Report to Trust Board - June 2013

Enclosure 6

Title	Quality Account 2012/13
Sponsoring Executive Director	Director of Quality and Safety / Chief Nurse
Author(s)	Deputy Chief Nurse- Sarah Bloomfield
Purpose	Requires Trust Board approval
Previously considered by	Trust Board & Quality and Safety Committee

Executive summary

The Quality account is the one of the most important documents to be published each year by provider organisations and seeks to provide information on the Trust's performance in relation to the previous year's quality priorities plus a range of other Key Performance Indicators. The Account also sets out the priorities for improvement for the year ahead which span the 3 domains of quality; patient safety, clinical effectiveness and patient experience.

National statutory requirements (Health Service Regulations) have established a series of mandatory statements which each Quality Account should contain, as well as expected information for sections on research, clinical audit and information governance. A prescribed list of KPI's must also be included. The accuracy of two selected KPI's and the mandatory content sections are audited externally by KPMG.

A series of internal and external stakeholder discussions have influenced the clinical priorities for 2013/14 and these have been presented within the document.

This account in its draft form has now been shared with statutory stakeholders in order to gain their formal commentary which is included in the final draft Quality account.

Related SATH objectives	SATH Sub-objectives
C1-6	

Risk and assurance issues	Provides assurance on a range of safety and quality measures.
Equality and diversity issues	Outlines improvements made on a range of equality and diversity issues
Legal and regulatory issues	This document forms part of the statutory requirements established for provider organisations as set out in the Health Service regulations

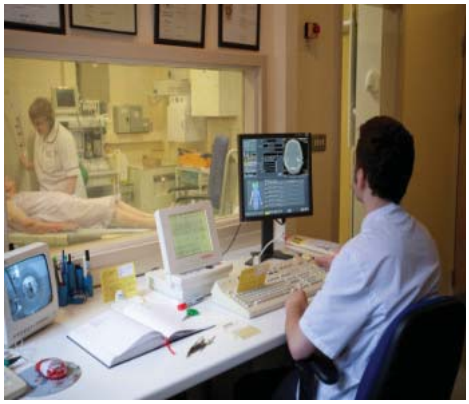
Action required by the Committee

The Trust Board is asked to **APPROVE** this Quality Account 2012/13.

The Shrewsbury and Telford Hospital NHS
NHS Trust

The Quality Account

2012-13



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Chief Executive statement

Quality, experience, safety and outcomes clearly must be the central driving principles for every NHS trust. Here at The Shrewsbury and Telford Hospital NHS Trust we have set out our clear commitment through our vision of Putting Patients First.

Joining the Trust during the year, several things I was very keen to understand were how we are performing, what our patients think about us and what their real experience is within our wards, clinics and departments. I also wanted to know what inspires and motivates our staff to always strive to give of their best.

This Quality Account is a vital and valuable snapshot of these various themes. It shows issues and areas where we have progressed well and made improvements such as a reduction in falls resulting in serious harm, the introduction of a frail and complex service, and improvements in our discharge pathways. These are clearly things that we need to build on, but there are also many other areas where significant improvement is still needed.

My commitment as Chief Executive as I begin my first full year with the Trust is to ensure that this is an organisation that is relentless in its pursuit of the patient's interests. Exceeding the expectations of our patients and the communities that we serve must always be what drives us.

In order to do this, the Quality Account sets out the priority areas that we need to focus on. These have been driven and identified by our patients, partner organisations and staff and by comparing ourselves with how other organisations across the NHS and beyond are delivering consistently high standards of care.

They include a focus on communication with our patients, relatives, GPs and community teams, and ensuring patients have a safe and effective discharge from hospital. Other priorities include continuing to reduce the numbers of patient falls, and the ongoing reconfiguration of inpatient services to meet the changing needs of our patients.

It is clear that in some areas of quality we have not delivered the standards that our patients and communities have the right to expect. I think there are two key issues that sit at the heart of this. The first is culture, which I will return to later. The second is capacity and flow.

It has been very clear that a big challenge for us, and also for the whole health and care system, has been the ability to meet, in a timely way, the urgent and emergency care needs of our communities. This issue is reflected throughout the Quality Account, and it is a significant contributory factor in cancelled operations and an increase in pressure ulcers, and has had an impact on patient experience.

This is why for me, ensuring that both within and outside hospitals we have got the right plans and the right capacity in place to deliver compassionate urgent care has been a significant focus during my first few months in post.

Knowing what we do today about demands for health services, I personally believe that this organisation would not come to the same conclusions as last year when it decided to reduce bed capacity (and the staffing associated with this). Our patients have felt the impact of this and our staff have also felt this impact. However, I am confident that we are much closer to getting it right as a health and care system.

