Enclosure 2

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Trust Board - 24th November 2011

Quality Report

EXECUTIVE RESPONSIBLE	Vicky Morris, Director for Quality and Safety/Chief Nurse
AUTHORS	Vicky Morris, Director for Quality and Safety/Chief Nurse Justin Barnes (Medical Performance Manager) John Cliffe (Interim Associate Director of Operational Management
STRATEGIC DOMAIN	C. Quality and Safety
ORGANISATIONAL OBJECTIVE	This paper relates to all objectives within the Quality and Safety Domain of our Strategy: C1. Ensure that we learn from mistakes and embrace what works well C2. Design care around patient needs C3. Provide the right care, right time, right place, right professional C4. Deliver services that offer safe, evidence-based practice C5. Meet regulatory requirements and healthcare standards C6. Ensure our patients suffer no avoidable harm
SUMMARY	The strategy of The Shrewsbury and Telford Hospital NHS Trust is based on the central principle of Putting Patients First. Putting Patients First means giving the best **patient experience** we can, doing so safely (**patient safety**) and using the evidence of what works best to inform our practice (**clinical effectiveness**). The Board has put in place systems and processes to report on progress and provide assurance on patient experience, patient safety and clinical effectiveness. This includes: • The monthly Strategic Performance Report, which tracks performance on key areas of Quality reflecting the six organisational objectives listed above. • The Quality Account, which provides an annual review of quality in the Trust, focusing on progress and challenges in the previous year and setting priorities for the year ahead • The Quality and Safety Committee, which focus on the agreed priorities and reports to the Board on a monthly basis. • Quality Reports, which provide a regular opportunity to share key issues with the Board across the three dimensions of Quality. This Quality Report provides more detailed information on current issues affecting patient experience, safety or clinical effectiveness in the Trust. This includes the current waiting list challenges in the Trust and the impact of this on our patients, prevention of venous thromboembolism, continued progress to reduce in-hospital mortality, and the findings and recommendations of recent quality reviews.
RECOMMENDATION	The Trust Board are asked to **NOTE** the Quality Report and the actions being taken to improve patient experience, patient safety and clinical effectiveness.

Quality Report
24th November 2011

1.0 Introduction

The strategy of The Shrewsbury and Telford Hospital NHS Trust is based on the central principle of Putting Patients First.

Putting Patients First means giving the best **patient experience** we can, doing so safely (**patient safety**) and using the evidence of what works best to inform our practice (**clinical effectiveness**).

The Board has put in place systems and processes to report on progress and provide assurance on patient experience, patient safety and clinical effectiveness. This includes:

- The monthly Strategic Performance Report, which tracks performance on key areas of Quality reflecting our organisational objectives
- The Quality Account, which provides an annual review of quality in the Trust, focusing on progress and challenges in the previous year and setting priorities for the year ahead
- The Quality and Safety Committee, which was established to provide a formal process for the Trust to focus on the all three dimensions of Quality, understand trends and themes and brief the Board on key areas of concern.
- Quality Reports, which provide a regular opportunity to share key issues with the Board across the three dimensions of Quality.

This Quality Report provides more detailed information on current issues affecting patient experience, safety or clinical effectiveness in the Trust. This includes:

Issue	Quality Dimensions	Section
The current waiting list challenges in the Trust and the impact of this on our patients	Patient Experience Patient Safety	See Section 2
Prevention of venous thromboembolism	Patient Safety	See Section 3
Continue progress to reduce in-hospital mortality	Clinical Effectiveness	See Section 4
Forming a five year Strategy for Quality Improvement	Patient Experience Patient Safety Clinical Effectiveness	See Section 5
Findings and recommendations of recent quality reviews and Improvement plan	Patient Experience Patient Safety Clinical Effectiveness	See Section 6

2.0 Update on Waiting Times and the Outpatient Improvement Programme (Patient Experience, Safety)

2.1 Introduction

The Board has received regular updates on the challenges facing the Trust in relation to waiting times, the impact of these challenges on patients and the work underway to ensure sustainable delivery of the 18 weeks Referral to Treatment Target (including the Outpatient Improvement Programme).

