also includes statements from local Primary Care Trusts, local Involvement Networks and Health Overview and Scrutiny Committees in relation to the quality of services provided in the Trust.

3.1 Overview of Performance

What were our Quality Priorities for 2010/11 and how have we performed?

3.1.1 Performance against our Quality Priorities

In last year's Quality Account we outlined six quality priorities for 2010/11. For each priority we have provided a report outlining the work undertaken within the Trust to underpin the improvements required (section 3.2).

3.1.2 Monitoring Quality

Alongside the detailed priorities in section 3.2, we also monitor quality in a wide range of other ways. Some of our main measures are regularly discussed at the Trust Board and at formal sub Committees. Some of these quality measures are reported in this Quality Account, so that you can understand some of the work being undertaken and the improvements made. These are set out in section 3.3.

Section 3.4 sets out our clinical incident reporting systems which we closely monitor. Section 3.5 sets out how we gain feedback from staff and patients and ensure that we make the continual improvements that they tell us about.

To ensure that this Quality Account is focused on 'putting the patient first' we have taken patient feedback (negative and positive) and put an extract onto each page, as a constant reminder of the areas of care where we have met the patient's needs and expectations and other areas where we have clearly not, and this underpins the improvements we want to make.

During 2010, senior clinicians and staff have outlined to the new Chief Executive the need for clinical leadership and focus on quality and safety. Through increased review of actual care delivery, the Board have recognised the need to improve the safety and quality of care delivery.

To support this a formal sub committee of the Trust Board was formed in November 2010. One of the Non Executive Directors chairs this Committee, with 2-3 other Non Executives forming membership of this Committee along with the Chief Nurse/Director of Quality and Safety and Medical Director.

The Committee provides a level of scrutiny of the care delivered within the Trust and undertakes a patient safety walkabout on a monthly basis prior to the Committee and ensures that all members meet with staff and patients to review care delivery. The Committee also listens to a patient story prior to starting the formal agenda to ensure this places the patients experience at the heart of the business of the Committee.

Quality Priorities 2010/11	Commentary
Reducing Healthcare Associated Infections	Report on page 26
Improving Dignity in Care	Report on page 28
Achieving year-on-year reductions in Falls	Report on page 30
Preventing avoidable pressure ulcers	Report on page 32
Preventing Venous Thromboembolism	Report on page 33
Improving Stroke Services	Report on page 33

3.2 Update on Quality Priorities for 2010/11

3.2.1 Priority A: Reducing Healthcare Associated Infections

What is the issue and why we did we make this a priority?

Healthcare associated infections go to the heart of public confidence in the NHS. The Trust was successful in achieving its target for Methicillin Resistant Staphylococcus Aureus (MRSA) bloodstream infection during 2010/11, however it is vital that this issue is still given the highest priority in our hospitals.

Whilst we did achieve our target for Clostridium difficile (C.diff), we recognised that we could make further progress to achieve "zero preventable infections".

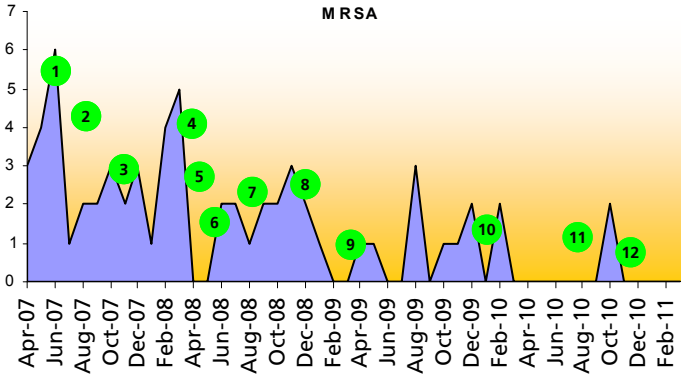
It is more difficult for hospitals providing emergency care to completely eradicate infections such as MRSA bloodstream infections. This is because some patients may be admitted as an emergency who have an infection already. However, when this happens it is vital that we provide them with dedicated care that treats their infection and reduces the risk of spread to other patients.

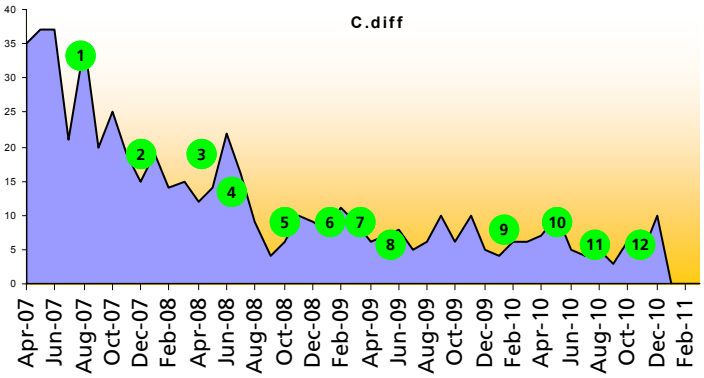
What were our goals during 2010/11?

Our goals during 2010/11 were to continue to improve infection prevention and control, and specifically:

- To reduce the annual number of post 48 hour MRSA bloodstream infections to no more than 6
- To reduce the annual number of C.diff infections in patients over age 2 to no more than 166
- Following the extension of MRSA screening, review the impact of this programme and make plans to extend this further
- Maintain our focus on hand hygiene, building on the progress to date, and continue our involvement in the national "Clean Your Hands" hand hygiene project.
- We will maintain our registration with the Care Quality Commission and continue to build on our own internal programme of environmental compliance monitoring to identify and share best practice.

	2008/09 infections	2009/10 infections	2010/11 infections		% change
MRSA bloodstream infections	15	11	2	✓	-82%
C.difficile (over age 2)	102	79	68	✓	-14%





Improvements in the reduction of MRSA bacteraemia

1. Introduction of Chlorhexidine/Isopropyl skin prep wipes
2. MRSA screening introduced for elective surgery
3. Wards responsible for Root Cause Analysis on bacteraemia
4. Cohort Ward opened
5. MRSA care pathways introduced
6. Chloroprep skin cleaner introduced
7. SMART cycler for rapid MRSA testing introduced
8. Gel station signage increases usage
9. Blood culture training for all Junior Doctors
10. Weekly IPC nurse ward round with Cohort ward manager
11. IV cannulation pack developed
12. MRSA screening for all emergency admissions

Improvements in the reduction of Clostridium difficile

1. 7 day testing for Clostridium difficile (C.diff)
2. Chlorine based cleaning introduced
3. Daily review of C.diff patients by Cohort doctor
4. Additional Antibiotic Pharmacists appointed
5. C.diff care pathway introduced
6. Enteric precaution signage implemented
7. Increased usage of chlorine-based cleaning
8. Cohort ward using for c.diff patients
9. Weekly IPC nurse ward round with Cohort ward manager
10. Root Cause Analysis on all c.diff cases
11. Bed and commode cleaning videos developed
12. Use of 'typing' to search for c.diff 'clusters'

What we did well

We continued to focus on key interventions to prevent cases of healthcare associated infections.

MRSA

Identifying any gaps or weaknesses through continued Root Cause Analysis on each case of MRSA bloodstream infection. This has led, for example, to alerting clinicians to the importance of correct antibiotic use before surgery in patients with a history of past MRSA carriage.

We are reducing all MRSA infections, not just the bloodstream infections, by reducing the chances of patients picking up the bacteria in the first place.
We do this by screening all our emergency and elective admissions for MRSA apart from those in very low risk groups such as most paediatric and obstetric patients.

If MRSA is detected the patient is kept in isolation and offered a clearance regime with topical creams and sometimes milder antibiotics. The number of MRSA screens sent increased by 26% from 51,101 in 2008/09 to 64,348 on 2009/10. In 2010/11 the number of screens increased to 70,000.

Clostridium difficile

The cohort ward (previously used predominantly for patients with MRSA), is now also being used to isolate patients with C difficile. This has become possible as the numbers of MRSA positive patients has dropped.

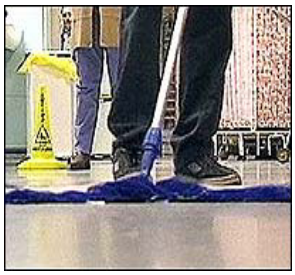
Tight control on antibiotic prescribing helps us reduce resistance. All prescriptions of antibiotics are audited against the antibiotic policy by ward pharmacists, and any non compliance is brought to the attention of the prescribing doctor. The two antibiotic pharmacists take part in the C. difficile ward rounds with the consultant microbiologists.

Hand Hygiene

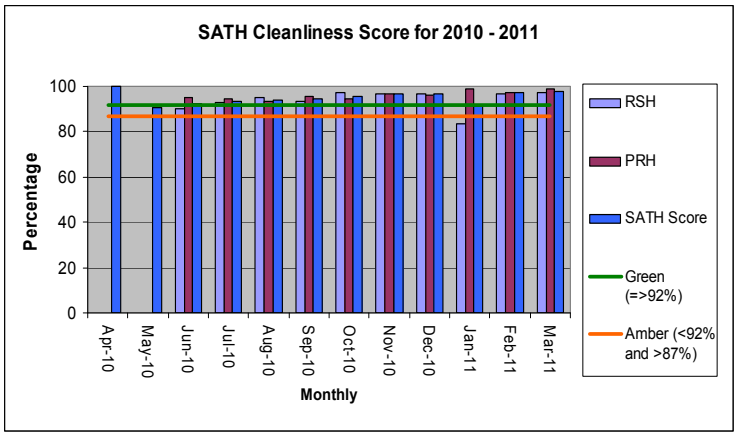
All areas carry out Hand Hygiene audits at least fortnightly. These audits are reported monthly and shared with the rest of the Trust. Hand hygiene compliance is a key performance measure and is displayed on ward notice boards.
The Trust has regularly achieved its 95% target score for hand hygiene compliance.

> ***"It is noticeable how good staff are at gelling their hands. It makes you feel more confident"***
>
> Visitor's views during hand hygiene roadshow event

Cleanliness and Hygiene



Continuation of increased cleaning, including use of chlorine based disinfectants the Deep Clean Programme continues.
Audits of cleanliness standards in wards and other hospital areas by the Compliance and Monitoring Team.
Our cleanliness scores measured against the Standards of Cleanliness have remained high, at 95%.



Standards the Trust agreed with the Commissioners (Primary Care Trusts) for 2011-2012:

Each year we agree with our Commissioners a series of standards for the coming year. For 2011-2012, they are:

- The Trust will have no more than 2 hospital associated MRSA bloodstream infections

The Trust had 2 hospital associated MRSA bloodstream infections in 2010-2011 - this compares to 20 cases the year before

- The Trust will have no more than 54 cases of Clostridium difficile

The Trust had 68 cases in 2010-11 which was a reduction from the 79 cases the previous year

- The Trust will reduce its hospital associated MSSA bloodstream infections *by 5%*

This measurement is new for 2011-12

- The Trust will reduce hospital associated E.coli blood stream infections by 5%

This measurement is new for 2011-12

External inspection and assessment

The Trust is regularly inspection by external organisations to ensure our infection prevention practices meet specific standards.
The Care Quality Commission (CQC) carry out annual inspections and we also receive regular inspections from the Health and Safety Executive as well as scrutiny from local PCT and the County Council.

What more do we need to do

Each year, the Infection Prevention and Control team produce, and work to, a clear programme of work. For the coming year, our focus will be on:

- Monitor compliance against MRSA screening, providing local support to areas of poor performance.
- Challenge existing assurance mechanisms and validate self-assessment.
- Follow up sub-optimal standard of hand hygiene by small minority of Medical staff. Clinical Centres who do not achieve target score will be given further support.
- Look in detail at root causes in order to reduce the annual number of post 48hr MSSA bloodstream infections.
- Look in detail at root causes in order to reduce the annual number of post 48hr E.coli bloodstream infections.
- Focus on decontamination of instruments/equipment outside of CSSD.
- Increase infection prevention and control information to visitors, through improved signage and the development of additional information leaflets.

3.2.2 Priority B: Improving Dignity in Care

What is the issue and why did we make it a priority?

The right to privacy, dignity, equity, and respect are core human rights and values that should be central to every thing we do in order to provide person centred quality health care.

"I was ill but my stay was great I got looked after well it felt like home"

Whilst ratings show the majority of our patients felt they were treated with respect and dignity not all did and we must focus on the reasons why these patients did not feel that they received the core standards of care we strive to offer. The key issues from patient and carers feedback include staff attitude, communication and customer care.

The population of health service users is ageing with growing numbers of elderly, frail and vulnerable patients, with an increasing number of patients with dementia. Not only must we be able care for a patient's clinical condition we must respond to the social and emotional needs of the individual and their family with compassion and sensitivity.

We must strive to provide the highest standards of dignified care every time to every patient.

What were our goals for 2010/11

- Continuing to improve Same Sex Accommodation, including further refurbishment work to improve same sex toilet and washing facilities.
- Strengthening the systematic review of complaints to identify issues and themes around privacy and dignity and take corrective action.
- To gain greater understanding of the patient experience by using patient stories.
- To continue to monitor dignity in care through the patient experience quarterly audits and to use the findings from these audits to make improvements.
- Incorporating dignity in care into medical staff appraisals and training.
- Developing and implementing Trust-wide strategies for dementia and end of life care.

Where are we now

Same Sex accommodation

We have been committed to ensure that patients do not share their sleeping accommodation or washing and toilet facilities with members of the opposite sex. Mixed sex accommodation will only occur when clinically necessary for example where patients need specialist equipment such as in our Intensive Care Unit, or when patients actively choose to share for instance in our day care centres such as the Renal Dialysis Units.

Last year we implemented a number of initiatives to ensure the delivery of same sex accommodation. This included improved sign posting for designated same sex accommodation, toilets and washing facilities.

"I cannot praise the doctors, nurses enough. They were diligent, caring and totally committed 24/7 "

Improvements in the operational management of our admission areas have resulted in significant reductions in the number of times male and females share the same sleeping accommodation/bays with a zero tolerance to mixing. These improvements are reflected in our scoring in the 2010 Annual Patient survey with 89% of patient's reporting they were nursed in same sex accommodation compared to 73% in 2009.

We recognised that we still had work to ensure that males and females did not have to share washing facilities and a programme of refurbishment and installation of additional bathing facilities is being rolled out to ensure we can provide same sex accommodation amenities.

Dignity in care

We have continued to ascertain the views of our patients by undertaking quarterly patient experience postal surveys. This survey was developed in response to the Department of Health dignity in care campaign and 10 point Dignity Challenge. The survey explores nine core dignity domains Autonomy, Communication, Eating and Drinking, Privacy; Personal Hygiene, Pain, Social Inclusion; End of Life Care and Safety.

These domains were considered fundamental by patients and a wide range of stakeholders.

A number of patient stories have been captured and shared with clinical areas to develop and improve practice.

We have continued to raise awareness and support the development of staff through a number of Dignity in Care workshops.

We take the comments received from patients very seriously and use negative patient feed back to drive through improvements in patient care.

What we need to do more of

Ratings from the CQC Annual Inpatient Survey show that we score similar to other hospitals across England and that we have scored marginally higher on overall standards of care in our hospitals in 2010 compared to 2009. However both the national and our own patient surveys have identified areas for development and opportunities to learn and improve on the standards of care we provide.

The key areas for development are:-

- Reducing the disturbance of noise at night for patients.
- Ensuring patients have an opportunity to talk to a doctor about their condition.
- Responding to patient call bells more promptly.
- Supporting patients with meals.
- Patients being involved in decisions about their care and discharge planning.
- Ensuring patients are provided with information on discharge.
- Enquiring about and meeting patient's religious and spiritual beliefs.

The quarterly postal surveys have provided us with baseline information but we need to capture the views of patients in all areas on a more regular basis so we gain an accurate picture of the real time patient experience across all wards and departments in the Trust.

We are now undertaking patient surveys in all our wards on a monthly basis. These real time audits will enable staff to continually reflect on patient feedback. They will also provide us with opportunities to act quickly on the results to change and improve practice speedily but also to recognise and acknowledge good practice.

"Kind and caring staff a real credit to the NHS "

We need to meet with more patients and carers who express concerns so we can listen to their experiences first hand and give assurances.

We need to develop robust systems and process to record changes that have taken place following the results of the surveys so that the Trust is able to demonstrate that it is listening to patients and acting on their feedback.

3.2.4 Priority C: Achieving year-on-year reductions in Falls

What is the issue and why did we make it a priority?

Rationale

Slips, trips and falls are a common cause of injury to patients that may result in pain, distress, delay in discharge, and loss of independent living. The Trust is committed to reducing the risk of harm to patients while they are in hospital, whilst ensuring that patients are empowered to maintain their mobility as far as is possible in order to assist with recovery from illness.

The causes of falls are complex and older hospital patients are particularly likely to be vulnerable to falling through medical conditions including delirium, heart, neurological or muscular-skeletal conditions, and side effects from medication, or problems with their balance, strength or mobility. Problems like poor eyesight or poor memory can create a greater risk of falls when someone is out of their normal environment on a hospital ward, as they are less able to spot and avoid any hazards, whilst continence problems can mean patients are vulnerable to falling whilst making urgent journeys to the toilet.