It's critical that we focus on the culture of the organisation and ensure that this is founded on the values of the Six C's - ***Care***, ***Compassion***, ***Courage***, ***Communication***, ***Competence*** and ***Commitment***. As Chief Executive, this will be my first priority for the year ahead – to ensure, engage, empower, and encourage a culture in this Trust where everyone feels able to provide the highest standards of care every time for every patient.

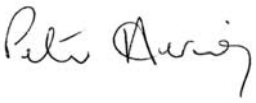
I want us to be a Trust which has the ***courage*** to be open when things go wrong and to have the ***competence*** to deliver what is expected and needed from us, whether we are providing frontline care or supporting those that do.

We need to ensure ***communication*** that is truly and fully focused on the needs of the patient in front of us and their family and loved ones, and that we have the ***compassion*** to always be present in the moment for the people we care for and work with.

I want us to have the ***commitment*** to always give of our best, and last but not least, to be a ***caring*** organisation that always **Puts Patients First**.

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.



Peter Herring
Chief Executive Officer

Part 1

Quality Review

1.1 A Review of Quality Performance in 2012 - 2013

In last year's Quality Account we outlined seven quality priorities for 2012/13. For each priority we have provided a report outlining the work undertaken within the Trust to underpin the improvements required.

Quality Priority 2012/13	Current Status of Priority	Comment	Further Details on Page
Preventing avoidable pressure ulcers		Despite continued focus on pressure ulcer prevention we have not eradicated grade 3 and 4 hospital acquired pressure ulcers over the last year. We have however, completed a baseline data collection of grade 2 ulcers and commenced Root Cause Analysis on these.	9
Reducing Inpatient Falls		A reduction was achieved in overall falls plus falls resulting in serious harm was reduced by 25%. Plus 94% of patients received a comfort round.	10
Safer Blood Transfusion		Improvements in training have been achieved, however observations have not demonstrated the required improvement	10
Using Patient Involvement to Improve Patient Experience		• A wide variety of work has been undertaken by the PEIP over the last year. • The Friends and Family question has been completed for 10% of discharged patients each week. • Ward to Board surveys have expanded with more planned for the next 3 months	11
Improving the Experience of Frail Elderly Patients		The Frail and Complex Service was launched successfully at the Royal Shrewsbury Hospital in December 2012 and at the Princess Royal Hospital in January 2013	11
Providing Effective Diabetes Care to Our Patients		• Good progress with e learning training with application for Certificate of Achievement being progressed by the Trust. • Single point lesions developed • Patient experience survey for diabetic patients completed • Awareness day held which was very successful	12
Improving the Patient Journey		• Expected Date of Discharge further embedded and now supported by PSAG • Improvements made in Outpatient Experience	13

Update on Quality Priorities in 2012/13

1. Preventing Avoidable Pressure Ulcers

Why was this a priority?

Last year we committed to eliminate avoidable Grade 4 pressure ulcers by December 2012 and Grade 3 pressure ulcers by March 2013. We have not achieved this and therefore must understand why we have not achieved our target in order to ensure that we achieve significant and demonstrable improvements in 2013/14.

The Trust is fully committed to achieving this priority as we recognise that the delivery of harm free care is as important to our patients as it is to us. Therefore we must and will provide an environment of safe and effective pressure area care to all patients at risk

What were our goals for 2012-2013?

Last year we committed to eliminate avoidable Grade 4 pressure ulcers by December 2012 and all avoidable Grade 3 pressure ulcers by March 2013.

We also said that we would do more to understand the number of grade 2 pressure ulcers and to improve the number of patients who received an assessment of their skin within 2 hours of admission.

What have we achieved?

We have experienced a 63% increase in reporting of Grade 4 pressure ulcers and a 100% increase in reporting grade 3 pressure ulcers. These figures however have not been fully adjusted as they reflect all hospital acquired pressure ulcers including those that were clinically unavoidable. To ensure a transparent process is followed, any pressure ulcers deemed by the Trust to be unavoidable are then put forward for ratification by our Clinical Commissioning Groups.

The majority of all Grade 3 and Grade 4 Pressure ulcers reported since 01/01/2013 appear to fall into the category of being unavoidable (still pending investigation). Since 01/01/2013 the Trust has declared three (3) Grade 4 pressure ulcers, two (2) of which are suspected as being unavoidable at the time of reporting. However, as outlined above these would all require ratification and would remain reported as avoidable within Trust data until agreed otherwise.

The process of confirming unavoidable pressure ulcers with our Commissioners has initially identified two (2) grade 3 pressure ulcers as matching the criteria for unavoidability (and therefore are not included in the figures identified), and a further 11 ulcers that are currently going through the ratification process.

	Grade 3	Grade 4
Confirmed SaTH (avoidable)	16	8
Unavoidable (confirmed by Commissioners)	2	0
Awaiting ratification (investigation in progress within organisation)	1	0
Pending ratification (with Commissioners to confirm as unavoidable)	11	5

What more do we need to do?