Performance in the Trust is currently behind the national standards for seeing patients within 18 weeks from referral to treatment. The booking and appointment systems we have had in place in the Trust in the past have not provided a good service to patients. Our patients, our staff and the Trust as a whole will continue to see the impact of this until theses issues have been resolved sustainably. Figure 1 and 2 within this paper outlines the reduced number of patients who are waiting to be seen.

This is still frustrating for patients who are waiting longer than expected to see a hospital specialist and receive definitive treatment (patient experience). It is important to note that whilst waiting for treatment – whether for one week, six weeks, eighteen weeks or longer - patients continue to experience the condition, concern or discomfort that has led to the referral (patient experience). In some cases the condition may worsen during the period until they are seen (safety).

It is also frustrating for our staff, who aim to provide the right care in the right place at the right time, every time for every patient and have found that the booking and appointment systems that the Trust has had in place in the past have not supported them to achieve this.

2.2 Reducing waiting times

Reducing waiting times requires co-ordinated action between the Trust, PCTs, GPs and other referrers (e.g. opticians, dentists). The Trust has worked with local NHS partners to review the position for each speciality and develop and agree a plan for sustainable achievement of the 18 week referral to treatment target.

Figure 1

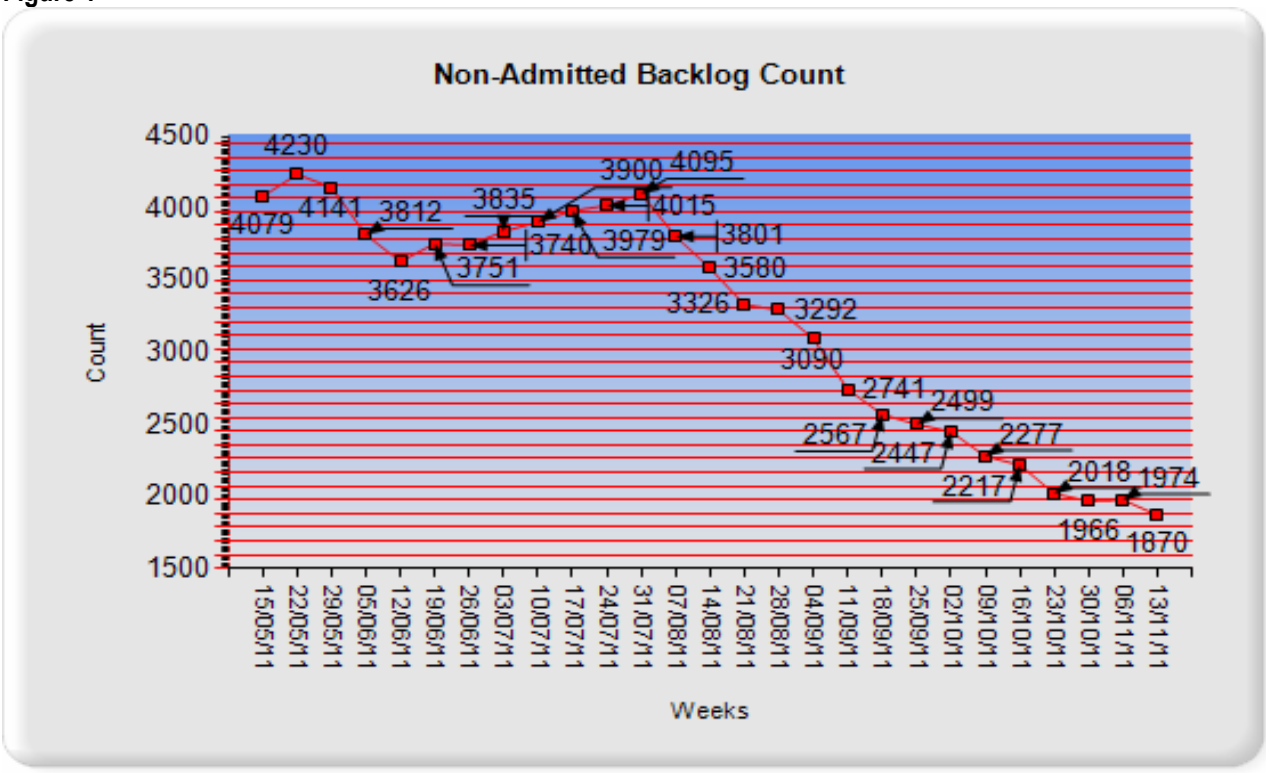
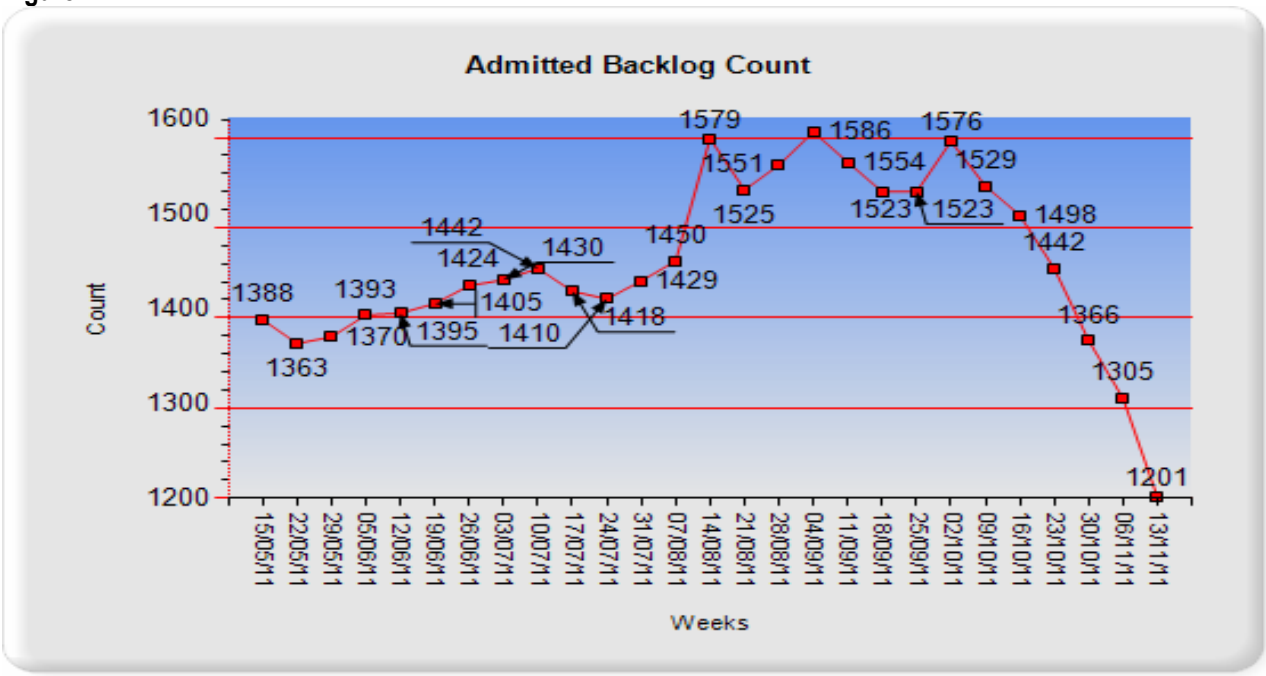


Figure 2



Sustainability plans have been produced for every specialty and are being implemented. Performance against these plans is monitored at the Trusts' weekly 18 week operational group and at the 18 week Local Health Economy Programme Board.

As expected, the Trust is not currently achieving the 18 week RTT target, however the Trust is working to achieve the target by the end of the year .

2.3 Outpatient Improvement Programme
The Action plan to improve the systems and processes within the outpatient function is on schedule. Work completed to date is a follows

- Booking staff were recruited as planned to support the improvements required with patient appointments
- Key Performance Indicators agreed and Dashboard in place.
- Choose & Book continues to be managed by PCT ..
- Standard Operating Procedures written and tested in OP & Waiting List and being implemented.
- Scanning of new referral letters initially in T&O introduced to improve safety.
- Clinic Outcome Form education programme and collection process redesign. Improvements have been noted but further measures required to ensure all required follow up ap[ointments or treatrments are managed as clinically required.
- Access Policy 'drop in' sessions took place in August and September 2011.