Aim

The Trust is committed to a year on year reduction in the number of slips, trips and falls sustained by patients whilst they are in hospital.

Project and Methodology

The Trust's work to reduce the number of slips, trips and falls will be sustained by older people in NHS provided care. This initiative is driven by a document called High Impact Actions for Nursing and Midwifery (Institution for Innovation and Improvement 2009).

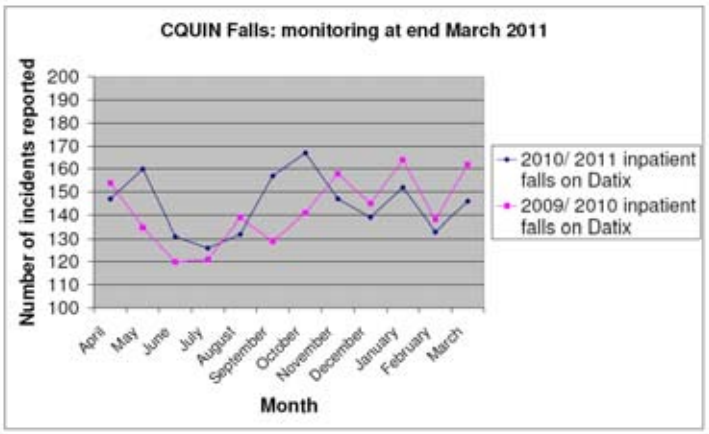
In May 2010 The Falls Taskforce Group was established, the direction for the group is, in collaboration with the wards and departments within the hospital, to implement robust systems and processes to reduce the risk of slips, trips and falls and minimise harm and injury.

Current Status

To establish a base line for the numbers of slips, trips and falls which occurred in the Trust, information was collated using our hospital incident reporting system. This system is widely used by staff within the Trust. It is recognised that the hospital admits a high proportion of vulnerable, elderly patients who have, with increasing age, an increased risk of falls.

Our falls rate for the year ending September 2010 was 5.91 per 1,000 bed days. In comparison, the National Patient Safety Agency data set gave an average rate of 5.6 falls per 1,000 bed days for acute hospitals.

Reference
www.nrls.npsa.nhs.uk/resources/?EntryId45=74567



Initiatives in 2010

Agreement by the ambulance service to bring into hospital all walking aids for emergency patients who require hospital admission.

Introduction of frequent comfort rounds on the wards, offering to accompany patients to the toilet and ensuring call bells are within easy access to the patients.

Nursing staff moving away from nurses stations and basing themselves within ward bay.

Introduction of 'Gold Square' above patients' bed. This is an alert to highlight that the patient is at risk of falling.

Introduction of the ward assurance monthly report. Included in this report are the numbers of falls that have occurred in individual wards. This information is monitored and evaluated monthly using key performance nursing indicators.

The Trust's Slips Trips and Falls has been revised and approved though the Trust's Health and Safety Executive Committee.

A root cause analysis investigation is undertaken for every patient whose fall results in a significant injury i.e., head injury or broken bone. The information gathered is shared with the matrons and ward managers to ensure lessons are learnt and improved practice is introduced.

Twelve 'low height' beds have been purchased and distributed to the wards to use for those patients who are identified as a high risk for falling.

The Moving and Handling team has introduced a mandatory training programme specifically for the moving and handling of patients who are at risk of falling for nurses and health care assistants.

Footwear provided by the Trust has been reviewed and replaced with alternative source of slippers to reduce the risk of falling.

Introduction of new nursing documentation which includes a Falls Risk Assessment for the Elderly (FRASe). This assessment is completed within 2 two hours of a patients admission to hospital. The Trust has agreed to use this assessment on all inpatients over 18 years of age.

Initiatives for 2011 to 2012

Trial of falls monitoring system to reduce the number of unwitnessed falls.

The development of an internet website which will provide information to patients and carers for staying safe and preventing falls whilst staying in hospital.

The development of an intranet website which will provide information to hospital staff for reducing slips, trips and falls sustained by patients admitted to our hospital wards.

Development of a falls management policy.

Trial of new prescription sheets which include a request for review of medication for those patients who are at risk of falling or who have experienced a fall whilst in hospital.

Continuing into 2011/12 as a Priority for Quality Improvement

We recognise that we have not done enough to reduce the number of falls. 25 falls resulted in actual harm which we deeply regret and must improve on. We will work with each clinical team, patients and their families to ensure the right level of support and information and care is provided to make the significant reduction needed.

3.2.4 Priority D: Preventing Avoidable Pressure Ulcers

What is the issue and why did we make it a priority?

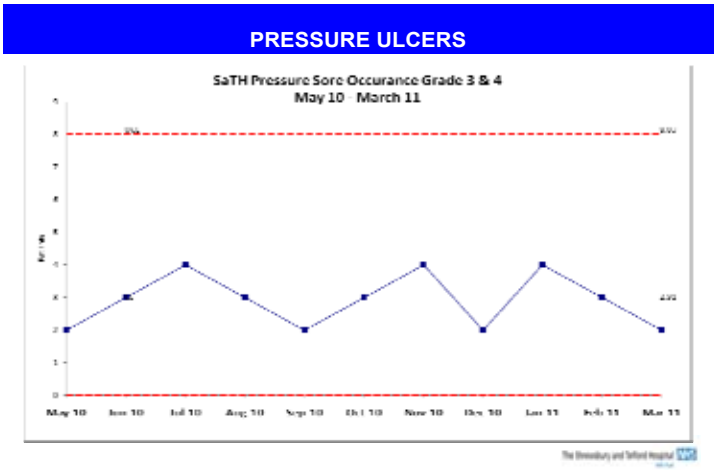
Rationale

The aim of the high impact action "Your skin matters" is 'no avoidable pressure ulcers in NHS provided care'. It is known that pressure ulcers represent a major burden of sickness and reduced quality of life for patients. They create significant difficulties for patients, carers and families, as well as increasing time in hospital and, therefore, cost to the NHS.

Aim

To demonstrate a year on year reduction in the number of preventable Grade 3 and 4 pressure ulcers sustained by patients while they are in hospital.

Current status



Pressure ulcers are quite common and are estimated to occur in between 4% and 10% of patients admitted to hospital. Figures for their occurrence in the community are more difficult to obtain, but it has been estimated that 20% of people in nursing and residential homes may be affected and up to 30% of the population in general. (Clark M, Bours G, Defloor T; 2004).

Pressure ulcers can occur in any patient but are more likely in high risk groups, such as the elderly, people who are obese, malnourished or have continence problems, people with certain skin types and those with particular underlying conditions.

A 'snap shot' audit in 2008 showed that 6.6% of our patients had some degree of hospital acquired pressure ulcer, this rose to 7.68% in 2009 and a recent survey in 2010 showed that this figure had dropped to 3.03%. Whilst this is encouraging it is recognised that there is still much work to do if we are to eliminate the patient harm caused by the acquisition of preventable pressure ulcers.

Initiatives in 2010

A tissue viability task force has developed an action plan which has implemented of a range of initiatives and activities to support the reduction in pressure ulcer acquisition.

These include:

- The roll out of an IT system for ongoing collection of pressure ulcer data.
- Improved electronic reporting mechanisms to enable staff to easily report any ulcers present on admission.
- An improved nursing documentation tool has been introduced which will assist in assessment and care planning in relation to patients skin condition.
- All patient acquired grade 3 and 4 ulcers are subject to a root cause analysis investigation and this is reviewed by our senior nurses/matrons in order to improve practice and share learning.
- An education and training package for all staff (which includes prevention and treatment
- initiatives) is currently being rolled out across the Trust.
- Initiatives such as 'SKIN SUNDAY' have been launched across the Trust to ensure all inpatients have their skin condition assessed and monitored properly, together with 2 hourly comfort rounds and repositioning charts.
  Nursing documentation in relation to tissue viability assessment and management is recorded, monitored and evaluated on a monthly basis by Ward Managers/Matrons. This is then reported as a key performance indicator to the Senior Nursing Team.

What has improved as a result of our initiatives

We have undertaken routine surveillance of all of our patients who have pressure ulcers, grades 0-4 and this has demonstrated the following:

- Our risk assessment of patients on admission has improved from 35 % to 98% enabling us to address skin issues before they deteriorate so promoting skin healing.
- The utilisation of the correct equipment to aid skin healing and prevent pressure ulcers is now being instigated at an earlier stage of the patient journey.
- Since introducing increased awareness of the importance of highlighting any grade of pressure ulcers our reporting has increased from below 20 per month to over 60 and this continues to show improvement.

Continuing into 2011/12 as a Priority

Continuing the focus on improvements in this area is absolutely vital. 33 patients have sustained a grade 3 or 4 pressure sore. With the right care, these are preventable and despite reviewing each set of patients' notes and sharing the reasons why a patient developed a grade 3 or 4 pressure sore, we have not made adequate progress.

The improvements required will be closely monitored and tracked with each clinical team to ensure best practice is achieved consistently.

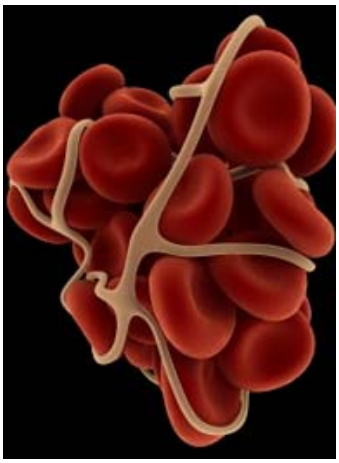
3.2.5 Priority E: Preventing Venous Thromboembolism

During 2010/11 the Department of Health recognised that all Trusts needed to demonstrate compliance with NICE (National Institute for Clinical Excellence) guidelines on the prevention of venous thromboembolism.

The requirement was that for every patient admitted to the Trust, we needed to undertake a risk assessment (determined by NICE and endorsed by the Department of Health) as well as prescribe the treatment required to prevent an embolism (clot).

Whilst most clinicians assess their patients for this risk, the Trust did not establish a process to monitor compliance against the required risk form/template and were unable to report nationally against the monthly target of compliance and achieve the end of year target of 90% of all patients having the required risk assessment.

The Trust had planned to use an electronic system for recording and auditing the risk assessment but this failed to be implemented.



A manual process of monitoring was introduced in January 2011 whilst the electronic system was developed further. By the end of the year we were able to identify that 45% of our clinicians were recording the risk assessment on the appropriate format. This means that we must improve our systems and processes to meet this safety requirement fully (90%).

The Medical Director has been working with medical colleagues to get rapid improvement in early 2011/12 and to ensure that all patients receive the treatment required as indicated by the risk assessment.

This safety improvement will continue to be a priority for us in the Trust and is set out in the list of priorities in section 2.1 of this Quality Account.

3.2.6 Priority F: Improving Stroke Services

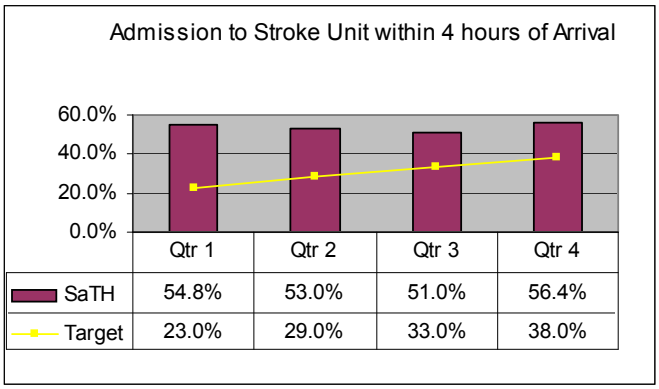
Background

Strokes affect up to 100,000 people every year across the UK, and almost 800 people are treated a year by the Trust. Many strokes are potentially avoidable, and early intervention following stroke can significantly reduce morbidity and mortality, increasing the opportunities for people to retain their health and independence following a stroke.
Local health services have been challenged to meet national benchmarks for rapid access to dedicated stroke services.
"Admission to stroke unit within 4 hours of arrival at hospital for confirmed stroke" is a CQUIN national quality standard, for 2010/11.

Aim

Our quality targets aim to facilitate the speedy and timely admission of stroke patients to receive the best quality and specialist stroke care both in hospital and in the community.

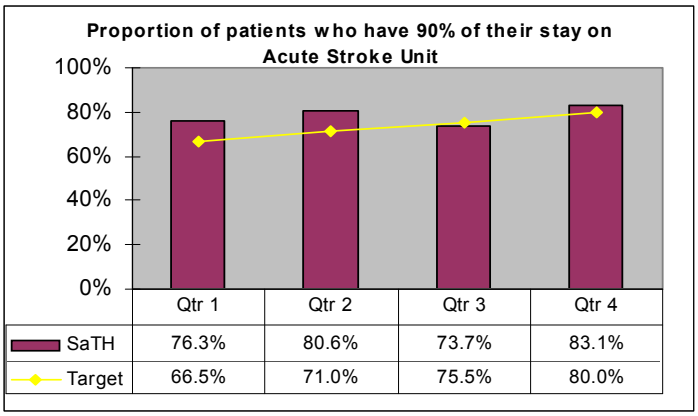
Current status



	Qtr 1	Qtr 2	Qtr 3	Qtr 4
SaTH	54.8%	53.0%	51.0%	56.4%
Target	23.0%	29.0%	33.0%	38.0%

Patients have access to doctors, nurses and therapists with up-to-date stroke skills. Staff on the Acute Stroke Ward will immediately put patients on the appropriate stroke care pathway, giving rapid access to CT scans, swallow screening, and therapies.

It is suggested that acute stroke units participating in stroke trials have better staff and care. We are currently running 2 trials at PRH: "ENOS", looking at lowering blood pressure in the acute phase of stroke and "SOS", looking at supplementary oxygen in the acute phase. The research team are also running a trial in the TIA clinic looking at unmet needs following TIA.



SaTH have realised a 14% improvement in the proportion of patients spending 90% or more of their stay on an Acute Stroke Unit, thus improving continuity and access to specialist care.

Transient Ischaemic Attack (TIA)

Feedback was received following a patient's stay on an acute stroke ward in the Trust: "***I now feel that unnecessary delay in arranging of a scan can result in bed blocking and extra expense***."

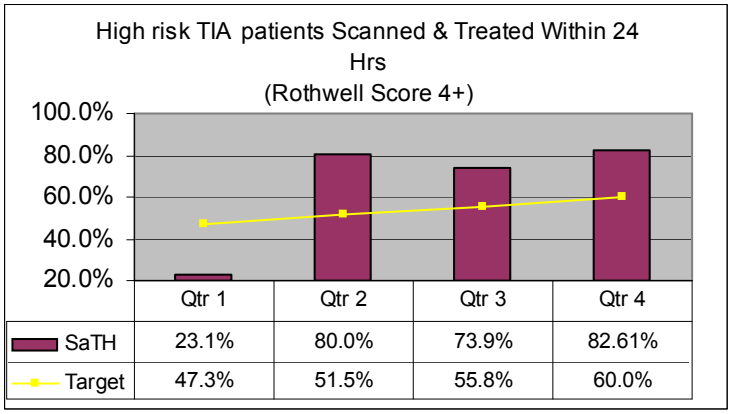
We have improved access to imaging for both stroke and TIA patients to improve the patient journey and experience. 81% of patients are now scanned within 24hrs of admission and 47% within 4 hours of admission facilitating faster diagnosis and timely start of appropriate treatment.

20% of patients experiencing a Transient Ishchaemic Attack (TIA) will go on to have a major disabling stroke within 4 weeks, which is why it is so important to see high risk patients within 24 hrs. It is estimated that 80% of these could be prevented with carotid intervention (the carotid artery is the artery that supplies the head and neck with oxygenated blood). SaTH have achieved a 58% improvement in 2010/2011 in seeing high risk TIAs within 24 hours of referral.

Initiatives in 2010

The Stroke Strategy group, representing the whole of the county, has worked to develop the following areas and implement a range of initiatives and activities to support the improvement of Stroke Services:

A revised TIA Care Pathway has been developed in partnership with the Primary Care Trust, using the Care Co-ordination Centre (July 2010) which has seen a 58% improvement in high risk TIA (see graph) patients seen within 24hrs of referral receipt.



Increased provision of stroke thrombolysis service (a treatment to breakdown blood clots) to cover 8am-8pm, 7 days a week, at both RSH and PRH sites with overnight thrombolysis service provided at PRH site, extending to both sites by May 2011.

"No complaints at all, nursing staff very attentive and caring". *SaTH patient comment, Acute Stroke Unit*

Looking forward: – Stroke Services

Thrombolysis

We aim as a Trust to increase our proportion of patients offered Thrombolysis treatment to 10%, undertaking an audit to understand rural and demographic issues via the Stroke Strategy Group.

Transient Ischaemic Attack

The Trust aims to provide a 7 day outpatient service for TIA referrals by appointing additional Stroke Specialist Nurses to enable us to offer weekend outpatient appointments.