Reducing and preventing hospital acquired pressure ulcers is seen as a priority not only nationally, but also locally. Included in this priority is not only the elimination of avoidable Grade 3 and 4 pressure ulcers, but also to significantly reduce the number of Grade 2 avoidable pressure ulcers that are hospital acquired.

From September 2012 Grade 2 pressure ulcers were more closely monitored and a Root Cause Analysis is now completed for each one. Validation of the grading is completed, and in just over 50% of cases the initial grading is classified as not Trust acquired, moisture lesion or not a pressure ulcer. This assists the Trust in understanding the scale of the target to be achieved and actions that will be required to achieve those improvements.

All ward based nursing staff complete a pressure ulcer prevention workbook and are supported by our Tissue Viability Team with expert knowledge to deliver care. The Trust also ensures that staff are supported to attend formal post graduate tissue viability training with Staffordshire University. In the year ahead practical pressure ulcer prevention training will be included within the "Fundamentals of Care" day which is described in more detail later in the Quality Account.

The Trust has developed a Pressure Ulcer action plan which will be delivered in full over the coming year. Examples of actions include;

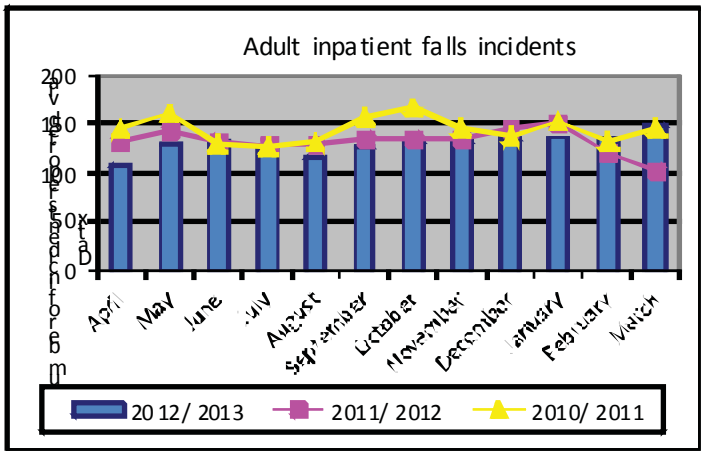
- Expanding our Tissue Viability team to provide an improved level of support and training to our staff
- Launching a Pressure Ulcer Prevention Group, chaired by the Corporate Nursing Team
- The Fundamentals of Care study day will be mandatory for ward based staff.
- Nursing documentation improved to support staff in making decisions about pressure area care.

We continue to use the Safety Thermometer and Pressure Ulcer reporting data to monitor and report our performance.

2. Further Reduction of Inpatient Falls

Why was this a priority?

It is recognised that patient falls in hospital have the potential to lead to loss of confidence, serious injury, and extended stays. It is also widely recognised that patients may be at higher risk of falling in the hospital environment than they would be in their own homes due to the less familiar change in environment.



What were our goals for 2012-2013?

Our quality priority was to continue to achieve a year-on-year reduction in adult inpatients falls (excluding spontaneous fits, faints and collapses) which we had achieved in the previous two financial years.

We also said that we would reduce falls resulting in serious harm by 25% and that we would ensure that 100% of patients received a comfort round according to their needs.

What have we achieved?

In the financial year 2011/ 2012, we recorded a total of 1590 adult inpatient falls excluding spontaneous fits, faints and collapses. In the financial year 2012/ 2013 we recorded a total of 1562 similar incidents, which represents a modest reduction. Notably, the pattern of month-on-month reduction was sustained from April 2012 to January 2013, but not for February and March 2013 which this year more closely reflected the seasonal pattern for the year 2010/ 2011 than the year 2011/ 2012 as we saw an increase in emergency activity during this period. During March 2013 we also saw a 75% increase in the number of Frail and Complex patients being admitted to our hospitals for more than 48 hours.

In the financial year 2011/ 2012, we reported a total of 29 falls resulting in serious injury to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). In the financial year 2012- 2013 we reported a total of 22, which represents a reduction of approximately 25%.

The Trust's Falls Group continued to be active in progressing falls prevention measures across the hospitals. The year's activities have included a small-scale trial of bed pressure sensors and alarms, a trial of a new style of falls risk assessment on Ward 16 (informed heavily by the national FallSafe research project which was published in July 2012 by the Royal College of Physicians), and continued oversight of the lessons learned from the Trust's root cause analysis investigations into falls resulting in serious harm.

What more do we need to do?