2.4 Managing patients who are still waiting for treatment
As mentioned above, this situation to be frustrating for patients who are waiting longer than expected to see a hospital specialist and receive definitive treatment. It is not acceptable that patients are being inconvenienced because our appointment and booking systems have not worked effectively in the past, and through the progress outlined in Section 2.2 and 2.3 we have been undertaking an improvement programme to rectify this situation as soon as possible.

Also, whilst waiting for treatment – whether for one week, six weeks, eighteen weeks or longer - patients continue to experience the condition, concern or discomfort that has led to the referral. In some cases the condition may worsen during the period until they are seen. We aim to ensure that risks are identified and addressed through a comprehensive quality review process involving:

- Ensuring that we see patients referred with suspected cancer within the much shorter waiting times standards for these conditions, and also give priority to patients referred as urgent. The Board are asked to note that as of the end of Quarter 2 all cancer targets (waiting times) are being met.
- Seeing patients who are waiting to be seen on the basis of clinical need and/or ensuring that those waiting longest are seen first.
- Identifying and reporting where a patient's condition may have worsened, and ensuring that this is discussed with them.
- GP-led and consultant-led review of the referral and/or notes of patients who have been referred and are waiting to be seen, so that we can review and confirm their priority to be seen and see them accordingly.
- Ensuring that there are systems in place to expedite appointment for patients in greatest clinical need.

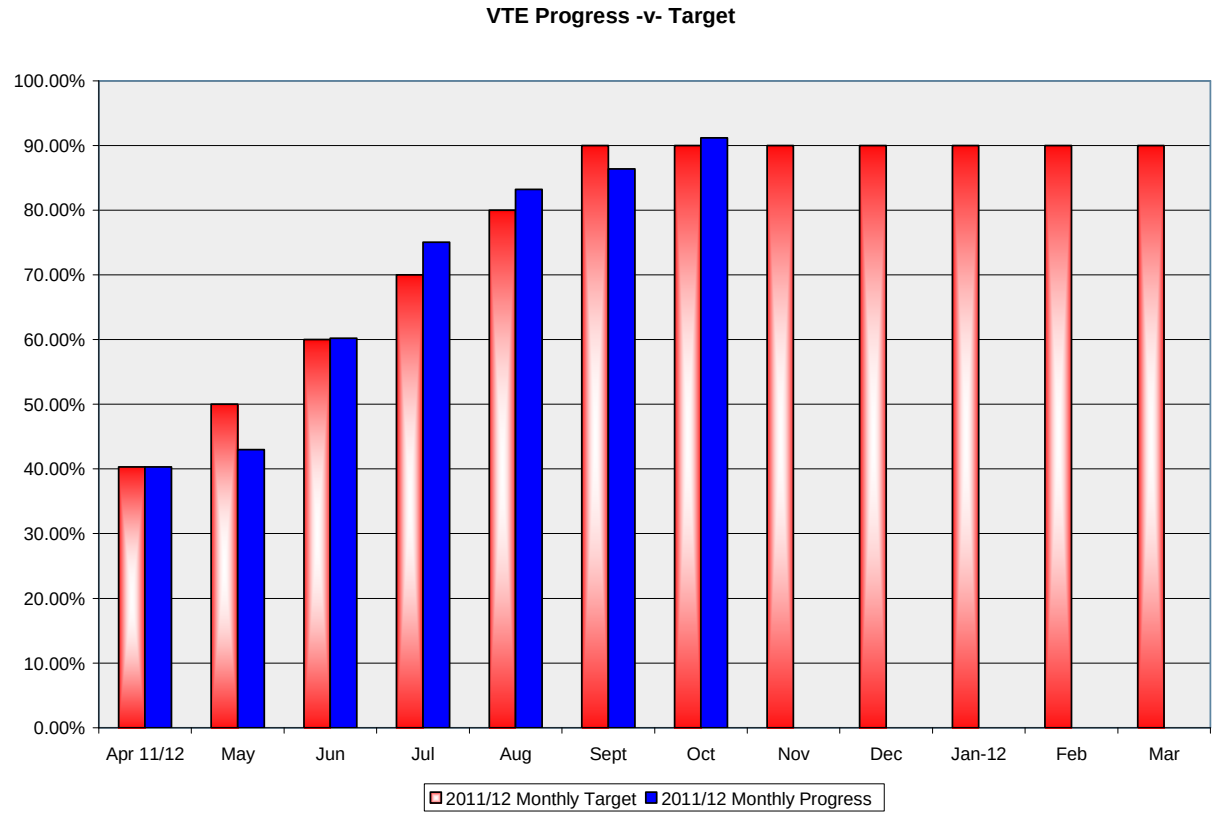
The Local Health Economy is working closely in partnership to minimise the impact of the Trusts capacity and demand problems on the patient.