Carotid Intervention, following TIA

The Stroke Team are working to develop a pathway to ensure patients receive surgery within 2 weeks of being identified as suitable for the operation. 20% of patients experiencing a TIA will go on to have a major disabling stroke within 4 weeks. It is estimated that 80% of these could be prevented with early diagnosis and/or carotid intervention.

Early Supported Discharge

The Trust is committed to enabling patients to receive appropriate rehabilitation in their own homes as soon as possible to allow patients to retain as much independence as possible. The Early Supported Discharge (ESD) project enables this transfer to happen wherever patients meet the Early Supported Discharge criteria. The ESD pilot commenced 10th January 2011 enabling stroke patients living within Shropshire County to be discharged from RSH or PRH with Physiotherapy, Occupational Therapy, Dietetic and Speech and Language Therapy services in place, giving rehabilitation support for the patient for up to 6 weeks after discharge, and has been extended for a further 6 months until September 2011, for Shropshire County patients. In order to ensure that we are delivering a service that meets needs and expectations we are asking everyone who uses the ESD services to complete a short survey. We aim to continually monitor and improve the service provided and to find out how satisfied patients are.

Psychological support

The Stroke Strategy Group are currently looking at how psychological support for stroke patients and their carers can be best provided.

Provision of Specialist Rehabilitation

Commissioners are pursuing options to deliver bed based specialist rehabilitation in a community setting. A 6 week pilot is under way at Whitchurch Hospital with 4 beds being provided for specialist stroke rehabilitation. As a result of the stroke rehabilitation project it was identified that there was a need to provide additional information to patients and carers. A Patient Booklet has been produced and is now available to hand to patients and carers who are given a choice of being transferred to Whitchurch Community Hospital for their rehabilitation.

Powys commissioners have identified Newtown and allocated 5 beds at their community hospital to support Welsh patients who need specialist rehabilitation facilities.

Stroke follow-up and care planning

A health and social economy group has agreed a joint care plan to enable effective ongoing health and social care support for patients in the community, which was implemented in March 2011. Agreeing a care plan with your health or social care professional means being able to talk about your condition, how it affects your life, what you want to do and what more you can do for yourself with the right support.

FAST campaign

The Stroke Strategy Group have commissioned a piece of work which will be clinically led to ensure that the public recognise the symptoms of a stroke and respond by dialling 999 using the FAST (**F**ace, **A**rms, **S**peech, **T**ime) tool. This work supports the FAST campaign, which was launched nationally and is being repeated again in 2011.

Network Telemedicine Project

The network-wide telemedicine project for the introduction of telehealth technology to assist in the diagnosis and treatment for patients who are admitted with a stroke is continuing.

- 24 hour thrombolysis service available for stroke patients at Shrewsbury and Telford Hospital.
- The telemedicine technology will be used alongside the thrombolysis service.
- Work on developing a patient feedback questionnaire to gauge patient perception of the new technology when it is in use.

3.3 Other Quality Monitoring and Improvement Measures in 2010/11

3.3.1 Leading Improvements in Patient Safety (LIPS)

During 2010 a core team from the Trust took part in the seventh programme of *Leading Improvement in Patient Safety* (LIPS).

The programme builds capacity and capability within hospital teams to improve patient safety. The programme is run by the NHS Institute for Innovation and Improvement's 'Safer Care' team and has been undertaken by over 100 teams from 99 Trusts. It aims to help NHS trusts develop organisational plans for patient safety improvements and to build teams responsible for driving improvement across their organisation.

The idea of the programme is to develop sustainable improvements by trying out small scale changes in order to sort out problems before the solutions are rolled out across the Trust.

We use the Institute for Healthcare Improvement's (IHI) Global Trigger Tool to provide the Trust with an understanding of the incidence of harmful events.

This tool requires the Trust to randomly select 20 clinical records each month and review for harmful events. The data produced by this tool has allowed us to develop the draft driver diagram (page 8).

Figure 1 helps us to illustrate the areas we need to work on in order to improve care to patients.

Figure 1

Primary Driver/ Executive Lead	Secondary Driver/Workstream	Clinical Leads
Nursing Care	Abolishing Falls	Ian Maclennan
Director Quality Safety	Pressure sores	Julie Hepplewhite
	Hydration Nutrition and Fluid balance	Vicky Morris
Medical Care	Reducing infections	Andrew Tapp
Medical Director	Abnormal results	Chris Beacock
Leadership and communication	Communication with patients and GPs	Darren Warner
Chief Executive	Communication with & between staff	Mark Cheetham
The deteriorating patient	The Response to the EWS	Rob Campbell
Medical Director	The Septic patient	Saskia Jones Perrott
Medicines management	Medicines reconciliation	Bruce McElroy
Medical Director	Drug Errors	Saif Awwad/Narayanan Srihari
Right patient, right place, right time	Scheduled Care	Ewan Craig
Chief Operating Officer	Unscheduled Care	Kevin Eardley / John Jones

Here is a summary of the key projects:

Care of the deteriorating patient

The Trust has an electronic system for recording a patient's vital observations. This system automatically works out a risk score for each patient, which allows clinical teams to identify the patients who are becoming acutely unwell.

Early work has shown that we need to do more to prevent patient deterioration, and to act more quickly when high risk patients are identified. Interventions will be developed during 2011 to help prevent patient deterioration.

Recognition of patients with sepsis

Early recognition and management of sepsis is vital for the successful management of the condition. Although a significant amount of work has been carried out in the education of medical and nursing staff, we are concerned that patients with sepsis are not always recognised and therefore do not receive prompt treatment in line with the sepsis bundle. An audit of the treatment of eight patients, carried out on a ward at RSH, indicated that no patient received treatment with all elements of the sepsis bundle.

A sepsis 'six pack' is being trialled on the ward. This is a box containing all of the required equipment, along with a summary of the guidelines and a short form of the antibiotic policy. Treatment of sepsis will be a key priority for the coming year.

Reducing surgical site infections

Evidence demonstrates that there are a number of ways of reducing infections following surgery. Although the Trust has low surgical site infection rates, a project to reduce this further has been carried out by reviewing two key actions.

All patients were found to have received antibiotics just prior to surgery; however the study raised some questions about the type of some antibiotics used. Appropriate guidance will be issued to staff following discussion and agreement with the microbiologists.

The second important action is to ensure that patients do not become cold during surgery. New equipment including thermal blankets was bought and guidance given to staff. The number of patients whose temperature was 36C or above increased from 70% to 87% following the project.

Next steps

The team were so impressed with the programme that the Chief Executive agreed to host a week long event in June 2011 to spread the learning throughout the different clinical teams within the Trust.

An introductory day was held in March 2011 which was attended by over 150 staff and primary care partners.

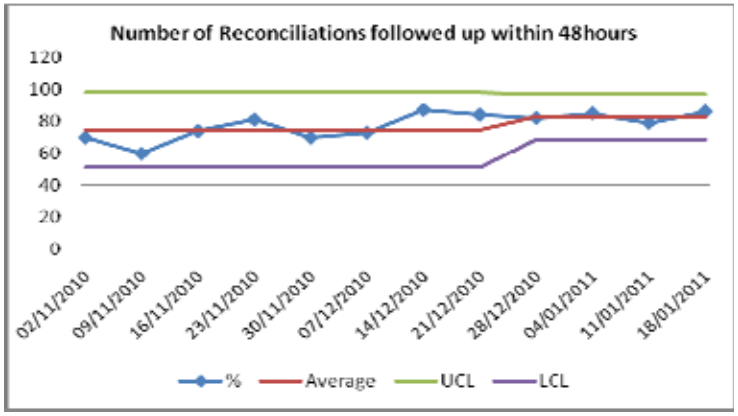
At this event the participants were given information on the LIPS programme; progress to date from the core team; and an overview from Jim Reinersten, a world renowned expert in patient safety.

An organisational safety driver diagram will be finalised by the end of April 2011 which will form the basis of the patient safety improvement strategy for 2011/12.

3.3.2 Medicines Management

When patients are admitted to hospital, the doctor completes a prescription chart for the patient based on the information received from the patient on admission. After this, the pharmacy team collate a drug history using at least two sources of information (e.g. from the GP surgery). They identify any discrepancies and omissions with the inpatient drug chart and inform the medical teams. This reconciliation should take place within 48 hours of admission.

A small project on one ward led to good progress but more work will need to be carried out to improve this further and will form part of the LIPS programme.



3.3.3 Priorities in Women's and Children's Services

What were the main issues?

The Women's and Children's Services provide care to over 5000 pregnant women a year within a Hub and Spoke model. Year on year birth increase has resulted in an urgent need to increase obstetric, midwifery and obstetric theatre staffing.

The RSH Consultant Unit (Hub) was built 40 years ago for 2500 deliveries per year and now is the environment for 4500+ births. The Spokes, our five Midwifery-Led Units are based at Bridgnorth, Shrewsbury, Oswestry, Ludlow and Telford. There are plans in place to relocate the Ludlow MLU to a purpose built PCT building in 2013/14.

Currently, at least 600 babies will be provided with additional support by the Neonatal Services, including an outreach community team. The size of this unit and its staffing levels are now insufficient to meet modern standards.

Paediatric outpatient and inpatient services are provided on both RSH and PRH sites, offering sub specialty care for complex childhood illness including diabetes, respiratory medicine, juvenile arthritis, cardiology, epilepsy, head and neck surgery and oncology. The RSH paediatric ward and outpatient department was moved from RSH South as a temporary solution over 15 years ago.

Gynaecological outpatient services are provided in various venues throughout the county but demand is currently outstripping capacity. Our Fertility Unit is based at RSH and has also become a victim of its own success, outgrowing the space available.

The main issues for the Women's and Children's Services during 2010/11 have related nearly entirely to two elements:

1. Staffing 2. Estate

Staffing Issues

Obstetrics:

Lack of Middle Grades
Lack of Consultants
Theatre team covered by midwives

Midwives:
High birth rate to midwife ratio

Anaesthetists:
Lack of dedicated 24/7 anaesthetic presence on the labour ward.

A business case was written and approved during 2010/11 to address the above issues and recruitment to these posts has begun.

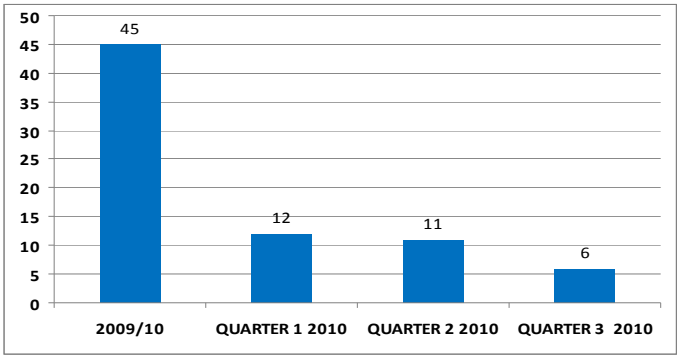
Estate Issues

- Need for antenatal/paediatric outpatient refurbishment
- Need for second obstetric theatre
- Need to refurbish the only maternity building lift
- Lack of space within the neonatal unit
- Lack of space in the fertility unit

What were the main goals?

- Continue achieving good clinical outcomes, whilst developing and enhancing the monitoring and reporting mechanisms
- Produce business case for improved obstetric unit staffing levels
- Develop gynaecological oncology service in line with Improving Outcome Guidance (IOG) for cancer care
- Continue to develop service model to support the safety and sustainability of midwifery led units

Fig 1



What we did well

- Achievement of good clinical outcomes across all Women's and Children's specialities, including:
  - Neonatal survival rate
  - Low caesarean section rate
  - Achievement of high number of women who stop smoking and breastfeed at delivery
- High rates of pregnancy following fertility treatments
- Increase in nurse support for paediatric cystic fibrosis services agreed

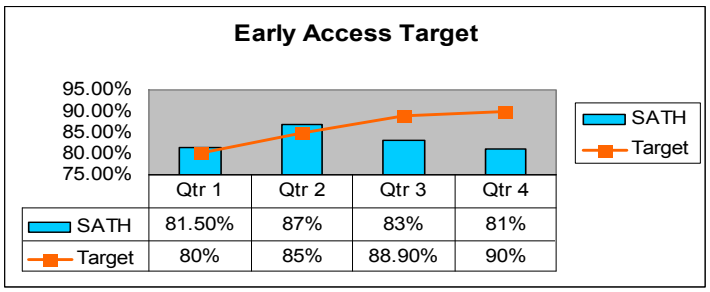
- Achievement of CNST Maternity Standards Level 1
- Excellent Paediatric Oncology Peer Review
- Excellent LSA and NMC External Review

- Excellent feedback from mothers using maternity services (CQC Questionnaire)
- Development of complaints process and reduction in complaints (Fig 1)
- Development of clinical outcome dashboard

Standards agreed with Commissioners

- CQUIN for neonatal care (breastfeeding and senior doctor contact)
- Maternity Specification 0.5% increase in breastfeeding initiation
- Implementation of Baby Friendly Stage 1
- Implementation of IOG compliance for gynaecological oncology

Fig 2



	Qtr 1	Qtr 2	Qtr 3	Qtr 4
SATH	81.50%	87%	83%	81%
Target	80%	85%	88.90%	90%

What more do we need to do?

- Improvement to Estates including:
  - Second obstetric theatre
  - Increased storage space for neonatal unit
  - Increase available consultation rooms in RSH Paediatrics OPD

- Achievement of CNST Maternity Standards Level 2
- Increase availability of Gynaecology and paediatric outpatient appointments
- Continue improving access to maternity care
- Achieve Baby Friendly Stage 1
- Increase breastfeeding initiation of breastfeeding rates 0.5%
- Patient/parent satisfaction questionnaires
- Develop paediatric nurse practitioner role
- Continue to improve the consistency of access to maternity care
- Develop urogynaecology nurse post and continence pathway
- Benchmark neonatal services against NICE Standards and the Neonatal Toolkit
- Increase capacity of day case surgery
- Implement new obstetric and anaesthetic staffing rota

- Need to further enhance training and equipment available to resuscitate and transfer sick neonates from Midwifery Led Units (MLU's).

3.3.4 Reducing in-hospital cardiac arrest and mortality through early recognition of the deteriorating patient

What is the issue and why did we make it a priority?

With the type of acute care a hospital such as ours provides it is expected that some patients will die. The Hospital Standard Mortality Ratio (HSMR)(1) is a national measure and an important means of understanding the expected numbers of deaths against the patients that actually die.
Between 2004 and 2008 the measure was stable, showing a similar number of expected deaths when compared to other hospitals.
But in late 2009/10 the Trust returned to measuring the mortality rate through the widely used Dr Foster tool and discovered the rate had increased significantly during 2009/10.

What where our goals during 2010/11?

As a result of seeing an increase in this measure our goals in 2010/11 were:

- To understand the reasons for the elevated rate of HSMR
- Ensure that clinical care within the Trust has not deteriorated since 2008, or failed to remain in line with the standard of care provided by other acute hospitals

Understanding the High Mortality Rate

To understand the reasons for the high mortality rate the Trust undertook a number of actions including:

- A review of 50 case notes of patients who had died
- An in depth analysis of the crude rate of deaths and HSMR deaths at each hospital site

The review told us that the problem was largely due to the way in which we coded the main diagnosis for patients, and not a reduced level of clinical care we were providing.

Improvements to the coding practices are being implemented as well as improvements to the way we record information in Patients notes. As a result the Trust is seeing a positive impact on the HSMR (Figure 1), however, the HSMR is still high and the crude rate of deaths is not reducing in the same way (Figure 2).

Figure 1 HSMR Measure of Mortality

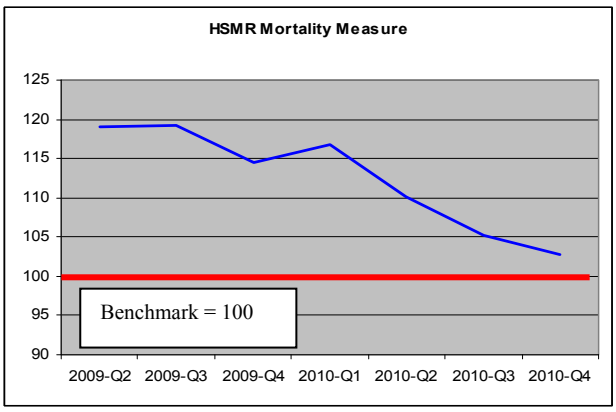
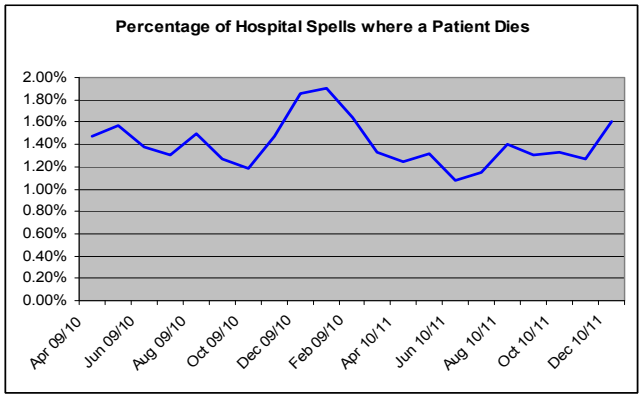


Figure 2 Crude Measure of Mortality



It is therefore wrong to assume that coding of the primary diagnosis alone is the problem. As we explain below, we have focused, and will continue to focus, on improvements to the clinical care we provide for our patients.