In recognition of the seriousness of the risk to patients arising from falls in hospital, in February 2013 the Trust Board approved a corporate action plan aimed at reducing falls resulting in significant harm in hospital, which will form a major programme of work for the Trust in the coming financial year. This work will be monitored regularly by the Quality and Safety Committee and the Falls Task Group.

Some typical examples of the work planned for the current year are:

- A major programme of falls prevention e-learning for ward-based staff;
- A larger trial of bed and chair pressure sensors, and a separate trial of one-way slide sheets for use in bedside chairs;
- The introduction of a new style of falls risk assessment and care planning which it is hoped will lead to more individualised care plans for patients judged to be at risk of falls.

3. Safe Blood Transfusion

Why was this a priority?

Previous audits and monitoring performance (including national benchmarking) showed there were three main areas relating to blood component transfusion that should be improved to increase patient safety and also meet a national demand to reduce wastage of this precious component as blood stocks are low.

What were our goals for 2012-2013?

1. Reduce the number of sampling errors
2. Ensure we record patients vital signs at the right time, every time
3. Waste less blood components

What have we achieved?

Training

Medical staff recording of theory assessment commenced in August 12 and was initially 37.7%. In the six months from baseline, we have achieved a steady increase to 52%. Nursing/support staff reached 85.6% compliance in August 12, however has since reduced slightly to 83% mainly due to new staff starting and some two yearly competency assessments expiring which are awaiting renewal.

Sampling errors

10% reduction in overall rejections
15% reduction in serious errors

Monitoring of vital signs

Monthly spot check audits matched the results of 140 transfusions in May 12, which means that we have not improved in this area. The increase in compliance in the March 13 audit is promising and we must maintain a focus on this to ensure sustained improvement.

Red cell wastage has been reduced by 27% through a change in blood collection by Portering staff. However plasma wastage has been increased possibly due to implementation of the national massive haemorrhage protocol. It is hoped that that this will show a reduction over the next year.

What more do we need to do?

- A systematic review of how to achieve the sampling competency assessment so that it is robust and effective. This will ensure that through training and education staff sample correctly by understanding processes and impact on outcomes for patients.
- Review a proposal for introducing an electronic add-on program to the BloodTrack system for safe sampling.
- Review processes of accountability for incidences of incorrect sampling and monitoring (and/or documenting) patients vital signs.
- Transfusion training to be prioritised by supporting link nurses to take on training of their own staff as this is not sustainable by the transfusion practitioners.
- Agree an action plan to improve platelet wastage.
- Reinforce a culture of not carrying out a transfusion if there is 'no time to perform basic safety checks' (non-acute situations)
- To improve compliance of recording vital signs.

A trial is being piloted over the coming months, the results of which will be fed back to Matrons for dissemination and action to benchmark our standards of practice with other Trusts across our region.

4. Using Patient Involvement to Improve Patient Experience

Why was this a priority?

We currently receive feedback from our patients in a variety of ways which we can then use to make improvements in the way that we deliver our services. Moving forward we need to involve patient representatives in the development of our services to deliver an enhanced patient experience, we also need to consolidate the role that the patient representatives have in the reviewing and monitoring of care

What were our goals for 2012-2013?

- Patient Experience and Involvement Panel (PEIP), to be involved in the monitoring and review of care delivery utilising a comprehensive programme of work.
- The implementation of the Friends and Family test across inpatient areas with the aim of achieving a 10% response rate and a ten point increase on the April 2012 benchmark score. Our benchmark figure was set in April 2012 at 63.12 , we achieved 75.7 for March 2013.
- Expansion of the ward to board metrics to outpatient and speciality areas such as Outpatients and Renal Unit.
- Develop clear action plans to address the issues identified in both inpatient and outpatient surveys

What have we achieved?

The patient representative panel has recruited representatives with a variety of special interests and backgrounds to increase the size and strength of the group.

Panel members have continued to build on last years comprehensive work programme and have been involved in a collection of patient stories, observations of care, quality assurance frameworks and audits of patient mealtimes. Over the last year panel members have been included in the recruitment process for senior nursing roles within the corporate team and have also been co-opted onto the project board of the Booking and Scheduling board.

We have implemented the Friends and Family Test across all inpatient areas, and in doing so achieved a response rate averaging above 20% and a ten point increase on our April 2012 benchmark score.

Monthly Outpatient satisfaction surveys are collected to allow monitoring of the areas in which the trust scored less well in the national survey. This has informed the review of the Outpatient action plan. The survey results show a sustained improvement in the eleven questions asked.

The trust has conducted quarterly inpatient questionnaires in which the questions asked have been designed to focus in on the areas in which the trust scored lowest in the National Survey 2011.

What more do we need to do?

We will continue the work with departments to improve the patient experience in the areas identified in the inpatient survey results. We will also expand the Friends and Family test to Maternity and Emergency Department services during 2013/14.

We must sustain and improve upon the level of involvement of PEIP members across a range of activities within the Trust.