A weekly meeting is in place to review the systems and processes to manage the assessment of patients and the PCT are currently working with GPs to assess the number of patients who may need to be seen on an urgent review basis.

3.0 Update on Venous Thromboembolism (patient safety)

This is a short update on the progress and actions underway to achieve the CQUIN Target for VTE assessments of 90% The current DRAFT rate of reported VTE assessments across the Trust for October 2011 is **91.18%.** This is draft until the final figure will be available on the 20th working day of the month.

This is the first month we will hit our target of 90%



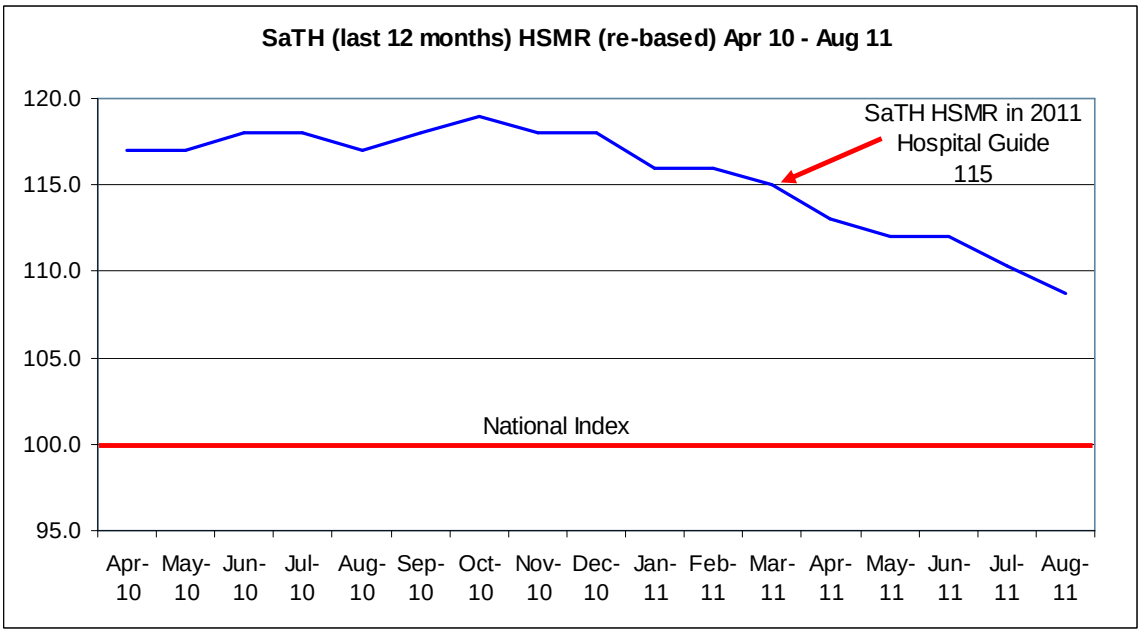
In order to sustain the assessment rates over 90% continued focus will remain with the areas that account for the majority of admissions:

- Medical and Surgical Assessment Units
- Day Surgery Units

4.0 HSMR

There has been excellent progress in reducing our HSMR over the last year with significant improvements being delivered since April 2011.

The HSMR for the last 12 months ending Aug 2011 is 108.7 against 110.8 last month. This reduction is expected to continue with the year to date (Apr – Aug 2011) HSMR being 102.



The most significant aspect is the reduction in the total number of in-hospital deaths when measured against the same period last year. This reduction reflects the real changes that have been implemented to improve Patient care across the whole Trust over the last few months.

