

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Trust Board - 1st March 2012
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) Samantha Hunter- Patient Services manager
STRATEGIC DOMAIN	C. Quality and Safety
ORGANISATIONAL OBJECTIVE	<p>This paper relates to all objectives within the Quality and Safety Domain of our Strategy:</p> <p>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</p>
SUMMARY	<p>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).</p> <p>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:</p> <ul style="list-style-type: none"> • 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. <p>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 internal quality reviews and the findings of the national Outpatient survey.</p>
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
1st March 2012

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.

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

2.1 Overview

This section of the Quality Report and accompanying appendices describe a range of actions undertaken by The Shrewsbury and Telford Hospital NHS Trust in partnership with Shropshire County and Telford and Wrekin PCTs. These actions have been taken in response to the identification of a cohort of patients who were waiting beyond 18 weeks in mid-2011 to start their consultant-led treatment following GP referral for non urgent conditions

The action taken by the Trust and the PCTs has significantly reduced the number of patients waiting over 18 weeks from GP referral, enabling the local health system to improve delivery against the rights and pledges set out in the NHS Constitution for England. At the same time, a thorough review of the Trust's systems and procedures for booking and managing patients awaiting care has been undertaken. Investigations have been carried out to ascertain whether any patient waiting in excess of 18 weeks had experienced a deterioration in their physical condition as a result of a delay in treatment.

A look-back exercise was undertaken to ascertain whether a cohort of Ophthalmology patients who had waited longer than expected for treatment had experienced clinical deterioration in their eyesight. This review demonstrated that the sight of a very small number of patients did indeed deteriorate because of a delay in treatment. This is deeply regrettable, and all the patients involved have been informed.

As a result of action taken SaTH is set to achieve 18 week waiting time standards by the end of March 2012. Alongside this and the detailed reviews outlined in this section the Boards of the Trust and the PCT Cluster can be assured that the levels of risk have been assessed and action taken to mitigate any future risk.

This section of the Quality Report was also presented to the Board of the West Mercia PCT Cluster on 28 February 2012.

2.2 Waiting Times

Commissioners in both England and Wales set standards for patient waiting times from GP referral to their first definitive hospital treatment. This treatment may be as part of an outpatient attendance (known as 'non-admitted') or as an elective procedure/treatment ('admitted').

The waiting times standards in England are as follows:

- For patients on "non-admitted" pathways: 95% of patients should begin their first definitive treatment within 18 weeks, and
- For patients on "admitted" pathways: 90% of patients should begin their first definitive treatment within 18 weeks.

The 5% and 10% 'tolerances' are in recognition of complex cases (e.g. where significant level of investigations are required to determine appropriate treatment) and patient choice (e.g. the patient was given the option of commencing first definitive treatment within 18 weeks but chose to wait longer).

As has been regularly reported in public to the Board of the Trust and to the Boards of both Shropshire County PCT and Telford and Wrekin PCT, a range of actions was jointly commissioned, under the auspices of the West Mercia Cluster of PCTs and informed by regular dialogue with the Strategic Health Authority, following the identification by the new management team at the Trust of a significant 'pending' list of patients in mid 2011. Patients may be legitimately placed on a 'pending' list for a number of reasons, typically relating to their informed decision to await treatment. Within the Trust we found that an inappropriate use of the pending list had arisen as a result of deficiencies in patient administration systems. This, coupled at times with a high level of demand for services at the Trust led to a growing backlog of patients waiting beyond their expected time for a hospital appointment. This issue was identified by the new management team, supported by the strengthened clinical leadership put in place at the Trust.

As at 11 July 2011, over 6,000 patients on pathways for hospital treatment were waiting longer than the 18 week standard set out in the NHS Constitution.

By early February 2012, the number of patients waiting over 18 weeks for their first definitive treatment had reduced to 1,081 (also referred to as "backlog open clocks"). Approximately half of these patients were on "non-admitted" pathways, and half on "admitted" pathways requiring hospital admission. The majority of these patients had dates for treatment.

The NHS Operating Framework for 2012/13 includes a requirement on all Providers to ensure the backlog remains at or below 8% of the total open clocks, with Commissioners given the authority to impose financial penalties on Providers who do not achieve this. Within SaTH the backlog exceeded 20% of the total for each month between April and August, dropping below 20% for the first time at the end of September (19.82%). The backlog at the end of January had reduced to 7.73%.

By the end of March 2012 it is planned that the Trust will be achieving the national standards for 18 week referral to treatment, and that the number of patients waiting over 18 weeks will have fallen further to around 600. This level will be consistent with the clinically expected exceptions allowed as part of the 18 week performance target.

The Trust and the PCTs have taken this issue extremely seriously for two main reasons:

- Firstly, there is a risk that a patient's clinical condition deteriorates while awaiting treatment. While any conditions warranting urgent intervention are - and always have been - treated as a matter of urgency, the national drive to reduce waiting times to a maximum of 18 weeks (as compared to the situation in the 1990's when patients could wait years for treatment) reflected the clinical risks of overlong waits as well as the public desire for quicker access to treatment.
- Secondly, there is a need to honour the right enshrined in the NHS Constitution for England for patients to be able to: "access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of alternative providers if this is not possible".

2.3 Action Taken

There has been concerted effort across the health system to fund and generate additional hospital capacity, primarily at SaTH, but also through the enablement of choice at other providers. The commitment to this by the Trust clinical and support staff, GPs and clinical and other managers to this action has been exemplary and is fully appreciated.

Alongside these actions, there has been a clinically-led focus to ascertain whether there was any deterioration in the condition of patients as a result of overlong waits for treatment. This clinical review also considered the extent to which patient administration systems within SaTH may still present a risk, however, minimal, of patients not being identified in a timely manner and thereby failing to track their care.