5. Improving the Experience of Frail Elderly Patients

Why was this a priority?

The Frail and Complex Service is one of the 4 key transformational change programmes within the Shropshire Unscheduled Care Strategy 2011-2014.

The Frail and Complex Service provides a joint approach between hospital and community health and social care staff to ensure that patients are getting the right care in the right place at the right time.

Nationally over the next 20 years, the number of people aged 85 and over is set to increase by 66% compared with a 10% growth in the overall population. Older people are admitted to hospital more frequently, have longer length of stay and occupy more bed days in acute hospitals compared to other individual groups. They have the highest readmission rates and highest rates of long term care use after discharge.

In addition, key local reasons for change include:-

- The need to provide an high quality, financially efficient service.
- Reduce the reliance on hospital beds and care for frail and complex patients in a community setting wherever possible
- Improved support for patients from community care resources
- Current fragmented services are failing to meet the needs of the population

What were our goals for 2012-2013?

"To achieve the best outcomes for frail older people through an integrated health and social care whole systems approach with inter-disciplinary/agency teams who understand the complex needs of this patient group, delivering a range of interventions at different stages along the patient journey from prevention and early identification through to services that manage acute illness (or exacerbations of chronic illness) without resorting to admission to specialist services in acute hospitals. Health and social care services are strategically aligned with shared leadership within a joint regulatory and governance framework".

Programme Description of the Frail and Complex Service

This is a three year project. Much of 2012-13 was spent establishing the foundations for integrated working across the health and social care economy. The specific operational aim for 2012-13 was to launch this new way of working in both of SaTH's acute hospitals.

What have we achieved?

Following a series of monthly stakeholder workshops and operational meetings including patient representatives, the RSH Frail and Complex Service commenced on the 3rd December 2012 with the PRH Frail and Complex Service commenced on 28th January 2013

What more do we need to do?

The launch of the service in the acute hospitals is only stage 1 of the service development programme. The next critical step is to roll out the service across the county to strengthen the 'admission avoidance' element of the work on a more equitable basis for Shropshire residents and to target over 14 day length of stay patients in SaTH to strengthen the earlier supported discharge focus. The Frail and Complex Team have just begun dementia screening to support CQUIN requirements and in order to work more closely with colleagues in the RAID service as there is considerable overlap in this patient group. Running parallel to this is the need to explore active case management in GP Practices, work in partnership with Powys health board to develop a similar model of care and develop single point of access and a demand and capacity information hub

6. Providing Effective Diabetes Care to Our Patients

Why was this a priority

Diabetes is a condition that affects a significant proportion of patients either directly or indirectly through carers and relatives. 1 in 5 patients admitted to our hospitals have diabetes. Following the implementation of the "Think Glucose" campaign across the Trust during 2011, several areas for increased awareness and improvement have been highlighted for focus across all 3 domains of quality during 2012/13 with the overall aim being to reduce incidents relating to the prescribing and administration of Insulin and to improve outcomes and experiences for patients with Diabetes.

What were our goals for 2012-2013?

We will see a reduction in the number of prescribing and administration errors recorded on DATIX, the Trust's incident reporting system. This will be achieved by the following;

- 80% of appropriate staff will complete the learning modules as outlined by the NPSA
- Single Point Lessons will be developed and made available to staff which act as a quick reference guide and will cover a variety of subjects such as; complications of diabetes prescribing insulin, managing emergency situations.
- An awareness campaign led by the Endocrine Consultants and Diabetes Nurse Specialists which is supported by the board which focuses on specific diabetes related subjects and incorporating and awareness day and road show for a variety of staff
- A survey of diabetic patients to capture their experience of care delivered by the Trust
- An audit of identified inpatient areas against Key Performance Indicators

What have we achieved?

We have seen a slight increase in the number of errors recorded on the DATIX system. This may however be a reflection of the increased awareness of diabetes related issues with in the trust.

A review in October 2012 showed that 135 members of trust medical and nursing staff have completed the module on safe use of variable rate insulin infusions and 537 members of trust medical and nursing staff have completed the safe use of insulin module

We have developed single point lesson plans, which have been developed for all the key areas relating to diabetes. In addition we established an awareness campaign led by the Endocrine Consultants and Diabetes Nurse Specialists which is supported by the board and focuses on specific diabetes related subjects.

In November; a repeat patient experience questionnaire was sent out to 200 patients with diabetes that had been in to hospital since April 2012. The results of this showed:

- 3% improvement in timely monitoring of blood glucose levels
- 19% improvement in patients ability to self administer diabetes medication whilst in hospital
- 12% improvement in accessibility of medications in order for self medication purposes
- 14% drop in overall satisfaction with care.

What more do we need to do?