5.0 Developing a Quality Improvement Strategy- A five year programme

In March 2011 the Board were provided with a programme towards developing the Quality Accounts 2010/11 and a 5 year Quality Improvement Strategy. The Quality Account was approved by the Board in June 2011 and Appendix 1 outlines the revised programme towards developing the Quality Improvement Strategy for Board approval in March 2012.

The Trust implemented a significant Safety programme in June 2011, to which over a 100 clinical staff attended and from that launch in June, the Trust has agreed the overall safety aims of the Trust for the next 2 year period, these core improvements were outlined in the Quality Accounts 2010/11 and will be included within the Safety section of the Quality Improvement Strategy when approved by the Board in March 2012.

In the meantime the leading Improvements in Patient Safety (LIPS) teams continue to focus on small steps of improvements in patient safety issues which contribute to wider improvements in patient safety and patient flow. These include improvements in the nutritional status and support to patients, reducing the number of falls whilst under our care, reducing harm through hospital acquired pressure sores and improving our management of patients whose condition deteriorates.

5.1 Engaging our staff in developing a Quality Improvement programme

Through a series of staff listening events in September, we have listened to the issues that frustrate our staff and get in the way of them providing optimum care for their patients. They have outlined a number of improvements that they want to make and this is very similar to many of the issues that have concerned the Trust Board and senior managers. They have outlined the need to make improvements in the waiting times and access for patients and also the care provided for patients who come to the Trust via the emergency route. These patients often have to wait too long in A&E prior to a bed being found and significant work is underway to ensure that we reduce discharges and support the timely flow of patients through the Trust so that they are cared for in the right place at the right time by the right professionals.

In December 2011 a team of staff who have indicated that they want to be part of the “Early adopter teams” to make these improvements will be holding their own “Listening events, so that they can engage a wider group of staff to support the improvements that they want to make.

5.2 Engaging our patients and health colleagues in the Local Health Community in identifying priorities for Quality Improvements.

It is really important that our patients, the public and patient representative groups are actively engaged with us in identifying what aspects of care need to improve. The Trust has formed a patient involvement and engagement Board which has met monthly since July and this group will form a key part of the process to identify what improvements need to be made.
Local Health economy partners have been invited to workshops being held over the next 2-3 months to build on current priorities for Quality improvement, to ensure that any document approved by the Board in March is representative of the range of improvements required.

5.3 The Improvement Plan for the Shropshire and Telford Health Community

The plan outlined in the July Trust Board is being actively monitored through the Quality review group led by the Primary care Trust (PCT) and the Performance meetings held between the Trust and the PCT.

6.0 Quality and Safety Review Visit

A Quality and Safety Review Visit was undertaken jointly by the Strategic Health Authority, the West Mercia PCT Cluster, Shropshire County PCT and NHS Telford & Wrekin in July 2011. This section provides an update on the 3 key priority actions that were identified during the visit.

The purpose of the visit was to review the safety and quality of the Trust's clinical services, including an assessment of patient experience. The visit also focused on leadership and clinical governance arrangements within the Trust. The visit involved a team of twelve people, the majority of whom were experienced clinicians and included several specialist advisers from other trusts.

Three issues were identified for urgent attention:

1. **Medical outliers require regular and systematic review. The current arrangements were reported to be ad hoc and pose a potential risk to patients.**
   - Significant work has been undertaken and is still being actively managed to improve patients being in the right ward to ensure their specialty needs are met. We closely monitor any outlying patient and have a campaign to reduce the number of delayed transfers of care, so that emergency patients receive timely intervention on the specialty ward required. Appendix 2 outlines the Bed bundle promotions currently being displayed within the Trust.

2. **Medical staffing at night, weekends and bank holidays requires review to mitigate the current risks particularly in acute medicine.**

   - Significant work has been undertaken within the Trust to ensure improved medical cover within the Trust, with significant improvements being made with Senior clinician and Consultant cover out of hours and at weekends being made. The Trust is now monitoring the impact that this is having on the care of patients in the Trust and will be providing detailed reports through the Quality and Safety Committee and to the Local Health Economy.

3. **VTE compliance** needs to progress at a greater rate than is currently evident. The identification of a VTE champion to drive change must be put in place quickly. In addition medical staff need to be held formally to account for poor compliance. (update included within this report).