What more do we need to do?

Under the leadership of the Medical Director we have formed the Mortality Group, members of which will co-ordinate initiatives that will have an impact on reducing the number of avoidable deaths in our hospitals.

The Mortality Group has identified that we need to focus on reducing all our deaths and not just those measured within the HSMR.

The Trust has already launched, using the Global Trigger Tool Methodology, a formal process to regularly review Patient notes on a random basis. This provides information that will steer us on what improvements we could make to patient care. The group that will decide on the priority of the needed improvement is the Quality and Safety Committee.

In addition we will implement a formal Trust wide process for the systematic review of patient deaths. This will also guide us on what improvements we can make to patient care in a focused way.

(1) The Hospital Standardised Mortality Ratio (HSMR) compares the number of expected deaths with the number of actual deaths. The HSMR is based on the diagnosis that lead to 80 percent of all deaths and are adjusted for factors statistically associated with hospital death rates. Severity of illness is an important factor and methodologies allow for this by using a measure of co-morbidity (Charlston index) which looks at a number of secondary diagnosis and scores them according to severity.

Key Improvements that will improve hospital mortality

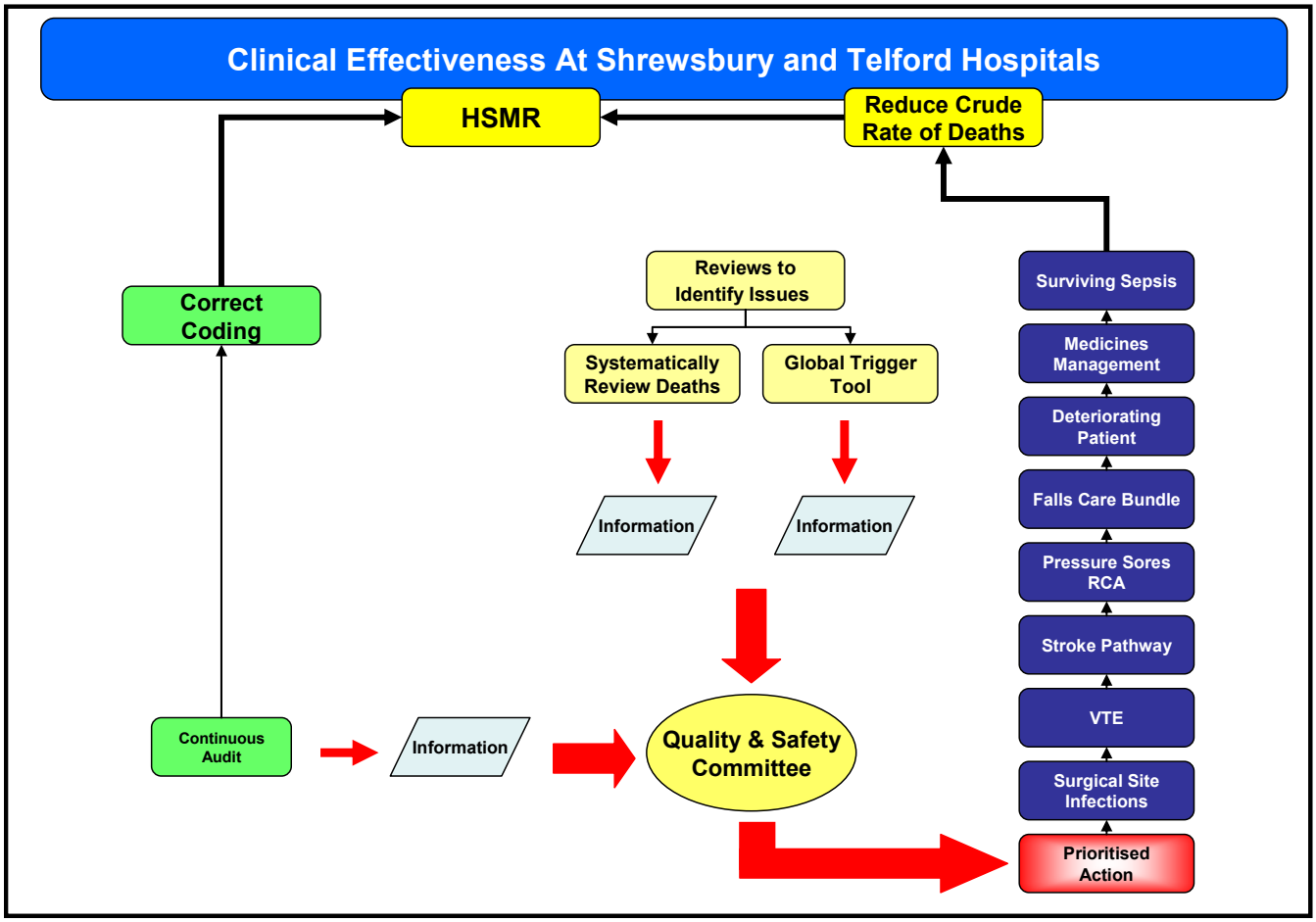
Most of the improvements below are being managed within the Leading Improvements in Patient Safety (LIPS) Programme, which is the main Trust-wide clinical improvement programme. These projects are expected to have an improvement on mortality rates within the Trust by delivering direct improvements to clinical care:

Correct coding– Better recording of patients' underlying conditions

Surviving Sepsis – See section on Leading Improvements in Patient Safety (LIPS) *see page 36*

Stroke Pathway – See section on Stroke Care *see page 33*

Deteriorating Patient – See section on Leading Improvements in Patient Safety (LIPS) *see page 36*



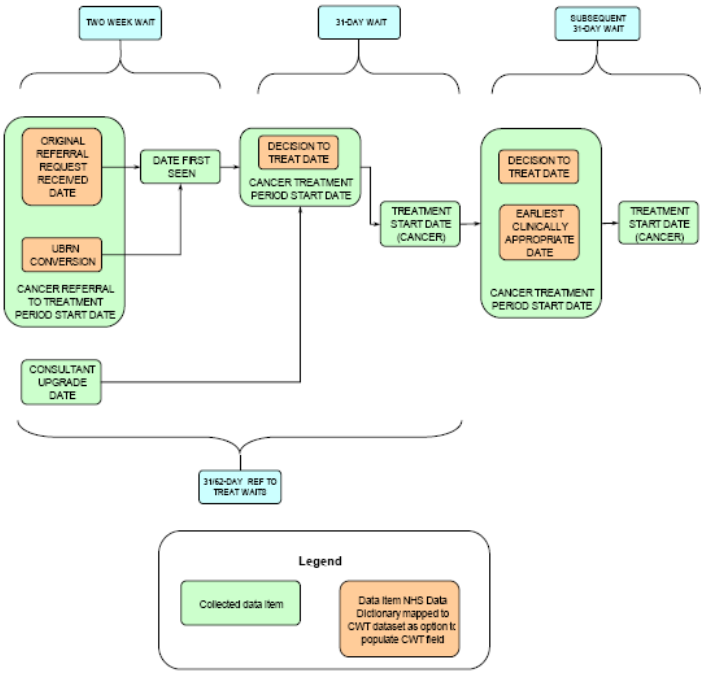
3.3.5 Achieving New and Existing Cancer Targets

What is the issue and why did we make it a priority?

If cancer is suspected, this can be a very anxious time. Rapid access to diagnosis and tests not only reduces the period of uncertainty, but there is also evidence that early diagnosis can improve outcomes.

In order to improve rapid access to cancer diagnosis and treatment, strengthened targets have been introduced.

- Any cancer suspicious patient, or patient with breast symptoms will be seen within 2 weeks of referral
- Any cancer treatment will occur within 31 days of a decision to treat
- 62 day standard can now begin at GP referral, cancer screening referral or consultant upgrade



What were our goals during 2010/11?

In order to improve quality of care by meeting these strengthened targets, NHS organisations need to:

- Redesign pathways in line with the new standards for the benefit of patients.
- Ensure pro-active pathway management by navigating patients through the system.
- Have robust information that tells you where patients are in the pathway.
- Ensure capacity meets the demand for cancer referrals.

Where are we now?

Our cancer services are provided across two hospital sites serving around half a million people in an area of over 2000 square miles. In order to provide a specialist cancer service for a dispersed population our clinics are provided on a rolling basis between our hospital sites.

Whilst this offers a local service for rapid cancer diagnosis and treatment, some patients choose to wait until an appointment is available at their most local hospital. This means that whilst we are normally able to offer an appointment within the Trust within these waiting time targets, we cannot necessarily offer an appointment at their hospital of choice (i.e. RSH or PRH). We believe that it is important to offer patients this choice, but currently the way in which the national targets are calculated does not allow for patients choosing to wait longer for local treatment.

To address this, we have reviewed all of our capacity in order to ensure that we can offer patients a choice of appointment and site within the 2 week urgent cancer referral time.

There are also a number of patients who have a complex pathway which means they have multiple problems which delay their treatment.

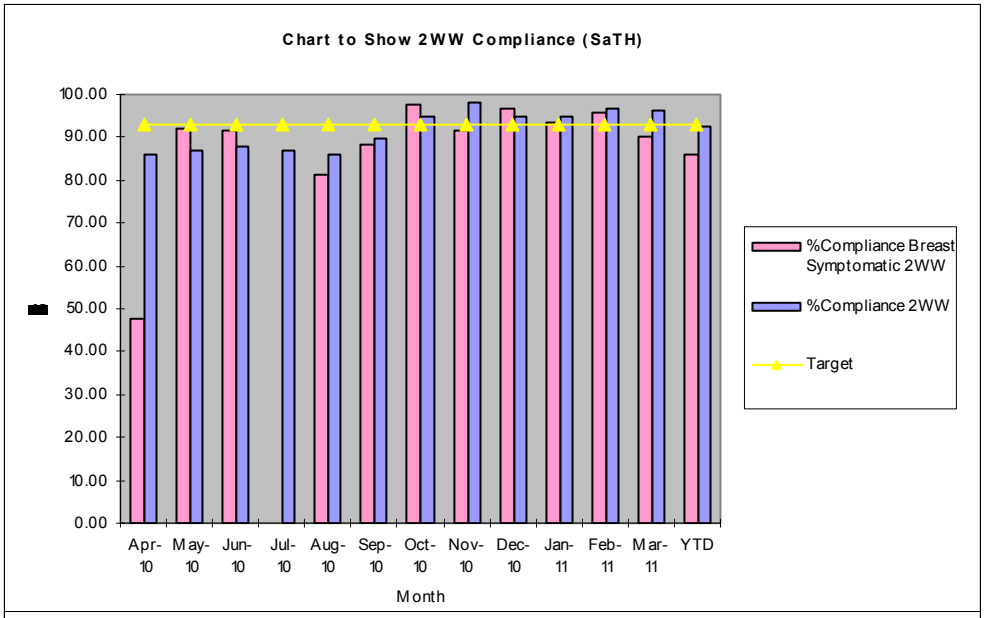
A Service Improvement Manager has been appointed to work with multi-disciplinary teams to redesign pathways for all tumour sites. This work will address delays in the pathway and improve the experience for patients as well as ensuring patients are treated within the target timescales.

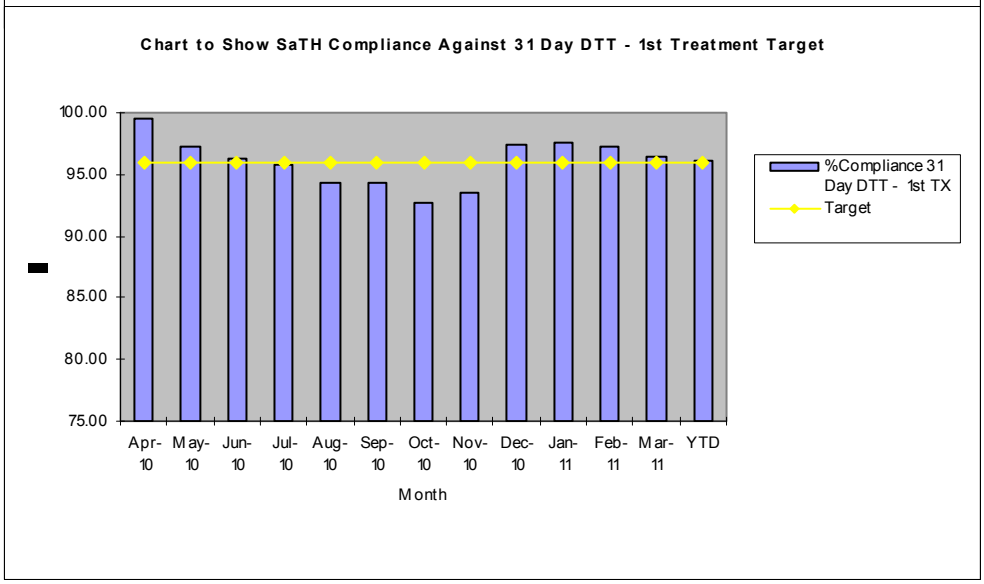
A new Cancer Information Manager has been appointed. His role will be to improve information available to clinical teams, and improve the tracking of patients through their pathway. This will prevent delays and identify areas for improvement within individual patient's pathways.

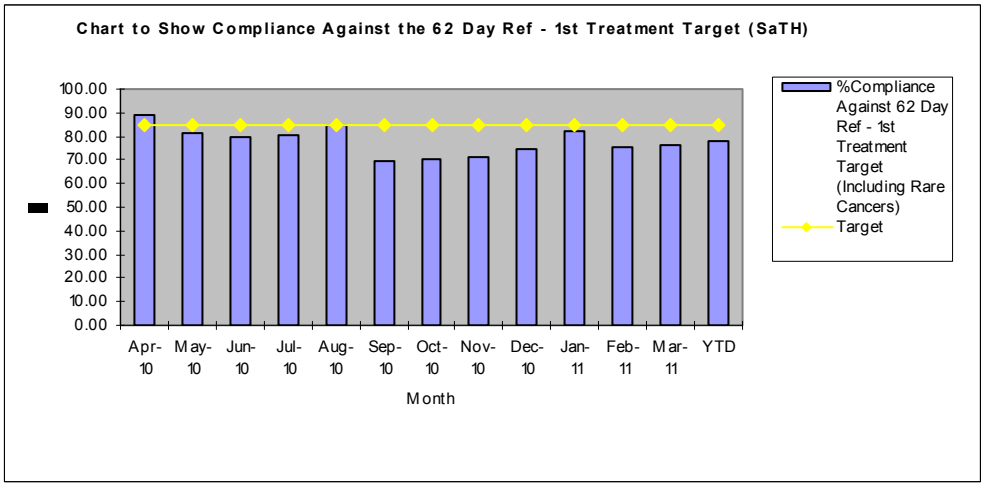
Cancer Waiting Times Performance 2010/2011

The cancer waiting times performance at the Trust during 2010-11 has been improving, but it is clear there is still more work to be done. Work has been undertaken in the department to ensure compliance improves throughout 2011-12 (as stated above and below).

On page 43 is a graphical representation of SaTH NHS Trust's performance against the 2 week wait GP referral to 1st appointment, 31 day Decision to Treatment and the 62 Day Referral to Treatment Target. It can be seen that performance has been improving since October 2010 in all these areas.







What we did well

We have consistently achieved the breast symptomatic target since October 2010.
The Trust has agreed considerable investment to support the cancer service which has meant that 7 new radiographers have been appointed into the Radiotherapy department.
This investment will mean that radiotherapy waiting times and targets will be met in accordance with national guidance.
The Trust has also agreed to appoint 3 new Consultant Oncologists, one of which came into post on 1 February 2011, the other 2 will be appointed by October 2011. This will mean that all patients with a cancer diagnosis who require input from an Oncologist will be able to be seen quicker.
We commenced planning for a new cancer build, which will be complete in 2012. This will provide state of the art accommodation for patients who require oncological care from outpatient appointment to chemotherapy and radiotherapy treatment. The funding for this project has been provided by charitable donations to the Lingen Davies Cancer Relief Fund, the Haematology Fund and the Head & Neck Cancer Fund. The new build will cost in the region of £5M.
We have prepared a business case for a replacement LINAC (Linear Accelerator) for delivering radiotherapy. This will be in place in 2012.
We received positive feedback in the National Cancer Patients Survey (2010) for quality of care in chemotherapy and radiotherapy. Some comments received are detailed below:
The Trust was rated in the top 20% in the country by patients and carers.
We have worked with PCT leads to develop action plans to achieve 14, 31 & 62 day targets consistently from April 2011.

What more do we need to do?

During 2011/12 we need to consistently meet all cancer targets and to continue to improve the experience for patients.
We will continue to redesign all pathways to ensure a seamless service is delivered for patients.
We will continue to improve the information we provide on cancer targets to ensure that the targets are 'owned' at all levels of the organisation and that patients are seen and treated within the target time.
We will appoint to the new posts in Oncology and Radiotherapy to improve waiting times for patients.
We will increase our outpatient and day case capacity for radiotherapy and chemotherapy within the new cancer build in 2012.