This has taken the form of three processes, all undertaken and co-ordinated within the auspices of the Cluster Executive and all reported regularly to the Strategic Health Authority (SHA) and, through the SHA, to the Department of Health. These links have enabled learning gained through review to be spread across the NHS.

The three processes are:

- The establishment of a clinically-led Task and Finish Group to review a snapshot of 1,149 long-waiting patients as of 11 July 2011, to ascertain the level and extent to which the clinical condition of patients may have deteriorated as a result of their wait for treatment. This is reported on at Appendix 1, wherein full assurance is provided that no clinical deterioration has been identified. However, we continue to recognise the potential for frustration, anxiety or emotional distress whilst waiting for treatment, which is why it has been vitally important to undertake this work in parallel with measures to reduce waiting times.
- A clinically-led look-back exercise, whereby a number of serious incidents associated with the delayed treatment of ophthalmology patients between 2009 and 2011, reported as serious incidents, were reviewed. The purpose of this review was to ascertain whether clinical deterioration had occurred as a result of overlong waits for treatment in this specialty. This review is reported on as Appendix 2.
- A review, again clinically-led, of the current state of the Trust's Patient Administration System, reviewing the extent to which identified shortcomings in the current system present risks in the tracking and management of patient care.

These three reviews were undertaken to ascertain the level of potential risk to patients and the means whereby any such risk could be mitigated. The Task and Finish Group report (Appendix 1) has provided full assurance that none of the 1,149 patients who had been waiting the longest and thereby at potentially greatest risk, had come to harm as a result of a delay in treatment. These patients have subsequently been treated fully in accordance with their clinical priority.

The outcome of the Task and Finish Group review is clearly welcomed as is the significant progress being made at pace to reduce the number of over 18 week waiters to meet national requirements. However, the failure of the local health system to meet patient expectations and honour NHS Constitution rights is unacceptable and deeply regrettable. Sincere apologies are extended to any and all patients who waited longer than they had a right to expect.

It is a matter of profound regret that the look-back review of Ophthalmology patients identified a very small number of patients whose eyesight had deteriorated during their extended wait for treatment. The eyesight of six patients was deemed to have been severely harmed with a further seven patients incurring 'mild/moderate or minor' harm. These patients have been notified through a full, individual discussion with a Consultant Ophthalmologist, which has also considered any actions which could be taken. The patients concerned have been offered a full apology and appropriate support including counselling. The local health system is committed to ensuring that these patients and their families continue to receive all appropriate support, if they require it.

The review of the Trust's Patient Administration System has enabled the risk of any similar incidents to be mitigated. Clearly the circumstances outlined in this report must not happen again and it is critical that local patients have full confidence in the local NHS. It is a credit to all clinical and non clinical staff that once concerns were identified, they have worked collaboratively and relentlessly to address them and to ensure public confidence in its local health services continues to be justified.

The experience and learning accrued over the past few months affirms the commitment of the Trust and of PCTs, Clinical Commissioning Groups and NHS Trusts across West Mercia to meet and surpass nationally-set waiting time standards, and, through active promotion of patient rights under the NHS Constitution, ensure that all rights and pledges made in the NHS Constitution for England are honoured, that patients have clearly informed expectations as to these pledges and that they have access to support if and when the NHS is at risk of failing to honour these pledges. These commitments will form the basis of an active communications campaign across the Shropshire, Telford and Wrekin health system to be launched in March 2012. This campaign will need to be mindful of the different waiting time standards set by commissioners in Wales.

2.4 Conclusions

Members of the Board are asked to:

- note action taken to tackle and reduce the significant backlog of long waiters identified in the Trust
- note assurances from the review undertaken by the Task and Finish Group
- note the findings of the look-back exercise undertaken with regard to a cohort of Ophthalmology patients and approve action taken and commitments given in the light of these findings
- to note action taken to assess and mitigate the risks associated with the identified shortcomings of the Trust's Patient Administration System and processes
- note the commitment of the local health system to promote a better public understanding as to what patients have a right to expect from the NHS in accordance with pledges made in the NHS Constitution.