Care Quality Commission

The Care Quality Commission (CQC) are the formal regulator for any organisation that provides care for patients. They are required to undertake an annual planned review of services at every Hospital and use clinical outcome measures to determine whether the Trust continues to comply with their statutory registration with the Care Quality Commission.

The CQC visited the Trust in October and outlined verbally to the Chief Executive a number of improvements that had been made since their last visit to the Trust , which included some ward areas who had adopted the principles of protecting meal times for patients and as a result the mealtimes were more peaceful. They also outlined some good support and protection of privacy and dignity whilst they observed care. They also noted the additional support put in place to support patients through "Comfort rounds" and noted the significant drop in use of agency staff.

Verbally there were a number of issues that were discussed for improvement which included the manner in which the patient's plan of care is described and evaluated in patient notes and whilst the Trust is yet to receive the final report, we have commissioned a formal review of nursing documentation to ensure improvements are made.

The Trust has implemented a number of internal assurance processes which provide a means of monitoring the standard of care delivered to patients. These reviews are undertaken by ward managers, Matrons and Senior Nurses and collectively forms a process called "Ward to Board" reporting. The Quality and Safety Committee are reviewing the detail of the outcomes of these reviews and this will start to be reported through the Trust Board from January 2012.
CQC noted that the improvements made in monitoring care.

Conclusions
The will continue to be updated through a quarterly Quality Report on a range of Quality Improvement Issues in addition to the Quality and Safety Committee update to the board.

The Board are asked to **NOTE** this update.

Vicky Morris
Director of Quality and Safety/ Chief Nurse
November 2011

Appendix I

Quality Improvement Strategy Development Programme and Timetable – update 01/11/11

Original (as per Board paper March 2011)	**Revised Date**	**Action/ Task**	**To be completed by**	**Achieved?**	**Further Considerations / Notes / Lead**
April 2011	Sept/ Oct 2011	LiA programme commences and provides a detailed programme of engagement and involvement in the programme (6 staff conversations)			Did not start in April as planned; took place in September/ October
May 2011	December 2011	Initial feedback to staff and patient groups from the initial process	13 December 2011		See detail below
June 2011	N/A	LIPS programme to define the safety plan		Yes	Needs to feed in to first draft of the Quality Improvement Strategy
July/ August 2011	November 2011	First draft principals outlines to Q&S Committee (Key)	1 December, before the NED workshop – see detail below		See detail below
September 2011	December 2011	First draft outline principals / objectives feedback to staff and patient groups	End December		See detail below
October/ November 2011		Refining 5 year improvement objectives			See detail below
Revised Dates (as at 01/11/11)					
	November 2011	Set up workshops • Decide on attendance • Assign leads	End November		• University 3/11 • NMF 10/11 and 7/12 • PPI 23/11 • WM 29/11
	November 2011	Governance arrangements around linkages between Centres and the Board	4 November 2011		VM to write out to Centre Chiefs, Matrons, Clinical Managers
	November 2011	Updated Timetable on the Quality Improvement Strategy to the Board	24 November 2011		Original went in March 2011, public Board.

Original (as per Board paper March 2011)	**Revised Date**	**Action/ Task**	**To be completed by**	**Achieved?**	**Further Considerations / Notes / Lead**
	November 2011	Baseline Quality Assessment Framework to the Board	24 November 2011		
	December 2011	Workshop with the Q&S NEDs, other attendees	1 December 2011		Attendees – • execs • NEDs • Consultant rep • Governance • PCT execs • PCT Provider Arm • GPs • other
	December 2011	NMF thoughts on Centre objectives (following November meeting)	7 December 2011		
	December 2011	Medical Team briefing/ engagement (TLT)	16 December 2011		
	January 2012	First draft completed by end January 2012	5 January 2012 PPI 19 January 2012 Q&S 24 January 2012 F&P		
	January 2012	PCT Quality Review Meeting	tbc		
	February 2012	Final draft to Q&S Committee for approval	16 February 2012		
	February 2012	Draft to Board	23 February 2012		Paper to be tabled/ presentation on process and key issues
	March 2012	Final version of Quality Improvement Strategy for Board approval	30 March 2012		