3.3.6 Improving Emergency Services and Inpatient Flow

What is the issue and why we did we make this a priority?

The Local Health Economy recognised the need to influence and control urgent care streams into SaTH by the provision of a range of access services in conjunction with the NHS and Social Care partners. However, we also need to monitor referral and admission patterns to optimise patient flow and of course clinical outcomes. We equally need to improve and expedite both 'routine' and 'complex' discharge from hospital to facilitate promptly and appropriately admitting those patients who require inpatient acute care. Internally, we in SaTH need to improve decision making and patient flow in order to improve the quality of the patient experience and overall outcome.

We have made admitting the "right patient, in the right place at the right preferred first time" our strategic priority.

What were our goals during 2010/11?

Our goals during 2010/11 were:

1) The appointment of additional A&E consultants at PRH and RSH
2) To ensure that non-A&E patients are redirected from A&E to more appropriate community services
3) The appointment of additional acute medicine consultants at both sites
4) Modified rostering to improve junior medical input on the medical assessment units
5) The utilisation of the portering tele-tracking system at SaTH to optimise patient movement/ flow in and out of A&E/MAU
6) The implementation of improved control room administration measures to optimise effective and responsive bed management at SaTH
7) The implementation of rapid access clinics on the MAU at PRH, with an eventual roll-out at MAU at RSH
8) To reduce turn-round time on the medical assessment units
    a by improving medical staffing
    b by reducing time for blood tests
    c by reducing time for imaging
    d by introducing a rapid turn-round service for non acute elderly patients
9) To facilitate nurse led discharge on the wards
10) To ensure that the specialist wards can discharge patients into the community in accordance with agreed expected date of discharge (EDD)
11) To work with commissioners to ensure services are available to enable (8)d and (10)

Dashboard Table

	2008/09 Actual	2009/10 Actual	2009/10 % YoY Variance	2010/11 Actual	2010/11 % YoY Variance
A&E Attendees (Acute)	101844	103098	1.23%	106329	3.13%
98% A&E Target (unmapped)	97.06	96.29	-0.79%	94.99	-1.35%
98% A&E Target (mapped)	97.83	97.46	-0.38%	96.94	-0.53%
A&E Admissions (%)	19.31%	20.65%	6.90%	20.11%	-2.60%

What we did well

We placed increasing focus on both improving patient throughput and enhancing patient discharge:

1) The employment of a middle grade doctor in A&E through the night
2) Improved medical and nurse staffing in the A&E departments
3) The introduction of an enhanced system of triage in the A&E departments
4) The employment of patient transfer teams
5) Improved clinical site management/bed management
6) The setting up of bed management control rooms in both hospitals
7) The appointment of an acute medicine consultant at PRH
8) The further development of the discharge lounges at both PRH and RSH

What more do we need to do?

In order to optimise the throughput of emergency medical admissions in A&E and in the hospitals we need to:

1) Optimise the capacity of the medical assessment units
2) Reduce turn-round time for assessment on these units (to less than 24hrs)
3) Ensure that patients can be moved from the assessment units into the community or onto a specialist ward in a timely fashion
4) Ensure that the specialist wards can discharge patients into the community in a timely fashion
5) Improve our discharge planning, processes and patient experience.

A&E Department

- Middle grade shortages is a national issue - other Trusts have found alternative ways of providing this resource including enhanced roles and cover from other specialties within the organisations

- Resolving some of the minor injuries flow issues by exploring new models of working
- Siting of the Acute Referral Centre has a big impact on A&E and needs to be re-examined
- The wider Trust issue of medical outliers has a significant impact on flow through the A&E department and an impact on elective admissions

Priorities for 2011/12

- Continue with the work started in 2010/11 to improve patient flow through the unscheduled pathway across the health and social care economy
- Improve multidisciplinary review and expected date of discharge information to patients and carers
- Ensure senior decision makers are available at the earliest point in the patient pathway

Medical Assessment Unit

- Social care and assessment is a key area that needs to be improved and causes some issues for both the Unit and its patients
- Need to continue to improve the joint working relationship with PCTs to enable seamless transfers for patients

Priorities for 2011/12

- Appoint further acute physicians
- Develop clinics (booked) and ambulatory assessment unit with appropriate therapy support
- Work with commissioners to ensure appropriate community support services are further developed
- Explore the option of CCC as single access point for community support services
- Implement good practice on both sites – e.g. job plans, operational protocols, urgent care pathways

Measures and Targets

The following key performance indicators would enable us to effectively measure the success of the strategic plans and priorities identified above. Details by department are shown below:

<u>A&E</u>

- 4 hour wait
- Median time in department
- Ambulance turnaround
- Initial review in 15 minutes
- Time to see decision maker
- Number of re-attenders in 1 week
- Number who leave before being seen
- Measures around flow (to monitor change)
- Coding accuracy % of coded episodes/% of errors/omissions
- Patients referred by GPs to A&E who should have gone to MAU
- 4 hour breaches due to waiting for beds

<u>MAU</u>

- Re-admission rates
- Delayed discharge to community because of lack community support
- Delayed discharge due to 'no bed'
- LOS
- Acute clinic review patients who should have gone home on the day
- Senior clinical review within 12 hours
- Time waited to see clinician
- Time of discharge

3.4 Trust Wide Information - Learning and Listening

3.4.1 Incident Reporting Across the Trust

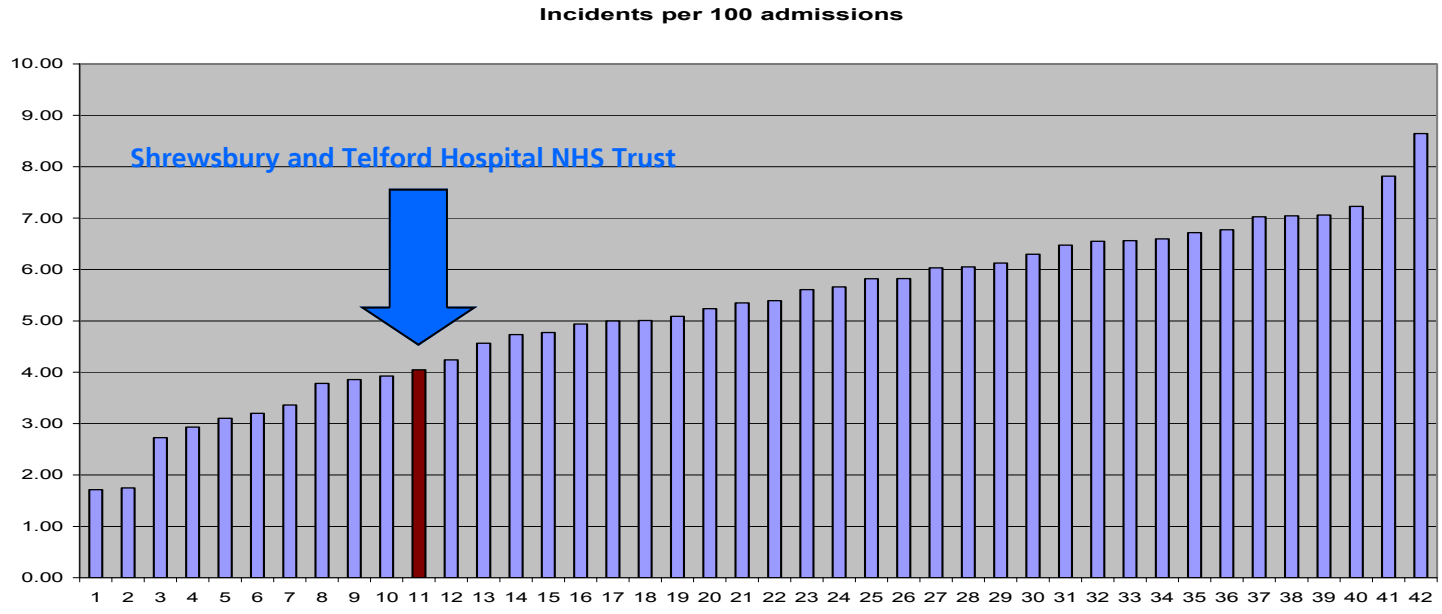
Introduction
It is important that we have a culture where staff recognise the need to report any untoward incident with either patients, staff or environment. By investigating each incident, the organisation can see what they need to improve and also identify trends and themes that need particular focus to improve.

Many of these trends and themes have now been placed as priorities for improvement as set out earlier in this document. Some of these are the improvements required with patient falls, reducing pressure sores and other patient safety issues such as timely response to the deteriorating patient, waiting and access times for treatment.

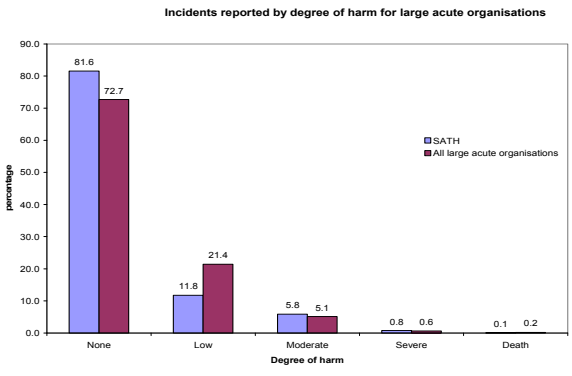
considered good practice. The Trust reported incidents to the NRLS regularly throughout the year. This allows the Trust to compare SaTH's reporting rate to other Trusts within the large Acute Trust cluster.

The number of incidents uploaded to the NRLS is lower than previous 6 months due to delays in processing incidents during 2010, which has now been resolved.

The Trust is launching a " Listening into Action" to ensure that the Trust has a full engagement programme with staff to listen to their views and opinions. We will be able to listen to their concerns and their views about clinical situations and incidents and we will be able to report on this next year.



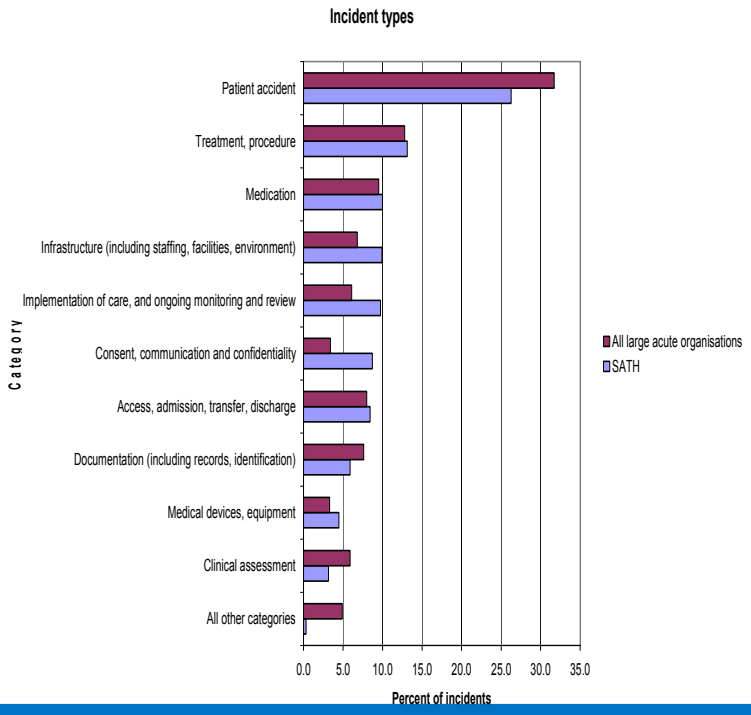
Degree of harm to patients



Nationally, 68% of incidents are reported as no harm and just under 1% as severe harm or death. However, not all organisations apply the national coding of degree of harm in a consistent way which can make comparisons of harm profiles of organisations difficult.

In 2010/11 reporting to the National Patient Safety Agency (via the NRLS) was a voluntary system (except for certain categories of very serious incidents), but is

Incident Type



3.4.2 Workforce—Listening to our Staff

In the last year the focus has been on the following:

- Engaging with the workforce to design a clinically led organisation structure
- Ensuring the right number of staff with the right skills are employed to deliver high quality care to patients
- Ensuring that effective systems are in place for workforce planning

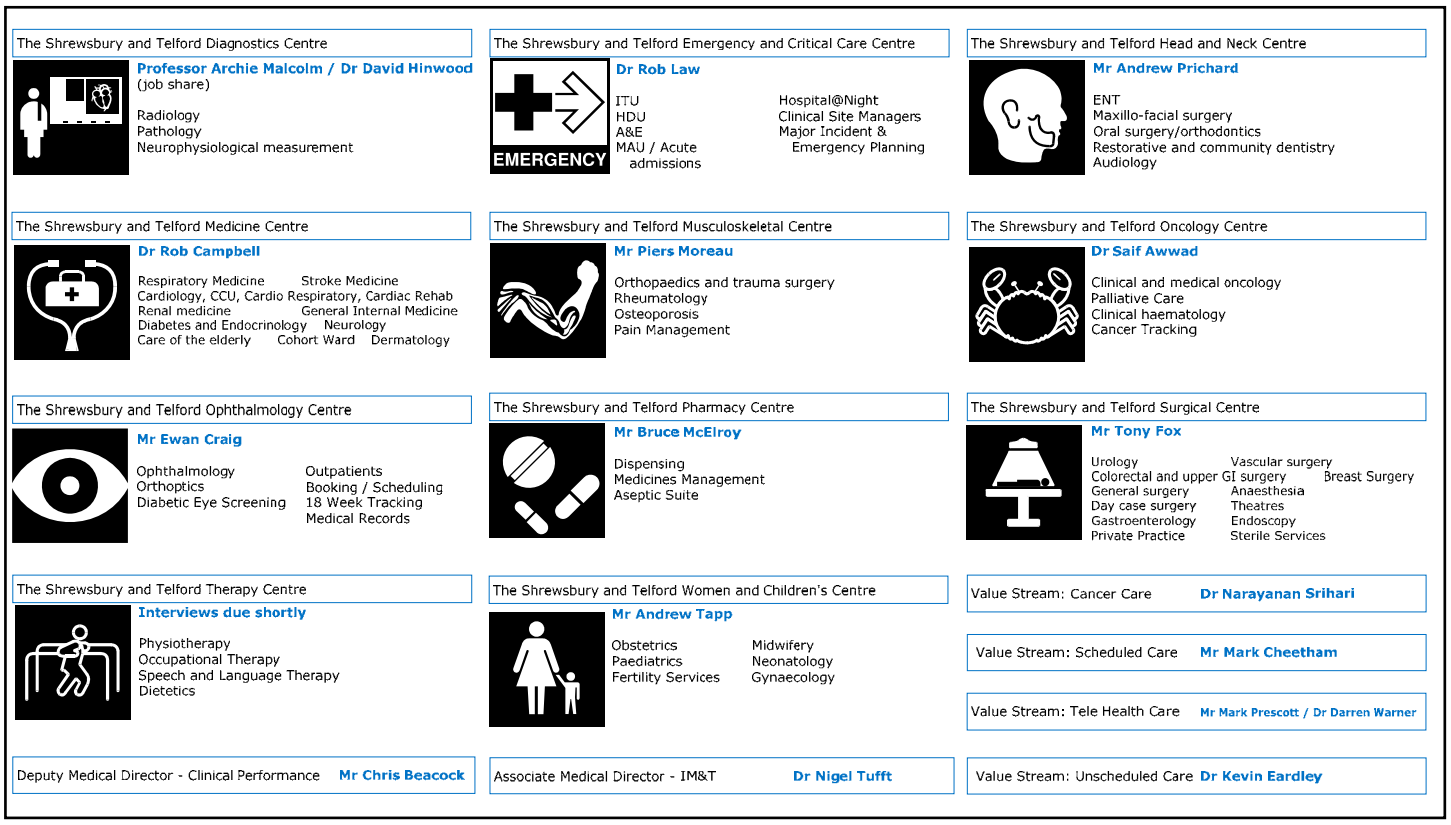
This work will continue in the coming year to ensure that we have the right structure in place with the right people working effectively and efficiently to deliver the best care to our patients

3.4.3 A Clinically Led Organisation

In October 2010, the Chief Executive launched a consultation with all staff about an organisation structure that puts clinical leadership at the heart of the Trust and supports our guiding principle that "Everything we do is organised around putting patients first. Our first thought is always what's right for the patient?"

The Chief Executive ran a number of roadshows and invited everyone in the Trust to comment on the proposal. Everyone who responded personally to the Chief Executive received a personal reply and account was taken of comments in designing the final structure.

The new structure is effective from 1 April 2011 and Centre Chiefs (Senior Clinical Staff) will be supported to develop strong leadership skills through our Leadership Academy and engaging LIPS programme.