3.0 Update on Venous Thromboembolism (patient safety)

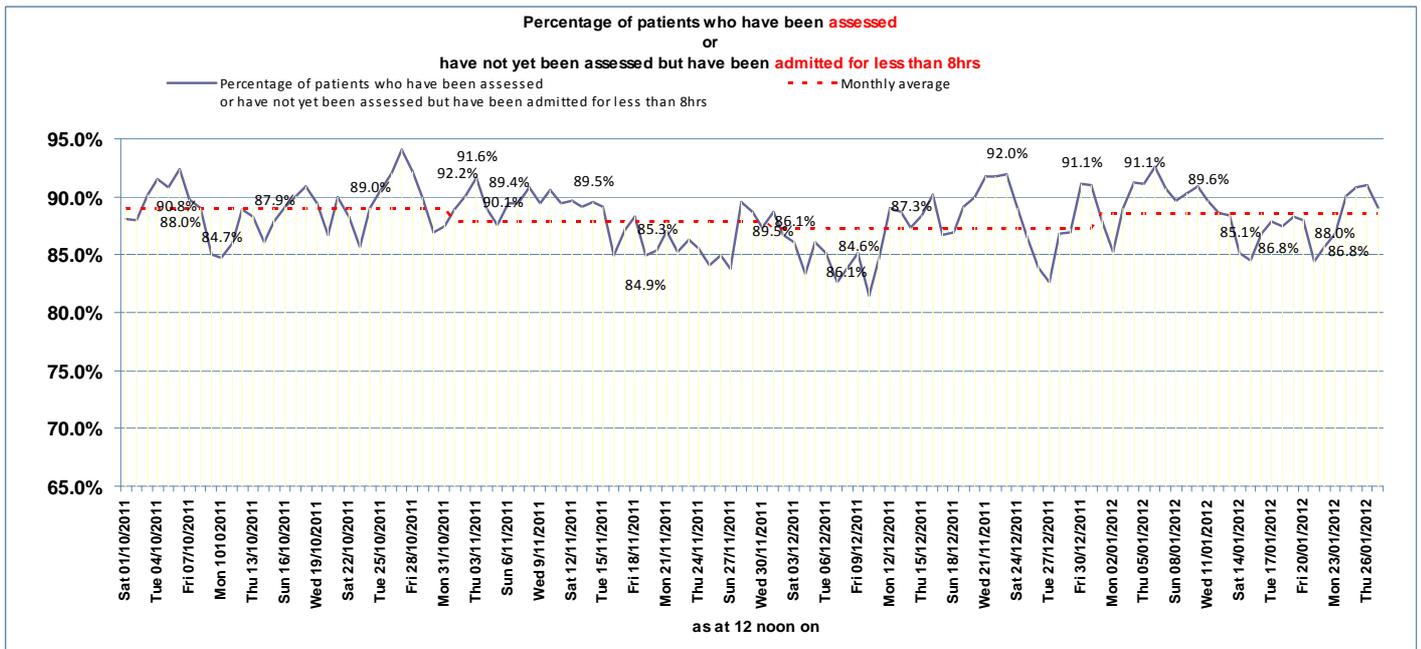
3.1 VTE: Current Status

The rate of reported VTE assessments across the Trust for December 2011 is **91.47%**. The draft figure for January is not yet known and the final figure will not be available until the 20th working day of February. The Vitalpac average for January is up on last month so we expect to continue to achieve the 90% target.

3.2 Issues and Ongoing Actions - VTE

In January a league table report was developed that identifies the correct admitting doctor responsible for ensuring the VTE assessments are completed. This report will be launched in early February with a target of all VTE assessments to be completed within 24 hrs of admission. This is in line with the CQUIN requirement.

Table 1: VTE Assessment Compliance



4.0 Current Status - HSMR

At the end of November the Dr Foster Hospital guide 2011 was published with additional coverage given in the Daily Telegraph. In this report SaTH was highlighted as an outlier with an HSMR of 115 for the year 2010/11.

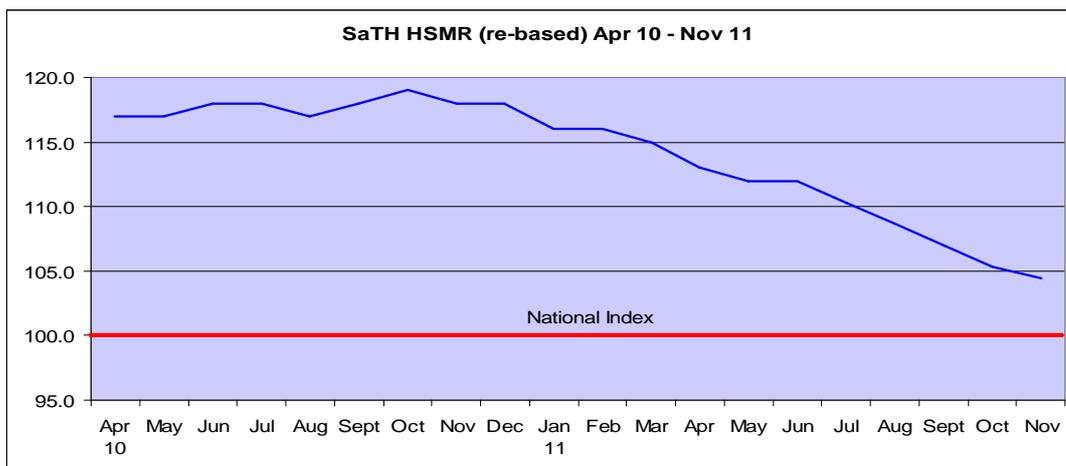
Since November 2010 there has been a solid downward trend in the HSMR with the current rates being (Rebased):

- HSMR for last 12 months – 104.4
- Year to date (Apr – Nov) – 100

In August 2011 there was the first sign of a reduction in the crude rate of deaths, especially in Medicine. This trend has continued in November with there now being 112 less deaths year to date than the same period last year. This represents a 7.84% reduction in in-hospital deaths against last year.

We continue to be on track to achieve the HSMR National index of 100 by Oct 2012.

Table 2: HSMR Year to Date



4.1 Ongoing Actions - Mortality

Dr Campbell (Associate Medical Director – Quality) has taken over the lead for the Mortality Group with the aim of formalising the review of deaths within the Trust and implementing clinical bundles in support of specific areas of concern that are derived from the reviews.

An initial pilot of the mortality review process has been launched into Medicine in Jan 2012. Rollout across all other Centres will be completed by end March 2012.

5.0 Quality monitoring and assurance

5.1 Ward to Board

The Nursing Care Ward to Board metrics were reviewed in January 2012. The revised metrics will be used for data collection during February and reported to the Quality and Safety Committee in March.

Table 3: Nursing Care metrics for January 2012

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012
MEDICATION STORAGE AND CUSTODY	100%	91%	98%	91%	95%
INFECTION CONTROL & PRIVACY & DIGNITY	90%	87%	86%	85%	84%
PATIENT OBSERVATIONS	94%	79%	87%	88%	86%
PAIN MANAGEMENT	92%	84%	85%	89%	93%
TISSUE VIABILITY	77%	77%	72%	84%	76%
NUTRITIONAL ASSESSMENT	84%	76%	87%	84%	78%
FALLS ASSESSMENT	86%	92%	91%	94%	92%
CONTINENCE ASSESSMENT	86%	69%	88%	89%	85%
Total	89%	83%	86%	88%	86%

5.1.1 Nursing metrics

Six out of eight nursing metrics measured have fallen this month with no obvious reason for the decline of these results. The metrics illustrated in the table below were taken from the Hearth of England NHS Foundation Trust's template. These metrics were reviewed by the Ward to Board project group, chaired by the deputy Chief Nurse, to ensure that they were tailored and relevant to the policies and practices of SaTH NHS Trust. The revised metrics will be implemented from 1 February 2012.