The diabetes team will be monitoring the DATIX reports received regarding diabetes within the trust in addition to review of medication incidences reported via E-script and will report twice yearly to the Clinical Governance Executive regarding performance and progress. The trust will need continue to support the 80% completion of the online diabetes modules by all medical and nursing staff. In addition these registers will sub categorised to each clinical area in order to target areas that do not reach the 80% compliance target. The diabetes team will continue to audit the clinical areas for compliance to Think Glucose performance indicators

7. Improving the Patient Journey

Why was this a priority?

We recognised that the patient's journey has many steps and that we need to ensure that these run as seamlessly as possible. We needed to ensure that when our patients are admitted to our hospital that we give them information about when they can expect to go home. For outpatients we needed to ensure that communicate the right information at the right time , whether that is before their appointment or after they have arrived.

What were our goals for 2012-2013?

Undertake a comprehensive review and revision of the patient information literature to ensure that accurate information is available for patients on admission about what they can expect during their hospital stay.

We said that 90% of our patients will have had an expected date of discharged communicated across the healthcare team. This information is gathered from our Patient Status at a Glance screens and discussed on daily board rounds.

We said that patients attending for an appointment receive timely and accurate notice of their appointment and that once they have arrived at the department they were kept updated about what they can expect to experience. We said that we update our patient experience survey to capture this information directly from patients. This information is gathered from our Outpatient survey results

We also said we would improve our Outpatient waiting area signage .

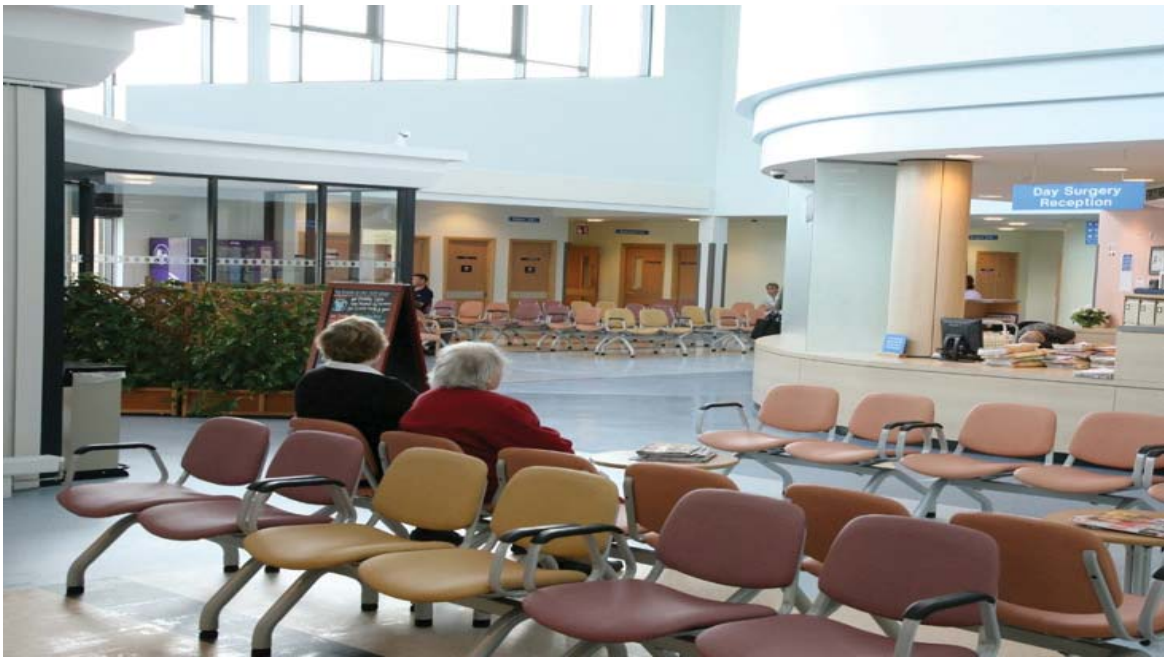
What have we achieved?

- 100% of patients have an Expected Date of Discharge (EDD), however we need to do more to keep patients updated.
- The Patient Information Panel was re launched and working with the Library services is developing database of patient information which is accessible, evidenced based and quality assured.
- Monthly outpatient patient feedback surveys have been completed which show a consistent improvement in the areas in which the trust have performed poorly in the 2011 National Outpatient survey.
- Patient representation on the Booking and Scheduling Project Board and patient representatives undertaking observation of care in outpatient's areas.
- Patient journey through outpatients reviewed at PRH, signage and waiting areas re configured as an outcome.
- Patient representatives involved in the development of clear outpatient action plans to improve the patient journey.

What more do we need to do?