Head and Neck Centre	Mr Andrew Prichard, Consultant ENT/Head and Neck Surgeon
Medicine	Dr Rob Campbell, Consultant Physician in Geriatric Medicine
Musculoskeletal Centre	Mr Piers Moreau, Consultant Orthopaedic Surgeon
Oncology	Dr Saif Awwad, Consultant in Clinical Oncology
Ophthalmology Centre	Mr Ewan Craig, Consultant Ophthalmologist
Emergency and Critical Care Centre	Dr Robert Law, Consultant Anaesthetist
Pharmacy Centre	Mr Bruce McElroy, Chief Pharmacist
Women and Children's Centre	Mr Andrew Tapp, Consultant in Obstetrics and Gynaecology
Surgical Centre	Mr Anthony Fox, Consultant and Vascular Surgeon
Diagnostics Centre	Professor Archie Malcolm, Consultant Pathologist and Dr David Hinwood, Consultant Radiologist (job share)
Therapy Centre	TBC

Value Stream Leads

Cancer Champion –	Dr Narayanan Srihari, Consultant Clinical Oncologist
Scheduled Care Champion	Mr Mark Cheetham, Consultant General and Colorectal Surgeon
Unscheduled Care Champion	Dr Kevin Eardley, Consultant Physician in Renal Medicine
Tele Health Care Champions	Dr Darren Warner, Consultant Physician in Diabetes and Endocrinology and Mr Mark Prescott, Consultant in Emergency Medicine (job share)

3.4.4 The Right Number of Staff with the Right Skills Doing the Right Things at the Right Time

The Productive Ward Programme has been developed through the NHS Institute for Innovation & Improvement and this Trust was a Learning Partner for the West Midlands Strategic Health Authority to pilot the initiative. The aims are to release more direct care time for ward staff to spend with patients and to improve the staff and patient experience.
The programme uses the principles of Lean methodology to focus on processes of care delivery to increase efficiency, reduce waste and save time. The roll out at SaTH has now moved onto the process modules, shift handover, medication rounds and meals. All wards have completed the Well Organised Ward module, releasing an average of 15% more direct care time with patients. All wards have also now completed the second foundation module of Knowing How we are Doing where they display graphs to share performance and quality data, such as rates of pressure sores and falls. The aim of this is for ward staff to understand their own rates and to formulate actions plans for improvement where required, linking to the High Impact Interventions and CQUINS.

Four fast track wards are taking the Patient Status at a Glance module down the electronic route, linking to our Patient Administration System, where interactive screens display colour-coded information about patients in a very visual way which not only reduces interruptions when staff are asked for information, but can also improve patient flow.

Most wards have now moved from the traditional shift handover away from the patient to handover at the bedside. The benefits of this have been immense. It greatly improves communication between patients and nursing staff, prioritises care and keeps patients informed as to their plan of care. In most cases it also saves time.

The four fast track wards are now working with pharmacy on improving medications rounds, and two other wards are working with dietetics and catering to undertake the meals module, both of which involve protected time. The benefits respectively are reducing drug errors and improving nutrition of patients.

The NHS Institute for Innovation and Improvement say that the Productive Ward programme improves outcomes and quality of experience for patients and delivers significant cost savings. The key to its success is that improvements are driven by staff themselves, by empowering them to ask difficult questions about practice and to make positive changes to the way they work. The process promotes a continuous improvement culture and underpins the quality agenda and improvement for our patients.
We have introduced e-rostering for nursing staff and are currently undertaking a project to align work schedules of our medical staff more closely with patient needs. This work has already led to increased efficiency and enhanced the patient experience. By rolling these processes out across the organisation over the next year, we will be able to ensure that the right staff with the right skills are treating patients at the right time and in the most efficient way.

3.4.5 Effective Workforce Planning

This year a new model of business planning has been introduced which ensures that workforce planning is fully integrated into the process so that we can ensure that in the short and long term the appropriate staff with the right skills are available to deliver care throughout the patient journey. We are also developing programmes of work to determine workforce models that will deliver care in the most efficient and effective way. This will result in the development of new roles.

3.4.6 Staff Training and Support

Staff education and training is a key component in the organisation's ability to ensure consistently high quality patient outcomes.

During 2010-11 we:

- ensured that over 80% of our staff had an annual appraisal with their line manager
- increased the attendance at patient and personal safety training from 62% to 70% of all staff
- enabled over 79% of staff to take up opportunities for work-related training and development
- enabled 150 staff to complete vocational qualifications in subjects such as Care, Physiotherapy and Occupational Therapy support and Clinical Laboratory support.

During 2011 we will:

- Provide tailored support for our new clinical leads in the form of Leadership and Improvement Academies
- Ensuring staff have improved access to information and data about new research and developments in clinical care
- Concentrate on providing education opportunities for staff which can be clearly demonstrated to impact positively on patient care, such as Leading Improvements in Patient Safety
- Improve our attendance at patient and personal safety related training
- Improve the impact of annual appraisals on staff performance
- Enable more staff to access learning and development via e-learning
- Support changing clinical roles to be effective

3.5 Learning from our Patients and Staff

3.5.1 A Listening Organisation

Following his arrival as our new Chief Executive in July 2010, Adam Cairns led a process of engagement across the organisation to hear from staff about the challenges they faced to deliver patient-centred care and the ways that the organisation needed to change and improve to support them to do this. This included interviews, focus groups, open staff briefings and a conference for nearly 200 members of staff, patient representatives and partners in September 2010. The conference was an opportunity to consolidate the issues that had been raised during the listening process and agree the key themes going forward. This resulted in an agreed programme of organisational transformation through Devolution and Cooperation. The key features of this are:

- Clarity about who is responsible and for what: everyone will know who to ask if they need a decision about an issue they cannot decide for themselves.
- Being very clear about roles and responsibilities.
- Speeding up decision making, eradicating unnecessary meetings, doing a better job of communicating (everyone must play their part in this).
- A focus on action: the outcome of decision making is not a decision – it is implementation.
- A clinically-led organisational structure, with lead clinicians (Centre Chiefs) having responsibility and financial accountability for setting the direction for the delivery, quality and safety of the clinical services they provide to patients.

Clinician champions (Value Stream Leads) for the different journeys our patients take through our services (scheduled care, unscheduled care, cancer care, tele health care).

A major milestone was reached on 1 April 2011 when the Centre Chiefs and Value Stream Leads came into post. This provides the foundations to achieve our priorities for 2011/12, which include completing and embedding the new clinical leadership and management and delivering the organisational development programme that will realise the intended benefits for patients.
Many of the actions outlined in the first part of this Quality Account have been placed as a priority as a result of listening to patient and family feedback and from staff-reported patient safety incidents.

3.5.2 Workforce Metrics

The results of the 2010 Staff Survey have been published in the last month.

71% of respondents indicated that they were feeling satisfied with the quality of work and patient care that they are able to deliver, representing a 4% increase compared with last years figures. However, there has been a 3% decline in the number of respondents agreeing that their role makes a difference to the patients (down from 89%).

The Trust scored average (compared with other Trusts) in relation to staff feeling that they were working in a well-structured team.

99% of respondents indicated that they had reported errors, near misses or incidents witnessed in the last month. This compared with a national average of 95%. However, there has been a 3% increase, compared to 2010 results, in relation to the number of respondents witnessing potentially harmful errors, near misses or incidents in the last month.

The number of respondents working extra hours has reduced marginally to 67%, compared to 69% in the previous survey. This is also echoed with an improvement on last year's figures, in relation to the Trust's commitment to work-life balance.

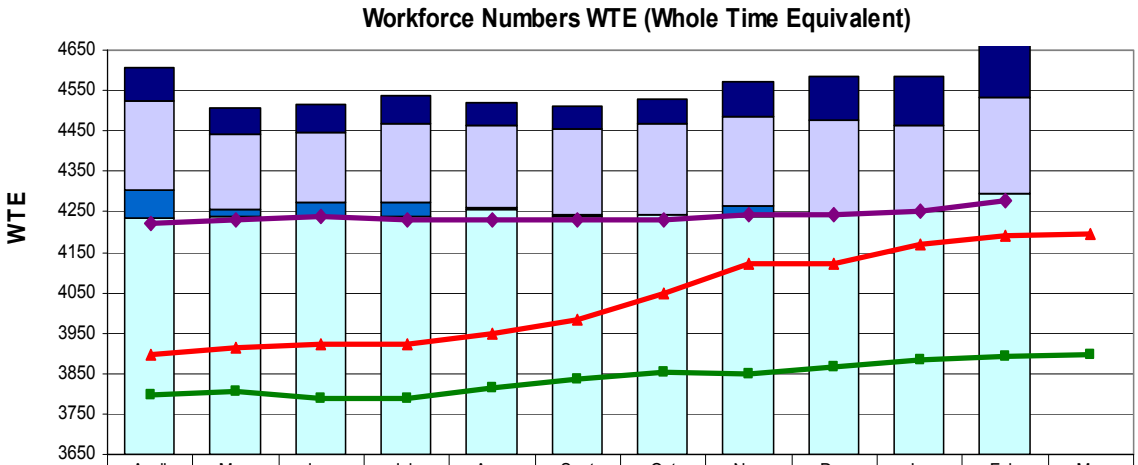
However, the results also indicate that staff job satisfaction and motivation has decreased within the Trust over the last 12 months. In addition, the staff experience has deteriorated with more staff intending to leave their jobs and an increase in relation to the work pressure felt by staff. Communication between senior management and staff remained consistent with last year's figure of 17%, however, this figure is significantly below the national average for acute Trusts at 26%.

Despite previous increases in nurse staffing levels, bank and agency usage has increased and staff sickness absence has risen. This is likely to be due to activity, uncertainty around both internal restructuring and countywide reconfiguration of services.

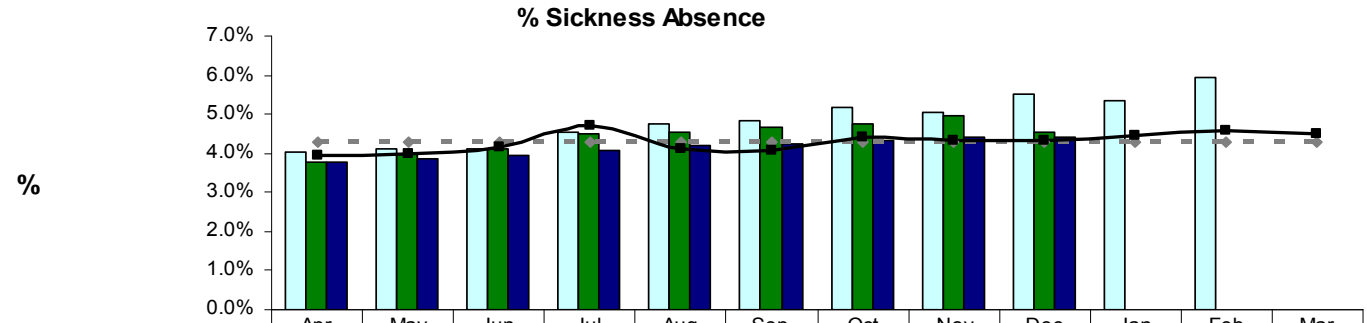
During the next year we will be putting in place measures to enable management to measure and monitor workforce issues so that efforts can be targeted more effectively to resolving specific problems.

Turnover year to date = 8.4% against 8.1% in previous year.

The Trust is implementing a major staff engagement process in 2011/12 called "Listening into Action" to ensure that all staff in clinical and non clinical departments have an opportunity to raise issues of concern or that need to be addressed and the lead clinicians (Centre Chiefs) and Executive team will work to resolve these. This process and other key actions will form the Trust response to the improvements required for staff who work for us.



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual Worked Agency Staff WTE 2010-11	83	68	69	70	56	55	62	87	106	121	141	
Actual Bank Worked WTE 2010-11	221	183	174	193	204	214	223.1	222	235	212	237	
Staff Utilised WTE 2010-11	67	19	38	37	6	2	-9	25	-20	-30	-35	
Contracted Staff WTE 2010-11	4235	4239	4237	4237	4255	4240	4245	4240	4243	4253	4297	
Total Staff 2010-11 (Excluding Bank WTE)	4220	4232	4239	4229	4231	4230	4231	4245	4242	4253	4279	
Total Staff 2009-10 (Excluding Bank WTE)	3898	3914	3921	3923	3950	3985	4047	4122	4120	4169	4191	4196
Total Staff 2008-09 (Excluding Bank WTE)	3796	3805	3790	3789	3814	3835	3852	3847	3865	3882	3893	3895



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
%2010-11	4.0%	4.1%	4.1%	4.5%	4.7%	4.8%	5.2%	5.1%	5.5%	5.3%	5.9%	
%2010-11 Validated	3.8%	4.0%	4.1%	4.5%	4.5%	4.7%	4.8%	5.0%	4.5%			
%2010-11 YTD Validated	3.8%	3.9%	4.0%	4.1%	4.2%	4.3%	4.3%	4.4%	4.4%			
% 2009-10 Average	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
% 2009-10	4.0%	4.0%	4.2%	4.7%	4.1%	4.1%	4.4%	4.3%	4.3%	4.5%	4.6%	4.5%

3.5.3 What Patients Say About Us - CQC Annual Inpatient Survey

Learning from comments, complaints and compliments

During 2010/11 a number of changes were made to the approach to dealing with complaints focusing on a patient-centred approach. More complainants were offered and accepted opportunities to come into the Trust and discuss their concerns. In 2009/10 27 complainants opted to come in for complaints meetings and in 2010/11 this rose to 46.

	2009/10	2010/11
Total Number of Complaints	728	702
Response within statutory 6 month deadline	100%	100%
Referrals to PHSO for independent review	6	7
PHSO referrals Upheld against the Trust	1	0

Top 3 Complaint categories	**2009/10**	**2010/11**
Inadequate medical care	128	104
Waiting times for an appointment	96	93
Attitude	66	78
Top 3 Areas for Complaints	**2009/10**	**2010/11**
Outpatients	149	196
A&E	81	63
MAU RSH	30	32

Ratio of complaints to activity

Quarter 1	**2009/10**	**2010/11**
Patient Activity	121,957	131,231
Number of complaints	172	172
Rate per 1,000 episodes	**1.41**	**1.31**
Quarter 2	**2009/10**	**2010/11**
Patient Activity	132,508	132,692
Number of complaints	156	201
Rate per 1,000 episodes	**1.18**	**1.51**
Quarter 3	**2009/10**	**2010/11**
Patient Activity	124,997	131,626
Number of complaints	195	157
Rate per 1,000 episodes	**1.56**	**1.19**
Quarter 4	**2009/10**	**2010/11**
Patient Activity	128,998	138,279
Number of complaints	205	172
Rate per 1,000 episodes	**1.59**	**1.24**

Trends picked up through the complaints process highlighting hotspots within the Trust led to improvements being made. A prime example of this was seen within the appointments department where in quarters 1 and 2, 69 complaints had been received. Improvements made brought a reduction in the second two quarters of the year to 24. It is anticipated that improvements will bring about a reduction in the number of complaints next year. The last two quarters highlighted some concerns over patient discharge, which are currently being investigated. Whilst the number of complaints has not increased this year in comparison to last year, the severity of the concerns has increased, particularly with regards to the safety of the discharge.

This year the two main areas of concern were medical care and attitude of staff. The Trust offers a Customer Services Training Course which staff are able to attend and Ward Managers can send staff to attend as part of their learning and development. This will be an important area to address in the forthcoming year, as the number of complaints in this area has increased since last year. With regard to the inadequate medical care, investigations often appear to show that the medical care received is often correct, however due to poor communication with the patient about their care this leads to misunderstandings and subsequent complaints being received. Although this has improved since last year in terms of numbers of complaints, it is still clearly an area which needs improvement.

The Trust aimed to share patient stories with the Quality and Safety Committee, introduced in 2010, with an aim to increase these during the forthcoming year. This will enable the Committee to gain an understanding of patient experiences and establish any areas which may require improvement within the Trust.

The Trust supports feedback on its services through a number of methods including via the NHS Choices website, the Trust website, the PALS service and more recently through the introduction of comments cards which have proven to be a very popular mechanism. The cards allow patients to make a compliment, concern, comment or complaint and these can then be fed back to the relevant departments. Over the last quarter of the year there has been an increase in the amount of these received as a feedback method or to raise a formal complaint. We anticipate that this numbers will continue to rise in the next year.
There were 224 complimentary letters acknowledged from the Chief Executive's office.

	Letters	Donations	Gifts	Total
2009/10	1399	121	1905	3425
2010/11	1368	105	2012	3485

Below is a selection of comments from some of the letters received:-

'Having spent the last 5 days in PRH I wish to say as an ex-nurse I am proud of the staff, the care and standards within our NHS hospital'.

'During her stay she was at all times treated, by all levels of your nursing and support staff, with the ut-most care, kindness, respect and boundless patience for which I and our family will always be grateful – not forgetting your catering team who produced attractive and varied meals'.

'Housekeeping, H.C.A.s, porters, nurses and doctors were all totally dedicated, professional and yet very caring. This was commented on by everyone who visited. Ward 23N is a shining example of the NHS'.

'I really wanted to comment on the quality of the meals I was served during my stay especially after recent media reports. I was really impressed with all the food I received. I was determined to eat everything nutritious to aid my recovery but also found it tasty and enjoyable'.

'…. To take this opportunity to acknowledge the wonderful care she received whilst in the hospital and to formally thank all of the staff involved. My mother was given excellent care and as a family we were given regular updates regarding her treatment and progress'.

'The treatment I received all the way through by each and every member of staff was exemplary and would like to thank them for their care. The hospital should be extremely proud of the staff whose professionalism and humanity are exceptional'.