5.1.2 Comfort Rounds.

Comfort rounds continue on all wards. The comfort round document is currently being updated alongside the audit tool to reflect more accurately the patients pressure area care. It is anticipated the revised document will be implemented in March 2012. This update is in response to staff feedback and it is envisaged that the new document will also incorporate information in relation to the Dementia Care Plan. Improving the diagnosis of Dementia is a national CQuIN target for 2012/13.

6.0 Patient Experience

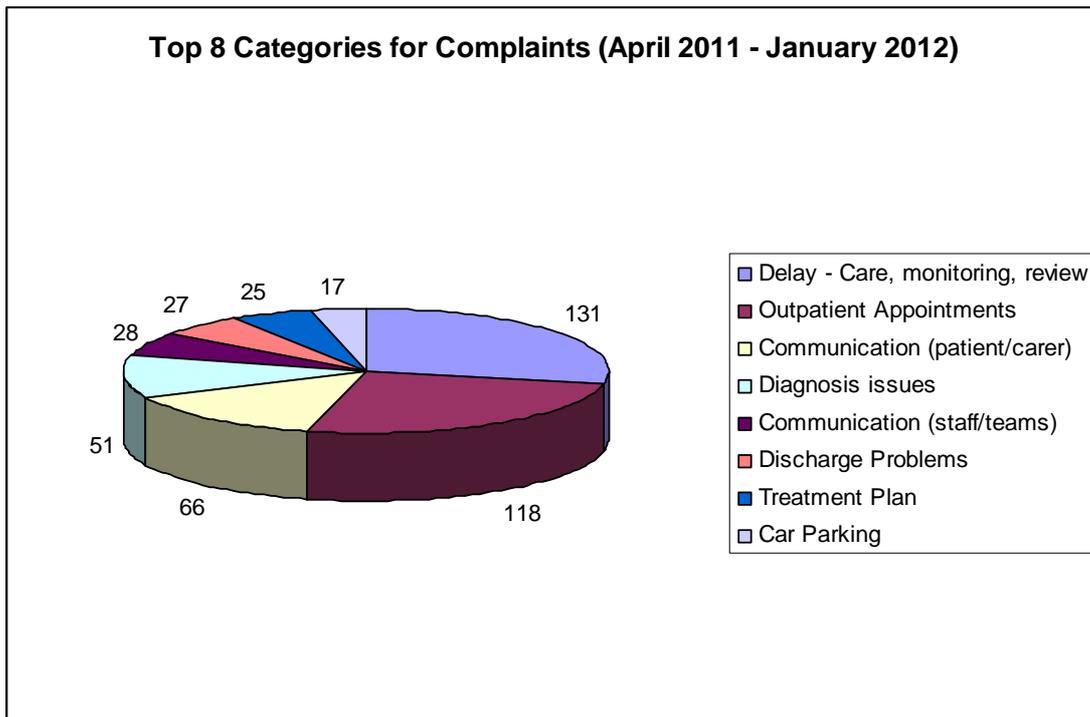
6.1 Introduction

The following report is intended to inform the Trust Board of current trends and activities associated with patient experience. This includes data from complaints, PALS (Patient Advice and Liaison Service) contacts, real time 'patient experience' surveys and 'privacy and dignity' surveys.

6.2 Summary

6.2.1 Complaints – YTD report

General complaint themes



The above diagram includes data from 75% of all complaints received in the period 1 April 2011 to 31 January 2012. That is, data derived from 463 cases out of 621. The other 25% of complaints received, include cases that do not have defined categories for analysis, and cases that fall into categories with less than 10 occurrences of any single issue.

The largest three themes/categories comprise delays with care and reviews mostly in respect of inpatient admissions or emergency attendances; outpatient appointments (the majority of which are issues with the actual appointment); and, communication failures as experienced by carers or patients.

The areas most commonly involved in complaints about "Delay in Care, Monitoring and Review", are:

- A&E (both sites) 21
- Outpatient Department 14
- MEC and MAU 9
- Wards 22S, 10 and 28 5 (per ward)
- Wards 15, 20 and 28 4 (per ward)

Outpatient concerns accounted for 118 complaints received in this reporting period, although in total 172 cases involved outpatients and associated services. Besides overlap with other categories, such as the 14 instances of

outpatient concerns included above in the “Delay in Care, Monitoring and Review” category, the primary concerns and issues were:

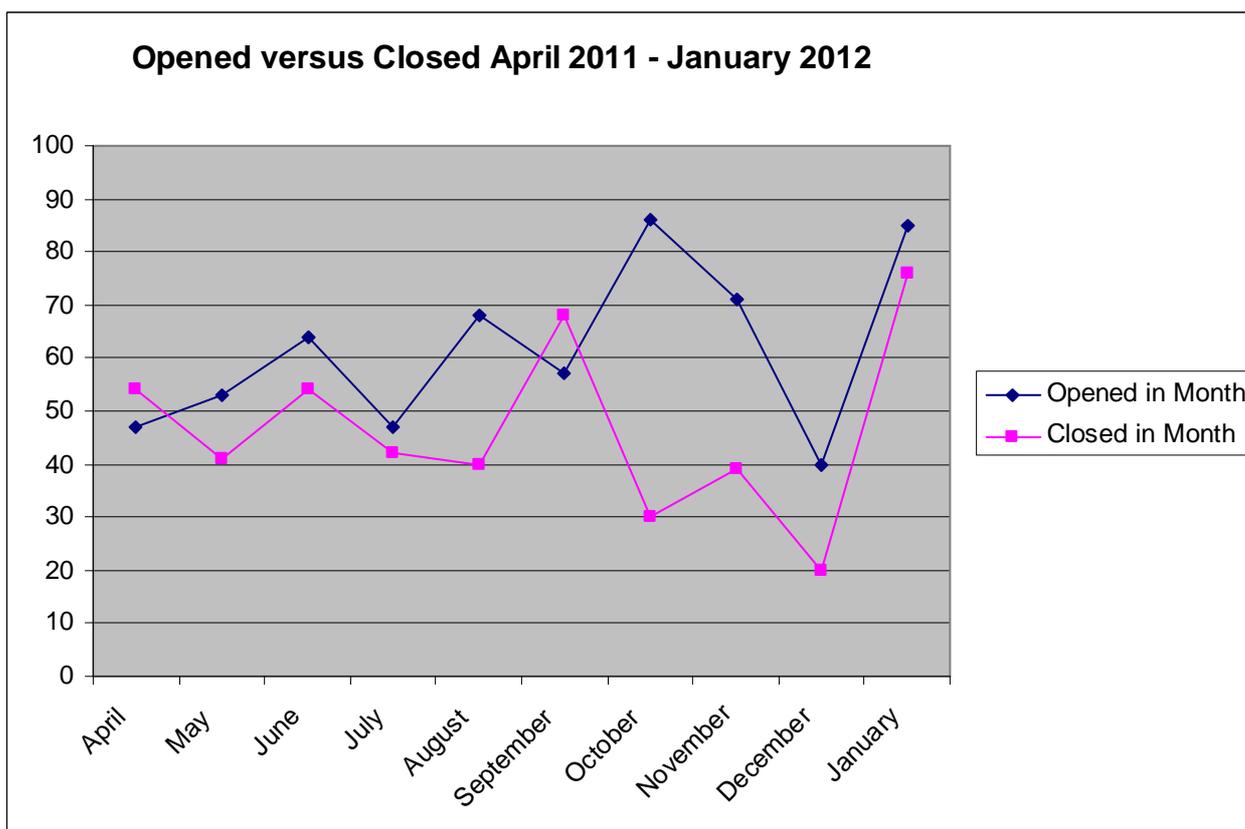
- Appointment problems 93
- Communication issues 24
- Diagnosis concerns 14

6.2.2 Monthly Complaint activity and performance YTD

The number of complaints received and closed each month is now being monitored and analysed closely. This has informed ongoing work to review the way in which complaints are handled and efforts to decrease the overall active caseload, so as to achieve earlier average response times. Regular audits are undertaken to improve the accuracy of electronic information available about complaints and their status.

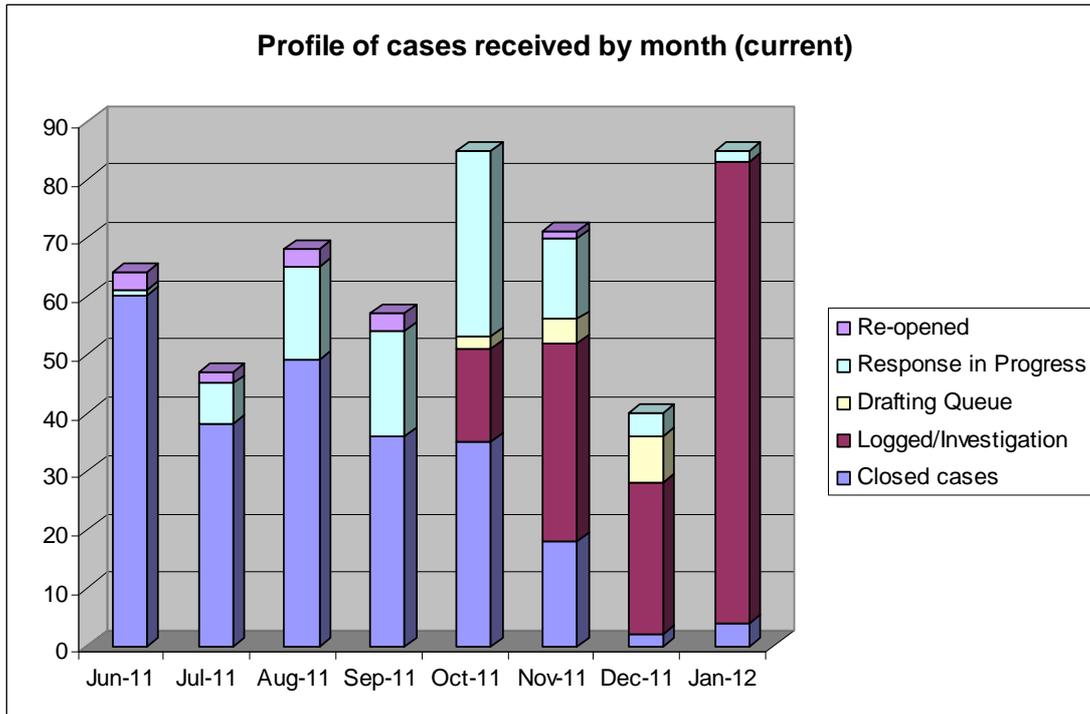
The following diagram plots month on month trends in the numbers of cases opened and closed each calendar month. With more cases being received than closed, a backlog of cases was being accrued at a rate of 15 to 30 cases per month. In October 2011, there was a significant increase in new cases, and a backlog of older cases, which affected the closure rates over the next three months.