There are many further opportunities for improving the patient journey and just because we have achieved the points above does not mean we should stop striving for best practice in this area. Our increased focus on improving patient flow in our hospitals has highlighted several areas to prioritise for improvement over the coming months. From the patient's entrance to the hospital via the Emergency Department or assessment areas to their discharge from our wards we have identified opportunities for improvement. A key theme from this has been the planning and execution of the discharge process which is why we have included this as a priority for the year ahead. Discharge should be safe and effective every time and we must make this happen.

With relation to the outpatient journey we will continue to work with our patient representatives to develop ways of improving patient flow within the outpatient department. We will also engage with hard to reach community interest groups, such as young carers, to seek out their experiences of outpatients and how we can improve our services to them.



1.2 Our Quality Priorities for Improvement for 2013 - 2014

How we developed our Quality Priorities for 2013/14

Through engagement with our staff and with external stakeholders we have listened to what matters to our patients and staff and this is reflected in the priorities below. These priorities span the 3 domains of quality; Patient safety, clinical effectiveness and patient experience and also reflect key areas of feedback for us such as the national inpatient survey.

	Patient Safety		Clinical Effectiveness	Patient Experience	
	Reducing inpatient falls resulting in serious harm	Preventing avoidable pressure ulcers	Safe and effective discharge every time	Communication with relatives and carers	Non inpatient patient experience
Why is this a priority?	Although we have successfully reduced our overall falls 2 years in a row and achieved our goal for reduction in falls resulting in serious harm last year, there is still work to do to reduce these falls further and to address some common themes.	Although much work has been done to eliminate grade 3 and 4 pressure ulcers and reduce grade 2 ulcers, we still have not achieved our goal in this area. Therefore we must continue to prioritise this very important work until we achieve success.	We have experienced increased pressure on our emergency services which in turn means that the flow of patients through the hospital on their journey of care has been affected. Discharge can often be a complex process, requiring several processes to be followed by our staff and other partner organisations. We know that we do not always discharge our patients well and must work hard to ensure that discharge is safe for patients and their carers.	We know that through our complaints, feedback and patient experience work and also through our inpatient survey that we need to improve on the information we give relatives and carers. This may be about discharge or about patients conditions and ongoing care, where to access help and support if you care for someone with dementia, or even about visiting in hospital and what to expect.	Much of our patient experience work involves inpatient areas and whilst this is highly valuable and must continue we also need to ask our patients in other areas of the hospital what their views are and get their feedback on the service they receive.
Where are we now?	We achieved the reductions we set out to do in last year's quality account and through the increased focus on falls resulting in serious harm have identified key trends and themes that will form the focus of our work over the coming year.	Last year there were 28 grade 3 and 13 grade 4 ulcers that were acquired by patients while under our care. A further 2 grade 3 pressure ulcers were agreed with our commissioners as being unavoidable and 15 and currently still undergoing the ratification process (with a further 2 still going through internal verification).	A comprehensive work plan is underway to improve the flow of patients through the hospital and to support and train our staff to ensure we achieve safe, timely and effective discharge. Estimated Dates of Discharge are identified and recorded on our PSAG system for discussion on the daily board round that occurs on our wards.	Our patient experience work currently involves patients only and we need to extend this work to include carers and relatives.	We have extended our "Friends and Family test" into areas such as the Emergency Department and will be looking to extend this to other areas over the course of the year.

What are our plans for 2013 - 2014?	• Reduce fall resulting in serious harm by 25%, by implementing falls action plan.
	• Deliver the actions within the corporate falls action plan which covers the trends and themes identified, eg;
	  • Ensure we improve our processes for the use of bedrails.
	  • Standardise our handover processes between nursing shifts
	• Develop a falls service to support the above plan and provide expert advice and training
		• Eliminate grade 3 and 4 pressure ulcers
		• Reduce grade 2 ulcers by 50%
			• Improved discharge policy by Summer 2013
			• Strengthened discharge team
			• Discharge training for every registered ward nurse by March 2013
			• Improved discharge information for patients and relatives
			• Faster internal processes for simple and complex discharges
			• Audit that patients receive discharge information, achieving 80% compliance
			• Discharge checklists will be completed for every patient being discharged from our wards
			
			We will report these results in our monthly quality report to the Quality and Safety Committee, and to our Commissioners through Clinical Quality Review meeting.
				• Develop a suite of literature/information for relatives and visitors.
				• Expand our patient experience work to include relatives and carers by developing a range of questions similar to those used in our Ward to Board survey
				• Ensure relatives and carers are represented on our Patient Experience and Involvement Panel
				• Ensure that we signpost carers of those suffering from dementia to access help and support services.
				