'I am writing to thank both surgeons and all their support staff for the care and consideration and the very professional manner in which this surgery was carried out. The nursing staff were very reassuring and comforting both before and after the operations and the tea and toast was most welcome!'

'I feel I have had the best possible treatment from the Gynaecological Department and I am very grateful. The nurses were so friendly and pleasant, encouraging me every step of the way'.

'The standard of cleanliness was quite excellent everywhere with a friendly team of cleaners'.

Below is a selection of comments from complaints letters received:-

"It really is frustrating…what is the point of an appointment system if you never stick to it".

*"He did later say while examining her that she was thin. The damage had already been done for myself and ****, we felt like an inconvenience to this Consultant and not worthy of his time."*

"Even though other medical emergencies may have arisen during this time which the ambulance may have been needed for, I find it unacceptable that delays such as occur when they could have been quite easily avoided with just a simple level of competent communications between all parties involved."

"Hopefully he will be reprimanded for what was a totally incorrect and unkind way to deal with persons such as myself, who are unfortunate enough to suffer from permanent incurable disabilities, often generating insupportable levels of pain."

"…had to wait over 5 hours for a commode/ toilet which caused some discomfort and she had to face staff who seemed less that happy to have to assist"

"I would like to think that this would not happen to me again, however, I hold no confidence in this and feel that I have to write this letter as how I was first treated for the first three hours of my stay was totally inept. If I had been on my own, god knows how I would have coped or even managed to find a nurse or a doctor to see me."

"Altogether a very unpleasant, upsetting and distressing experience which has made me fearful of continuing with the procedure."

"We were surprised she had been discharged as she certainly had not seemed well enough on the previous evening"

"Patients who are not mobile, just get left or left unaided. No one seems to take or want to take responsibility."

"She started shouting at me…..by this time I was in tears and she said she may let me go sometime over the weekend"

CQC Annual Inpatient Survey

	Domain	How this score compares with other Trusts in England
7.6/10	The emergency / A&E department, answered by emergency patients only	ABOUT THE SAME
6.4/10	Waiting lists and planned admissions, answered by those referred to hospital	ABOUT THE SAME
7.7/10	Waiting to get a bed on a ward	ABOUT THE SAME
8.1/10	The hospital and ward	ABOUT THE SAME
8.4/10	Doctors	ABOUT THE SAME
8.4/10	Nurses	ABOUT THE SAME
7.2/10	Care and treatment	ABOUT THE SAME
8.3/10	Operations and procedures, answered by patients who had an operation or procedure	ABOUT THE SAME
6.7/10	Leaving hospital	ABOUT THE SAME
6.4/10	Overall views and experiences	ABOUT THE SAME

Results from the CQC Annual Inpatient Survey have been published. An initial review of the ratings identified that we score similar to other hospitals across England and that we have scored marginally higher on overall standards of care in our hospitals in 2011 compared to 2010. However the surveys have identified areas for development and opportunities to learn and improve on the standards of care we provide.

The key areas for development are:-

- Reducing the disturbance of noise at night for patients
- Ensuring patients have an opportunity to talk to a doctor about their condition
- Responding to patient call bells more promptly
- Supporting patients with meals
- Patients being involved in decisions about their care and discharge planning
- Ensuring patients are provided with information on discharge

3.5.4 Patients View on Our Environment

We are pleased with the excellent rating received for both cleanliness and privacy and dignity but recognise that although the quality of food delivered to patients on both sites was deemed excellent more work needs to be done to fully implement a protective mealtimes programme within the Trust. This work is underway and therefore we are confident we are able to achieve excellent for food in the 2011/12 assessment

The formal PEAT assessments were undertaken on 4 February 2011 at RSH and 1 March 2011 at PRH. A patient representative was on both assessments and an external validator also accompanied the team during the RSH inspection.

The results of the assessments are announced to Trusts and on the NPSA website each year around mid July.

The results of the 2009/10 Patient Environment Action Team (PEAT) Assessments are detailed below:-

Area of Performance:	**Environment and Cleanliness**
Metric (Method of Calculating Performance):	Environments/Cleanliness as assessed by the Environment Action Team (PEAT) including a Patient Representative and PEAT Validator
We are pleased to report the following scores for Environment, Food and Privacy and Dignity for 2010/11 for each of our sites	

Site Name	**Environment**	**Food**	**Privacy & Dignity**
Royal Shrewsbury Hospital	Excellent	Good	Excellent
Princess Royal Hospital	Excellent	Good	Excellent

3.6 Statements from Local Involvement Networks, Health Overview and Scrutiny Committees and Primary Care Trusts

Telford & Wrekin Local Involvement Network

Over the last twelve months Telford & Wrekin LINk has spoken with more than 300 patients about their experience of acute healthcare during visits to more than 30 wards at the Royal Shrewsbury Hospital and Princess Royal Hospital. Their views and those of a further four thousand members of the public who took part in surveys, focus groups and public meetings about ophthalmology, renal and maternity services and consultations about the future reconfiguration of acute, community and mental health provision have been used to inform our response to the acute Trust's Quality Account for 2010/11.

In relation to the update on progress made with last year's priorities, we can affirm that even though the incidence was already low, many members of the public supported the continued emphasis on reducing hospital acquired infections, and were reassured by how quickly this was achieved. The overall approach to infection control by the hospital is often praised by patients who mention being reassured by the high standard of cleanliness on the ward and use made by staff of gel hand wash, for example.

We can also concur with the Trust that its efforts to improve nutrition have been effective as most patients report that the quality of food served is very good, although more needs to be done to improve menu choice for people from other cultures. We are pleased that improvements to the way that patients who need assistance have been identified as a priority for 2011 but are dismayed that the red tray system is not already established as we had been advised that it was in place.

The focus on dignity and respect is also making a difference to the quality of care being provided as the majority of patients we spoke to confirmed that they are being treated well and that regard to their personal privacy is good.

Feedback from more than a hundred renal patients who took part in a LINk survey were especially complimentary about the quality of care they receive; they did, however, request that more investment is made in home dialysis treatments and also asked that dialysis patients are given better psychological preparation prior to treatment commencing and that support is offered to people waiting for a transplant, so we are pleased that the Trust has identified this in one of its statements of reassurance.

Some concerns have also been expressed by people from minority ethnic groups, people with learning disabilities, adults with sensory impairment and also people with underlying mental health conditions about the lack of awareness of their needs some perceive to be discriminatory. For this reason we would like to see a broader programme of staff training to ensure greater awareness of equalities and cultural needs, with which we are happy to assist. The Trust may also like to consider demonstrating its commitment to accessibility by making the Quality Account available in Easy-Read, Braille and audio formats.

Individual patients and carers who did identify concerns about the quality of care provided told us they were not willing to make a formal complaint because they feared retribution, or because they did not believe that the hospital would take their complaint seriously.

We would endorse the priorities identified for 2011/12 as being good choices as the improvements identified are achievable if the focus is placed on improving the quality of basic nursing care. However, we do feel that the year-on-year improvements identified lack urgency and would ask the Trust to aim higher.

We are also concerned that no reference is made to safeguarding arrangements for vulnerable adults or to the implications of the Mental Capacity Act in relation to the deprivation of liberty safeguards and would like the Trust to use its Quality Account to provide reassurance that systems are in operation so that activity can be monitored and reported throughout the year.

In reviewing progress made in 2010/11 our conclusion is that the progress made to patient care and safety in 2010/11 has been quite limited prior to autumn 2010; however, we are confident that the new CEO and Executive team have started to address the need to improve with enthusiasm and determination. We believe that the pace and scale of change demands closer and more frequent scrutiny by patients and their representatives and would like to explore how the local involvement networks could set up patient panels to help to monitor improvements throughout the of the year, in preference to simply commenting on them at the year end. As such a role would be entirely consistent with the changing function and purpose of the LINk as it evolves into local HealthWatch we hope that the Trust will enable us to help them to 'put patients first'.

Community Involvement in Care and Health Ltd

As CInCH - the Shropshire LINk we thank you for the level of our involvement in your Quality Accounts Process and are grateful for involvement in this year's accounts.

Patient Safety - We have concerns about both falls and pressure sores and these have been identified by contact with patients and carers/relatives. We hope for significant improvements in both of these areas. The LIPs programme is an important part of improvement in patient safety and we hope it will prove to be a key tool.

Patient Experience Dignity in Care - Another area where we have had contact from patients and carers/relatives complaining of poor quality of care particularly of the frail, elderly and confused and very poor communication with carers/relatives.

Nutrition - This is a subject of complaint to us. We hope to see the introduction throughout the Trust of the Red Tray System and protected meal times. It does need careful monitoring on the wards as currently it can take some time before problems are recognised.

Care delivered to Dementia Patients - This is again a subject of complaint to us and an area where contact with carers/relatives is very important as they can give so much information about the patient where the patient is unable to speak for themselves. The reduction in inter-hospital transfers is very important as these can have a very detrimental effect on the patients.

Patient Access - We are hoping for a clearer, more effective appointments system with a considerable reduction in cancelled appointments. We are very pleased that there will be a special focus on these areas to ensure significant improvements in care.

Reducing Delayed Discharges - We are representing the patients' viewpoint on both Delayed Transfers of Care Group and a Task & Finish Group which report to it. We commend the significant work in integrating all the partners involved in this work (clinicians, GPs, therapists, PCT, mental health, social services and private sector) which hopefully will make a real difference in this area.

Participation in Clinical Research - A member of CInCH sits on the Research & Development Committee and monitors the work in this sector.

Reducing Health Care Associated Infections- We hope the success to date will be continued.

Workforce- We are concerned at the result of the staff survey showing that the staff job satisfaction and motivation had decreased and that their experience has deteriorated. This is likely to affect the patients' care. This is demonstrated in the increase in complaints about staff attitude. We hope that the Trust will focus on improving this area as we see it as a key to improvement in patient care. The measures referred to should be addressed as a matter of urgency.
We are very happy about the recruitment of clinical staff which will bring about a reduction in time spent waiting for treatment.

Shropshire County Primary Care Trust & NHS Telford & Wrekin

Shropshire County Primary Care Trust (PCT) and NHS Telford & Wrekin commissioning organisations jointly monitor the quality and performance of the services delivered by the Trust. We use various methods including service user feedback, patient and staff surveys, complaints, compliments, performance and governance data and monthly Clinical Quality Reviews attended by clinicians and managers from all the organisations.

Based on the knowledge that commissioners currently have of The Shrewsbury and Telford Hospital NHS Trust, we believe that the information contained within the Quality Account is reflective of both the challenges and achievements within the Trust over the previous 12 month period.

The PCTs are currently working with clinicians and managers from the Trust and local service users to continue to improve services to ensure quality, safety, clinical effectiveness and the patient/carer experience is delivered across the organisation. We feel the Quality Account demonstrates the commitment of the Trust to improve its services.

We agree with the information given by the Trust regarding its partial achievement of the contractually approved 'Commissioning for Quality and Innovation (CQUIN) Scheme' for 2010/11. This was due to their failure and only partial achievement of a number of the elements of the scheme. Both PCTs acknowledge the declarations of the Trust to improve clinical care and outcomes for patients and have agreed a CQUIN scheme for 2011/12 with the Trust that supports a range of quality initiatives.

The PCTs recognise and support the priorities identified for future improvement and the planned reconfiguration of services. We acknowledge the need for partnership working and will continue to offer support to the Trust where appropriate to achieve its aims and ensure the quality, safety and effectiveness of clinical care. Whilst also recognising our obligation to continue to hold the Trust to account for the standard of services it delivers.

Other Comments

We welcome the approach taken by the Trust to act on both positive and negative feedback from patients, carers and other stakeholders such as complaints, compliments, surveys and serious incidents. We look forward to the Trust sharing how they have used the learning to improve services and patient experience.

We would welcome the opportunity to have involvement at an earlier stage along with other stakeholders in the development of future Quality Accounts

Accuracy of Information

The PCT has taken the opportunity to check the accuracy of data provided within the Quality Account in relation to the services commissioned from the Trust and believes it is a true reflection.

Shropshire Council Overview and Scrutiny Committee

The Shropshire County HOSC (Health Communities Scrutiny Committee) is pleased to receive the Quality Account's statement from SaTH.

The Committee agrees with the 3 selected priorities for improvement i.e. safety, patient experience and effectiveness.

Preventing avoidable pressure ulcers and achieving year-on-year reduction in falls will not only benefit the patient considerably it will also cut the length of time the patient stays in hospital to the satisfaction of both the hospital and the patient.

Improving dignity in care and the improvement of care of older frail patients is indeed a high priority as is the improvement in care delivered to patients with dementia or reduced capacity.

Improved patient access and waiting times along with reduced delayed discharges have long been a problem in Shropshire and it is hoped that good communications is set up with whole Shropshire Health and Social Services Economy.

It is good to see that with the leaner ward initiative of extra staff times can be used to support the welfare of patients and meal protection times will be used to assist less able patients to enjoy their meals.

There are targets for the reduction of grade 3 and 4 pressure sores, inpatient falls and the prevention of venous thromboembolism and it will be pleasing to see these improved over 2011/12.

Plans for improving the patient experience and the effectiveness during 2011/12 appear to be well thought out and should bring about many positive changes, particularly around the sharing of information on discharge dates with family and planning with the LHE and the LA for a successful discharge. In this respect communication and planning needs to be encouraged and started as soon as possible after admission.

The Committee likes the idea of a quality improvement strategy during 2011/12 but would wish to know how public participation will be sought and engaged.

SaTH has been subject to many audits and inspections during last year and appears to have had good results (page 15, 16, 17, and 18) and it is good to see that the Trust uses the experience and feedback from these to improve further the services and conditions that they offer.

The CQUIN goals, both national and local, appear to be based on sound principles and that 2010/11 were partially met. In 2011/12 with measures in place we are confident the Trust will improve on these goals. It is reassuring to see that the Trust was not subject to any enforcement by the CQC during 2010/11 and that the Trust has responded to the concerns of the CQC in matters of staffing (4) and welfare of service users (13).

The Trust has made massive improvement in infection prevention and control in 2010/11, improving on the targets sets for both MRSA - 82% and C.difficile -14% reductions in their set targets. This is indeed very good news and leads to greater confidence in the Trust.

Improving stroke services to the 800 people treated each year with admission to a stroke unit within 4 hours of arrival at hospital for confirmed stroke is an important CQUIN standard and the aim to have this at both RSH & PRH, where patients can be put on the appropriate care pathway, is a positive move.

The formation of the Mortality Group, using the Leading Improvements in Patients Safety Programme (LIPS) is to be applauded, as is the approach to improve the cancer targets.

The complaints target remains fairly static. It would be interesting to see how complaints compare to a similar sized DGH.

The Scrutiny Committee is concerned about the staffs' attitude to job satisfaction and motivation levels and the staff experience decrease during the last 12 months. It is to be hoped when the reconfiguration of the Trust beds in, together with the improvements stated in this Quality Account take effect, morale will rise and job satisfaction will return. However we are concerned that despite the increase in nurse staffing levels, bank and agency usage has increased and the sickness levels appear to be high in the last half of 2010/11.

The Committee is pleased with the aims of the Trust within this Quality Account and look forward to the implementation of the plans that are contained within it. We also look forward to the Trust's success and to working with the Trust in 2011/12.

Telford & Wrekin Council Overview and Scrutiny Committee

The majority of the work undertaken by Telford and Wrekin HOSC during 2010/11 focused on the proposed reconfiguration of the services provided by SaTH at both the Princess Royal site in Telford and Wrekin and the Royal Shrewsbury site in Shropshire. This work has been undertaken through the Joint HOSC with Shropshire Council and it has therefore been decided to submit a joint response to the SaTH Quality Account. In line with the guidance for HOSCs the Committee has restricted its comments to issues we scrutinised directly.

Reconfiguration of Hospital Services

SaTH informed the HOSC during the pre consultation period of the concerns the Trust had around:

- The fabric of the maternity building at the Royal Shrewsbury site and the risk this posed for future service provision
- The sustainability of two inpatient paediatric sites
- The sustainability of inpatient surgery across two sites

The Joint HOSC met formally on 3 occasions during the consultation period to consider evidence of the risks in the current model of service provision and the risks and opportunities in the proposed service reconfiguration. The Committee came to the view that the risks in the current model were such that maintaining the status quo was not an option. Members did question the level of risk and if urgent change would be required to mitigate these risks. The Joint HOSC was informed that it was important to plan service changes as part of the wider reconfiguration and it was unlikely that services would move between sites within the next 12 months. The Joint HOSC welcomed the open approach taken by SaTH during the consultation and was satisfied that the Trust had started work to develop the clinical pathways that would maintain effective and safe services in the county. Members were pleased to hear during the consultation process of the developments to introduce thrombolysis and AAA screening at the Trust. The Joint HOSC will continue to monitor the development and implementation of the reconfiguration to ensure that the concerns raised by local people are addressed.