The closure rate in January 2012 and into February 2012, has significantly improved, despite a large influx of new complaints in October and January, which was only offset by an unexpectedly low number of new cases in December 2011. It is expected that in the coming months, more cases will be closed than opened, and far fewer older cases will remain open and unresolved beyond a 12 week threshold.



In respect of the caseload at any one time, this has been averaging around 250 cases. That is, cases awaiting a first response, those that have been responded to but further work is required, and cases that are subject to review or re-investigation, perhaps following Ombudsman involvement.

At the end of January 2012, the following represented the active caseload being handled within the Patient Services team. The diagram includes data from June, as all complaints opened in April and May had been responded to and those months were therefore deemed “closed”.



6.3 Current Position

Of the 621 cases included in this complaints report, 417 are now closed. The active caseload continues to average around 200 cases, including about 20 cases that have been re-opened for further attempts at local resolution.

In the first two weeks of February 2012, more than 50 cases were closed, indicating a continued move towards greater closure rates, and reduction in the number of cases awaiting a response, which had been queued following investigation.

At present, around 20 cases are generally awaiting write up at any one time, and half of these are within the original specified timescale for reply. There is no longer a queue for quality assurance which has reverted to the anticipated timescale of 48 hours to complete where no further investigation is required. This is a reduction from a queue that in December 2011 exceeded 90 cases awaiting response and more than 70 cases awaiting quality assurance at any one time which added several weeks to the anticipated timescales advised for responses.

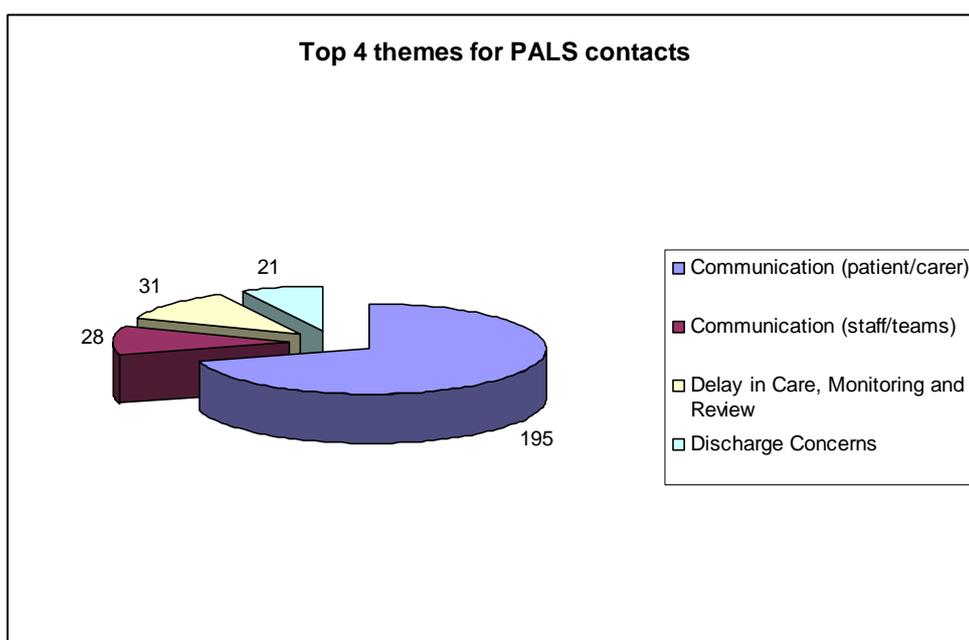
The complaints process and future resources for complaints handling remain under review. Audits are undertaken each month to ensure greater accuracy in the information available to monitor progress and assess delays and caseloads.

6.4 PALS Report

PALS (Patient Advice and Liaison Service) receive contacts from patients, carers and visitors, as well as referrals from staff, about the services of this Trust. Contacts can include enquiries, concerns, or requests for information or help. Where applicable, PALS will direct people to alternative services to obtain the help or information required.

In the reporting period October 2011 – December 2011 PALS received 485 contacts, up from 466 reported in the previous quarter.

The majority (57%) of these PALS contacts comprise the following top 4 themes:



The trend for PALS contacts therefore continue to reflect the issues being raised in complaints.

6.5 Inpatient Experience

All patient experience with the exception of information regarding medication side effects rose during January. Although this is a positive result, ward managers are encouraged to maintain a focus on improving the patient experience as there are six indicators that remain below 90%. Action plans for improvement are monitored through a Quality performance meeting

Table 4: Monthly responses to patient experience surveys

	Sep 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012
How clean is this ward (including toilets)?	95% ↑	94% ↓	91% ↓	92% ↑	97% ↑
As far as you know do the staff wash or clean their hands between touching patients?	91% ↑	92% ↑	92% ↓	91% ↓	95% ↑
Do you feel informed about potential medication side effects?	72% ↓	58% ↓	65% ↓	71% ↓	60% ↓
Do you feel you have enough privacy when discussing your condition or treatment with staff?	91% ↑	87% ↓	82% ↓	85% ↑	86% ↑
Do you feel that you have been treated with respect and dignity while you are on this ward?	97% ↑	96% ↓	96% ↓	90% ↓	95% ↑
Do you feel involved in decisions about your treatment and care?	68% ↓	77% ↓	82% ↑	80% ↓	83% ↑
Have hospital staff been available to talk about any worries or concerns you have?	84% ↑	86% ↑	90% ↑	81% ↓	90% ↑
Do you get enough help from staff to eat your meals?	83% ↑	86% ↑	92% ↑	83% ↓	90% ↑
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	100% ↑	99% ↓	100% ↑	97% ↓	99% ↑
Do you think hospital staff do everything they can to help control your pain?	96% ↑	88% ↓	90% ↑	82% ↓	90% ↑
When you use the call buzzer is it answered?	77% ↓	81% ↑	90% ↑	82% ↓	83% ↑
Have staff talked to you about your discharge from hospital?	32% ↓	50% ↓	61% ↓	52% ↓	55% ↓
Total	82% ↑	83% ↑	86% ↑	82% ↓	85% ↑

6.6 Outpatient survey 2011

The NHS National Outpatients Department Survey has recently been published having previously been conducted in 2009 and 2004/05.