Modernisation of Mental Health Services

The Joint HOSC has also considered the proposals to modernise mental health services in Shropshire and Telford and Wrekin. While the majority of the acute service provision is provided by the South Staffordshire and Shropshire Healthcare NHS Foundation Trust members of the Committee did also consider the mental health needs of patients receiving treatment at SaTH. Members were reassured that SaTH and the Mental Health Trust were working together to ensure that staff had the appropriate training to meet patients' mental health needs.
Members are further assured that SaTH has identified improving the care delivered to patients with dementia or

reduced capacity as a priority for 2011/12. Members understand that a major programme of staff training has been initiated to improve care for patients who have or possibly show symptoms of dementia. We commend the Trust for undertaking this as part of the local implementation of the National Dementia Strategy. We also note and support recent initiatives to address the issue of the dignity of patients.

Hospital discharge

Members for Telford and Wrekin HOSC attended a meeting of the Shropshire Council Healthier Communities Scrutiny Committee at which SaTH and other local NHS organisations responded to issues raised by the Shropshire LINk (CInCH) report into hospital discharge. The Telford and Wrekin Members who attended the meeting were assured that SaTH had taken this report seriously and were addressing the concerns raised. The Telford and Wrekin Members would like to see further work undertaken on the following points:

- Ensuring that vulnerable people who are discharged (e.g. elderly people who live alone, homeless people) have appropriate support once discharged and that services are joined up with the local authority and partner organisations.
- That clear information is given to patients on any changes to their prescriptions and medication and that this is communicated effectively to GPs and community services. Steps should be taken to ensure that medication that is no longer needed or out of dates is disposed of safely.
- That complaints received by the Trust as well as being responded to individually are also analysed to identify trends and underlying issues that need to be addressed.

Bereavement Support and Maternity Services

Members support the inclusion of the CQUIN regarding improving bereavement support within the maternity service. Members recognise the importance of providing appropriate support for all the family under these difficult circumstances. It was suggested that this work could be joined with the work following the scrutiny recommendations regarding bereavement support at schools.

Infection Control

Members were pleased to note the reduction in healthcare associated infections but will continue to monitor the rates of C.difficile.

Ophthalmology services

Telford and Wrekin HOSC received information during September 2010 that the PCT was working with GP practice-based commissioners to establish additional provision for ophthalmology services to reduce waiting times. It was confirmed that SaTH would provide this service at a new facility and members of the HOSC were satisfied that the proposals would improve the service to local people.

Section 4: Looking Ahead

Our second Quality Account sets out progress to improve quality, as well as areas where significant improvement is still required.

Our Quality Priorities for 2011/12, accompanied by CQUIN targets agreed in our contract with local commissioners, will support the local NHS to work together to make meaningful changes that will improve patient experience, safety and effectiveness.

By focusing on important issues such as dementia, care of the older person, venous thromboembolism, pressure ulcers, falls, dignity in care and reducing waiting and access times we aim to make a big difference in areas that really matter to patients.

Our work to maintain quality, and support and develop our workforce, will need to take place against the backdrop of financial challenge and recovery facing the entire country. This includes tackling the new priorities set by the Coalition Government. It is vital that the NHS, along with all other public sector organisations, identifies and grasps opportunities for Quality, Innovation, Productivity and Prevention. This will support us to live within our means whilst meeting the changing needs and expectations of patients and communities.

Developing our second Quality Account has been a valuable learning experience for the Trust. We will build on this in future, and we welcome your feedback. Please let us know your views, to help us enhance patient experience, safety and effectiveness.

Your Feedback Counts

We welcome your feedback on our Quality Account. You can let us know in a variety of ways:

By email to consultation@sath.nhs.uk – please put "Quality Account" as the subject of your email

By fax to 01743 261489 – please put "Quality Account" as the subject of your fax

By post to Quality Account, c/o Chief Nurse/Director of Quality & Safety, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ

We welcome your feedback on any aspect of this document, but specific questions you may wish to consider include:

- What do you think are our biggest opportunities for making progress on the Quality Priorities listed in Section 2.1? What actions should we be taking to improve quality in these areas?
- How should we involve patients and communities in our work to improve the quality of the services we provide?
- Do you have any comments or suggestions on the format of our Quality Account?

Looking further ahead, we welcome your suggestions for our Quality Priorities in 2012/13 – we will select three to six top priority issues across the three dimensions of quality (patient experience, safety, effectiveness).

Let us know if you want to be involved in developing our Quality Improvement Strategy, which will set the direction for improvements in the next 5 years.

Glossary

Guidance on Quality Accounts requires that we include detailed information about national and local clinical audits (see Section 2.2.2.). This section contains a large number of abbreviations and technical terms, and we regret that it is not possible to provide a definition in each case within the brief Glossary to the Quality Account.

18 weeks	A target for the NHS in England was that by December 2008 no patient should wait longer than 18 weeks from GP referral to consultant-led treatment. See www.18weeks.nhs.uk/endwaiting
A&E	Accident and Emergency. A range of services that provide care for people following accidents and emergencies. This includes local Minor Injuries Units in community hospitals as well as regional trauma centres that provide urgent treatment following major accidents.
Acute Care	Medical or surgical treatment usually provided in a district general hospital (also called an acute hospital).
Annual Health Check	An annual assessment of the Quality of Services and the Quality of Financial Management of NHS organisations, undertaken by the Care Quality Commission. See www.cqc.org.uk
CHC: Community Health Council	Community Health Councils in Wales have a statutory role to represent the interests of the public in the health services in their district. See www.wales.nhs.uk/chc
Clinical Audit	Information about clinical audit, including a definition, is available in Section 2.2.2. See www.hqip.org.uk
Clinical Governance	Clinical Governance is defined as: "A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (A First Class Service: Quality in the New NHS, 1998).
Clinical Governance Executive/Clinical Governance Forums	Our Clinical Governance Executive is a committee of the Trust Board, chaired by the Trust Medical Director and with representation from the Non Executive Directors. It is responsible for coordinating Clinical Governance activity throughout the Trust and providing assurance to the Trust Board that Clinical Governance processes deliver safe, high quality patient-centred care. It acts as the focus for wider review through Clinical Governance Forums in Divisions and Service Delivery Units.
Clinical Governance Strategy	This sets out our overall approach to clinical governance in the organisation.
Clinical Trials	A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both. Small studies produce less reliable results so studies often have to be carried out on a large number of people before the results are considered reliable. See www.nhs.uk/Conditions/Clinical-trials and www.nihr.ac.uk
Commissioners	Commissioners are responsible for ensuring that adequate services are available for their local population by assessing needs and purchasing services. Primary Care Trusts (PCTs) in England and Local Health Boards (LHBs) in Wales are the key organisations responsible for commissioning healthcare services for their area. Shropshire County Primary Care Trust, NHS Telford and Wrekin and Powys Teaching Health Board purchase acute hospital services from The Shrewsbury and Telford Hospital NHS Trust for the population of Shropshire, Telford & Wrekin and mid Wales. See www.shropshire.nhs.uk, www.telford.nhs.uk and www.powysthb.wales.nhs.uk
Community Engagement Forum	This is a regular meeting with patient and community representatives to help shape Trust policy and priorities.
CPA: Clinical Pathology Accreditation	Clinical Pathology Accreditation: An external audit and assessment process for pathology services. See www.cpa-uk.co.uk
CQC: Care Quality Commission	The Care Quality Commission is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. See www.cqc.org.uk
CQUIN: Commissioning for Quality and Innovation	A new payment framework introduced in the NHS in 2009/10 which means that a proportion of the income of providers of NHS services is conditional on meeting agreed targets for improving quality and innovation. See www.institute.nhs.uk/cquin

Developing Health and Health Care	A process to develop a vision for future health services in Shropshire and Telford & Wrekin. It aims to ensure that health services are safe and sustainable and that there is a clear strategic vision in place to guide health service planning to 2020. See www.ournhsinshropshireandtelford.nhs.uk
DH: Department of Health	The Department of Health is a department of the UK government with responsibility for government policy in England on health, social care and the NHS. See www.dh.gov.uk
Dimensions of Quality	In the NHS we normally refer to three dimensions of quality: patient experience (the experience of patients and their carers using our services), safety (protecting patients from harm) and effectiveness (using techniques and procedures that are proven to have benefit at a fair cost to the public purse).
Division	The Trust's clinical services are managed within three Divisions. More information can be found in Section 2.2.1. This is a term that we use within our hospitals, but other NHS Trusts may use different terminology to describe the way their services fit together.
HRG: Healthcare Resource Group	A Healthcare Resource Group (HRG) is a group of clinically similar treatments and care that require similar levels of healthcare resource. It forms part of the Payment by Results system by which providers of NHS services receive income from commissioners for the services they provide to patients. The sophistication of this system increases from year to year. Version 4 (HRG4) was introduced in 2009/10, including c.1400 HRGs. This replaced version 3.5 (HRG3.5) which contained c.400 HRGs.
Incident Review Group	This is a twice-monthly meeting in the Trust to review incidents, claims, complaints and 'soft' intelligence to identify early trends and take corrective action.
Information Governance Toolkit	This is a tool to support NHS organisations to assess and improve the way they manage information, including patient information See www.igt.connectingforhealth.nhs.uk
Integrated Performance Report	This is a "dashboard" of quality and operational performance information reviewed at meetings of the Trust Board, Management Executive and Finance & Performance Committee. It contains a set of key measures of the services we provide, and encourages scrutiny with the aim of maintaining and improving service standards. See examples in our Trust Board papers at www.sath.nhs.uk
LHB: Local Health Board	See "Commissioners"
LINk: Local Involvement Network	Local Involvement Networks in England are made up of individuals and community groups working together to improve local services. Their job is to find out what the public likes and dislikes about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. See also CHC. See www.cinch.org.uk and www.telfordandwrekinlink.org.uk
National Confidential Enquiries	These are enquiries that seek to improve health and health care by collecting evidence on aspects of care, identifying any shortfalls in this, and disseminating recommendations based on these findings. Examples include the Centre for Maternal and Child Enquiries (CMACE) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). e.g. see www.ncepod.org.uk
NICE: National Institute for Health and Clinical Excellence	The National Institute for Health and Clinical Excellence (NICE) provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. It makes recommendations to the NHS on new and existing medicines, treatments and procedures, and on treating and caring for people with specific diseases and conditions. It also makes recommendations to the NHS, local authorities and other organisations in the public, private, voluntary and community sectors on how to improve people's health and prevent illness and disease. See www.nice.org.uk
NPSA: National Patient Safety Agency	The National Patient Safety Agency is an arm's length body of the Department of Health, responsible for promoting patient safety wherever the NHS provides care. See www.npsa.nhs.uk
OPCS	OPCS is an abbreviation for the Office of Population, Censuses and Surveys Classification of Surgical Operations and Procedures (4th revision). This statistical classification translates operations and surgical procedures into codes. Classifications like OPCS-4 must be reviewed continuously to ensure they evolve with NHS policy, changing healthcare provisions, and the coding structures used in electronic health records. OPCS Version 4.5 was introduced in the Trust in 2009/10. See www.connectingforhealth.nhs.uk

Overview and Scrutiny Committees	Overview and Scrutiny Committees in local authorities have statutory roles and powers to review local health services. See www.shropshire.gov.uk and www.telford.gov.uk
Patient Experience Reporting	We ask our patients to tell us about their experience of our services in a variety of ways. These include the CQC Annual Inpatient Survey (see 3.5.3), our own internal surveys and the complaints and compliments we receive from patients and carers.
Patient Safety walkabouts	Trust Board members and other colleagues make focused visits to individual wards and departments. This helps to ensure that patient safety standards are being maintained, that Trust Board members are aware of the standards of service being provided within our hospitals, that Trust Board level debate is linked to frontline delivery, and that frontline staff have the opportunity to raise issues directly with Trust Board members.
PCT: Primary Care Trust	See "Commissioners"
Periodic Reviews	Periodic Reviews are reviews of health services carried out by the Care Quality Commission. The term "review" refers to an assessment of the quality of a service of the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services.
Pressure Ulcers	Pressure ulcers are also known as pressure sores, or bed sores. They occur when the skin and underlying tissue becomes damaged. In very serious cases, the underlying muscle and bone can also be damaged. See www.nhs.uk/conditions/pressure-ulcers
QIPP	This stands for Quality, Innovation, Productivity and Prevention. It is a programme where NHS organisations work together – and with patients, communities and other key partners – to improve quality, encourage innovation, increase productivity and ensure preventative approaches that improve health and reduce health inequalities.
Quality Account	Please see page 6 for a definition of a Quality Account.
Quality and Safety Assurance Framework	This framework sets out how aspects of governance and safety are to be integrated into the Trust's arrangements and how quality will be continually improved and monitored.
Quality Priorities	Every year we set between three and six quality priorities. More information can be found in Section 2.1.1.
Quality Report	We published a pilot Quality Report for 2008/09 in preparation for the new statutory requirement for NHS Trusts to publish Quality Accounts from 2009/10. This was included in our Annual Report 2009/10.
Registration	From April 2009, every NHS Trust that provides healthcare directly to patients must be registered with the Care Quality Commission. In 2009/10, the CQC registered Trusts on the basis of their performance in infection control. From April 2010 the registration process is a based on a much broader assessment of the services provided by the organisation.
Risk Management systems	These enable staff across the organisation to identify and report risks to the quality of care. The organisation is then better able to manage these risks, focusing on addressing those issues that are more likely to have a greater adverse impact on patient experience, safety and effectiveness.
SaTH: The Shrewsbury and Telford Hospital NHS Trust	The Shrewsbury and Telford Hospital NHS Trust, the NHS organisation responsible for hospital services at the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury. We are the main provider of acute hospital services for around half a million people in Shropshire, Telford & Wrekin and mid Wales. See www.sath.nhs.uk
SDU: Service Delivery Unit	Within each of the Trust's three Divisions we have Service Delivery Units focusing on specific areas of care, or specialties. For example, the Women and Children's Service Delivery Unit includes maternity services, gynaecology, paediatrics and fertility services. This is a term that we use within our hospitals, but other NHS Trusts may use different terminology to describe the way their services fit together.
Special Review	A special review is carried out by the Care Quality Commission. Each special review looks at themes in health and social care. They focus on services, pathways or care groups of people. A review will usually result in assessments by the CQC of local health and social care organisations, as well as supporting the identification of national findings.

SUS: Secondary Uses Service	SUS provides anonymous patient-based data for purposes other than direct clinical care, such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
TIA: Transient Ischaemic Attack	A transient ischaemic attack (TIA), or 'mini-stroke', is caused by a temporary fall in the blood supply to part of the brain which results in a lack of oxygen to the brain. This can cause symptoms that are similar to a stroke, although they don't last as long. TIA lasts only a few minutes and is usually resolved within 24 hours. See www.nhs.uk/conditions/transient-ischaemic-attack
Trust Board	The Trust Board takes corporate responsibility for the organisation's strategies and actions. The Chair and Non-Executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The Chief Executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.
VTE: Venous Thromboembolism	Venous thromboembolism (VTE) is a term that covers both Deep Vein Thrombosis (DVT, a blood clot in one of the deep veins in the body) and pulmonary embolism (where a piece of blood clot breaks off into the bloodstream and blocks one of the blood vessels in the lungs). See www.nhs.uk/conditions/deep-vein-thrombosis
WAG: Welsh Assembly Government	The Welsh Assembly Government is responsible for health policy in Wales. See www.wales.gov.uk

Other useful sources of information include:

www.nhs.uk	**NHS Choices**: NHS Choices is the online 'front door' to the NHS. It is the country's biggest health website and provides information about the NHS, services, conditions, treatments, and how to look after yourself.
www.sath.nhs.uk	**The Shrewsbury and Telford Hospital NHS Trust**: Our website provides information about the services we offer.
www.shropshire.nhs.uk	**Shropshire County PCT:** Find information about health and health services in Shropshire.
www.telford.nhs.uk	**NHS Telford & Wrekin:** Find information about health and health services in Telford & Wrekin.
www.powysthb.wales.nhs.uk	**Powys Teaching Health Board:** Find information about health and health services in Powys.

Annex to the Quality Account

NHS Trusts must produce a draft Quality Account by 30 April each year. This should be shared for comment and assurance with Primary Care Trusts, Overview and Scrutiny Committees and Local Involvement Networks.

Our draft Quality Account was sent to the following organisations for comment and assurance:

- Primary Care Trusts and Local Health Boards: NHS Telford & Wrekin, Powys Teaching Health Board, Shropshire County PCT.
- Overview and Scrutiny Committees: Shropshire Council, Telford & Wrekin Council.
- Local Involvement Networks and Community Health Councils: Community Involvement in Care and Health (the Local Involvement Network for Shropshire), Montgomeryshire Community Health Council, Telford & Wrekin Local Involvement Network.

These organisations were invited to review our draft Quality Account, provide feedback and provide statements for inclusion in the final published document.

The statements received by the Trust within the specified deadline are included from page 55.

Patient representatives, staff and partner organisations have been involved in the ongoing review and development of our Quality Account. This broad engagement has helped the Trust to develop the final version of the Quality Account for publication. One specific change has been made subsequent to the statements being provided, which was to correct an arithmetical error on page 51 of the report in the table highlighting letters of thanks, gifts and donations.

The Shrewsbury and Telford Hospital NHS

NHS Trust

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