Information drawn from the core questions in the Outpatients Department surveys are used by the Care Quality Commission (CQC) in its assessment of acute and specialist trusts in England, covering the period April/May 2011.

The table below provides an overview of the 2011 survey and compares 9 key sections with performance at SaTH OPD in 2009.

The 2011 response rate was 59% which compares favourably with the response rate for 2009 of 55.8%, and compares with the national response rate of 53%.

The results show that most areas results have remained fairly constant.

In 2011 of the nine sections surveyed the performance remains “about the same” in eight of the sections in comparison acute trusts in the UK. In ten of the questions the trust performance is significantly worse than 2009 but the scores in comparison to other acute trusts remains “about the same”. Overall patient experience has improved from (8.5/10) to (8.8/10)

Major areas for improvement identified

- Informing patients of wait times in OPD
- Information given to patients
- Improving patient choice in treatment pathways
- Improve the explanations given to patients about tests, treatment and medications

The purpose of the National patient surveys is to capture patient’s views. It is obligatory for all NHS Trusts in England to implement the survey on a regular basis with a random sample of their patients. The Inpatient ward to Board Indicators outlined in the previous section will be implemented within Outpatients during the first Quarter of 2012/13 and will provide a monthly analysis of the key areas highlighted in the 2011 survey and will provide the Centres and the Trust Board to track the improvements on a monthly basis.

The results of the NHS surveys should be used by Trusts to help them set priorities to ensure they are delivering a better service for patients. Information drawn from the core questions in the Outpatients Department surveys are used by the Care Quality Commission (CQC) in its assessment of acute and specialist trusts in England, covering the period April /May 2011 .Measuring and reporting patient experiences in a structured way helps ensure that improving patient experience remains a priority for NHS Trusts.

The following table shows both the changes in the key scores (measured in 9 domains) for the Trust and highlights the previous survey results and where we are in comparison with other acute trusts

Section Heading	A. Score out of 10 for our trust 2011	A. Score out of 10 for our trust 2009	B.Comparison of Trust with other acute Trusts in England 2011 score
Before the appointment	7.18	7.17	About the same
Waiting in the hospital	4.82	4.91	About the same
Hospital environment and facilities	8.72	8.54	About the same
Tests and treatment	7.88	8.28	About the same
Seeing a doctor	8.54	8.79	About the same
Seeing another professional	8.56	8.57	About the same
Overall about the appointment	8.06	No score	About the same
Leaving the outpatients department	6.34	No score	About the same
Overall impression	8.78	8.46	About the same

The Chief Executive, the Executive Team and the Board all have a major role to play in establishing a culture of safety. One highly effective way of demonstrating commitment is through Executive walk rounds, where senior Executives go to clinical areas and discuss with frontline staff concerns for the safety of their patients.

As a formalised framework, patient safety walkrounds were initially introduced by Allan Frankel, MD at Brigham and Women's Hospital, Massachusetts and have since been developed by the Institute for Healthcare Improvement as a tool to engage leaders and frontline staff in a meaningful discussion of patient safety concerns with agreed actions.

Benefits of Quality and Patient Safety Executive Walkrounds

In SaTH the safety of patients is seen as a priority, walkrounds can be instrumental in helping to develop an open and no blame culture in order to continue to improve the care which we deliver to our patients.

Walkrounds provide a formal process for Directors to talk with frontline staff about safety issues in their departments/wards and show their support of staff for reporting errors/near misses.

In summary walkrounds will add value to the organisation by:

- demonstrating top level commitment to patient safety
- establishing clear lines of communication about patient safety among employees, executives and managers
- provide opportunities for senior executives to learn about patient safety
- encourage reporting of issues, errors and near misses
- promote a culture for change pertaining to patient safety
- contribute to developing local solutions to minimise risk

The walkarounds commenced in October 2011 and have covered the following areas to date:-

Medical Engineering Services (31st October 2011)

Ward 26U- RSH (28TH Nov 2011)

Ward 4- PRH (19TH Dec 2011)

Ward 27- RSH (22nd Dec 2011)

Ward 15- PRH (19th Jan 2012)

Medical Records (23rd Jan 2012)

The outputs from those visits are shared with the clinical / non clinical teams and shared with the Executive team in their meetings as well as an overview in Quality and Safety Committee.

7.0 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 (QIS). During November, December 2011 and January 2012, the Director of Quality and Safety / Chief Nurse has facilitated a number of QIS workshops to engage staff and patients in their views about quality improvement. The Quality and Safety Committee have reviewed the outputs from those workshops and considered the improvement priorities. The Trust Board has reviewed a first draft of this Strategy document in a Board development session whilst consulting with Local Health Economy partners and stakeholders about the Quality Improvement objectives for the five year Strategy. The Strategy is on track for approval at the end of March Trust Board.

8.0 Engaging our patients and carer / patient representatives.

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, both in our Strategy as outlined above but also in evaluating patient experience in real time. The group has received their formal training to support an active work programme and will be commencing this in March 2012.

9.0 Conclusions

The Board 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
March 2011

Appendix 1: Task and Finish Group Review

Background

The Trust has experienced a significant backlog of patients who had waited longer than expected to be seen in the outpatient clinic (initial or follow up appointment), resulting from high levels of demand for services at the Trust coupled with issues with the appointment and booking systems.

The local health economy Task and Finish group (membership included senior level clinical representation from SaTH, Shropshire County PCT, NHS Telford and Wrekin, Shropshire County Clinical Commissioning Group (CCG) and Telford and Wrekin CCG) has undertaken a detailed review of a group of patients (1,149) who had passed their maximum wait for their outpatient appointment (initial or follow up appointment) at 11th July 2011

Clinical Review

Patients were prioritised by their GPs and Trust consultants through a systematic process. The Trust offered appointments and reviewed these patients in line with their clinical need. The exercise has highlighted a number of specialities (hearing assessment clinics, ENT, Gastroenterology and Ophthalmology) with a significantly higher number of patients waiting for their outpatient appointment past maximum wait

All patients from this cohort have been reviewed within an agreed timeframe except a small number of patients who have chosen to delay their appointment.

Assessment of Harm

A robust process to assess the impact of delay in appointment on patient was implemented. There is no evidence that patients from this cohort has experienced harm due to delay in their appointment

Communication

The local health economy and patients have been kept up to date with the progress in reducing the backlog of patient through a comprehensive communication, engagement and media plan

Parallel Work Streams

The Task and Finish group has established links with other working groups to align the various work streams undertaken by the local health economy to address the outpatient backlog.

SaTH has worked with Shropshire County PCT and NHS Telford and Wrekin to address the issue through a number of initiatives including

- Additional funding of £3.5m from the PCTs to provide increased capacity at the Trust
- Additional outpatient clinics
- Additional permanent booking staff
- Standardisation of appointment letters
- Strengthening of management support
- Introduction of a Referral Assessment Service at Shropshire County PCT through which routine referrals in some specialties are reviewed to identify community based or other services where patients can be seen more quickly. It is anticipated that this will help to ease the demand on our services. The specialties are urology, cardiology, dermatology, ophthalmology and ENT
- A high profile communications campaign is to be launched throughout Shropshire, Telford & Wrekin, Herefordshire and Worcestershire to raise patients' awareness of the rights and pledges set out in the NHS Constitution for England

Recommendations

The board is asked to note the work of the group in undertaking the look-back exercise and the current position as described in the report

Appendix 2: Report into Ophthalmology Delays

1. Introduction

The Shrewsbury and Telford Hospital NHS Trust (SaTH) identified a cohort of ophthalmic patients who had experienced a delay in their treatment as a result of deficiencies in patient administration systems.

A clinically-led review process was established between The Shrewsbury and Telford Hospital NHS Trust and the West Mercia PCT Cluster to:

- Identify whether any patient had experienced a deterioration in their condition as a result of this delay in treatment;
- Ensure openness and transparency with patients who had experienced a delay in accordance with the NHS “Being Open” principles;
- Provide assurance in relation to the systems and processes in place to track patients and ensure timely access to care.

2. Actions Taken

A range of actions has been undertaken as part of this review, including:

- Follow up of all patients in this cohort to identify and discuss the reasons for, and any impact of, the delay in treatment, and to provide further follow up and support where required.
- Clinically-led review of reported delays in treatment, including a root cause analysis to identify and address the reasons for delay.
- Improved systems in SaTH for reporting potential delays in treatment to ensure review and early intervention.
- Strengthened processes in SaTH for ensuring that the outcomes from outpatient clinics are tracked and followed up.
- Improved booking and scheduling systems in SaTH to address delays in appointments.
- Ongoing review between the Cluster and the Trust, for example through the regular monthly quality review meetings.
- External reviews and assurance, for example to improve planning for future capacity and demand.

As a result of these actions:

- A comprehensive and detailed review process has taken place, and the Cluster and the Trust plan to continue to build on this process to support ongoing quality review and assurance in the local health economy.
- There has been open and transparent discussion with patients in line with the NHS “Being Open” principles.
- This review has been formally signed off between the Cluster Executive and the Trust.

3. Outcome of the review of ophthalmology delays

As a result of this review it has been identified that the six patients had severe deterioration in their eyesight and seven patients had mild or moderate deterioration in their eyesight during an extended wait for treatment. In these cases either it is considered likely that the delay contributed to this deterioration, or the contribution of a delay in treatment could not be ruled out.

These patients have been informed through an open discussion with a Consultant Ophthalmologist, including the reasons for the delay, the impact on the patient, the potential consequences and the ongoing support available from the local NHS. They have also been offered an apology and access to appropriate support and counselling.

It is a matter of profound regret that patients have experienced a deterioration in their condition, and the local NHS is committed to ensuring that these patients continue to receive all appropriate support if they require it.

This review provides a high level of assurance that risks have been identified and mitigated through the actions taken and the improvements made.

4. Communication

The Trust and the Cluster Trust have continued to report publicly on the delays that have faced some patients waiting for treatment, and to remind patients of the routes for providing feedback and for raising concerns if they feel that waiting time standards are not being met and/or where they feel that their condition may have deteriorated whilst waiting for treatment.

Open and honest communication with patients and their families is at the heart of health care. The Cluster and the Trust have ensured that the principles of “Being Open” have guided communication with individual patients through this review.

The local health community across Shropshire and Telford & Wrekin plans to launch a campaign to promote the rights and pledges in the NHS Constitution for England in March 2012.

5. Conclusions

It is a matter of profound regret that patients have experienced a deterioration in their condition, and the local NHS is committed to ensuring that these patients continue to receive all appropriate support if they require it.

Alongside individual communication and support for patients and their families, a clinically-led review of systems and processes for tracking patients and ensuring timely access to care has taken place.

This review forms part of a wider programme of ongoing assurance in partnership between SaTH and the Cluster. Collectively, these reviews provide a high level of assurance to the Cluster and Trust Boards that risks have been identified and mitigated through the actions taken and the improvements made.