				We will audit this and will report these results in our monthly quality report to the Quality and Safety Committee to ensure that we are supporting people enough in these areas.
					• Continue to roll out our Ward to Board nursing care and patient experience metrics into the following non inpatient areas by October 2013
					  • Renal Unit
					  • Outpatients Department
					  • Fertility Unit
					  • Paediatric Wards
					  • Neo-natal Unit
					• Improve our Patient Experience and Involvement Panel work in non inpatient areas and also involve our staff in these areas in developing metrics
					
					We will report these results in our monthly quality report to the Quality and Safety Committee, and to our Commissioners through Clinical Quality Review meeting.

1.3 Other Quality Measures Which Remain a High Priority

Hospital Standardised Mortality Ratio (HSMR)

Understanding mortality and how do we measure it

With the type of acute care hospitals such as ours provides it is expected that some patients will die. We actively monitor our mortality rates using three measures:

- The Hospital Standardised Mortality Ratio (HSMR) (1). This is a national measure and an important means of understanding our mortality against other similar hospitals
- The Standard Hospital Mortality Indicator (SHMI). This is a new national measure that is being phased in, it is similar in many ways to the HSMR but also includes patients who die within 30 days of being discharged from our hospital
- Crude Mortality. This is a local measure and includes all deaths in our hospital

We report SHMI, HSMR and Crude Rate of mortality to the Trust Board as well as to the Quality and Safety Committee on a monthly basis.

What were our goals during 2012/13?

In 2009/10 the Trust was an outlier in the 2011 Dr Foster Hospital guide and we knew there were no quick fixes to this problem. Over the last 2 years we have set ourselves 2 major objectives relating to mortality.

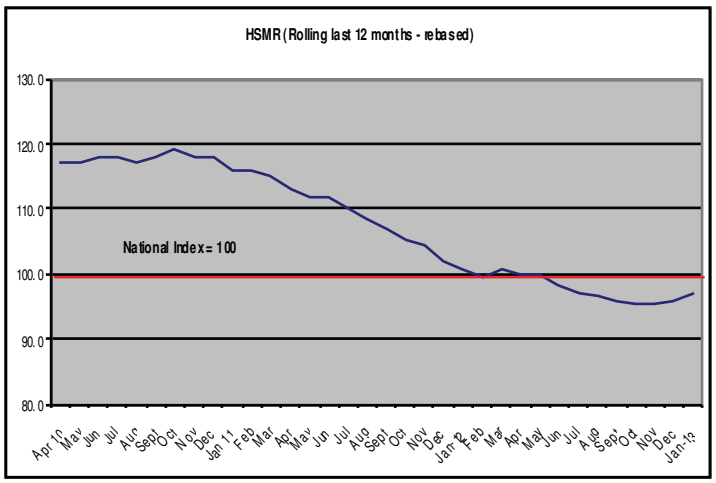
· Reduce our HSMR to the National index by October 2012

· Reduce our crude mortality by 350 fewer deaths within 2 years. This ends in June 2013.

Where are we now?

We have made significant progress in reducing mortality at Shrewsbury and Telford Hospitals and we have shown this in both our mortality measures that we report to the board each month.

The HSMR was reduced to the national index in February 2012 and continued to reduce to where it is now, at around 95 – 97. Although this is quite an achievement there is much still to do.



At the end of last year we were progressing well against our crude rate of deaths objective and this has continued into this year as well. As it stands in February 2013, we have achieved 336 less deaths and we have every reason to expect we will achieve this tough objective we set ourselves.

The most significant element about both these measures is that taken together they prove there has been a tangible reduction that has been achieved by real improvements to patient care.

What more can we do?

There has been much that the Trust has achieved in relation to improving patient care and achieving both tough objectives we set ourselves. As part of the Leading Improvements in Patient Safety (LIPS) and a joint approach with the West Midlands Mortality Group (WMMG) we had a drive to improve in-hospital mortality through the implementation of care bundles focused on specific diseases, these include tackling sepsis and pneumonia which are significant causes of in-hospital deaths. This has been successful and we must now turn our attention to working with the Clinical Commissioning Groups and Community Trust in reducing our mortality further.

The reason for this is that we have identified that the Summary Hospital Mortality Indicator (SHMI), a new measure of mortality that has replaced the HSMR as the standard national mortality measure, has not reduced in the same way as the Crude rate of deaths or the HSMR measure, but shows our Hospital as being slightly worse than the National Index. Although we are within "expected range" for mortality, we are committed to sustaining our focus in this area this coming year. .

As part of this we have formalised our Mortality Group and widened it to include Clinical Governance Leads from all Centres in the Trust in order to share and collectively drive improvements focussed on SHMI. SHMI information can be found on page 24

Cleanliness and Hygiene

Patient Environmental Action Team (PEAT) Inspections

The formal PEAT assessments for 2012 were undertaken on 6 February 2012 at PRH and 28 February 2012 at RSH and results reported in July 2012 A patient representative and an external validator joined us on both assessments.

The results of the assessments are shown in the table 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 2012

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

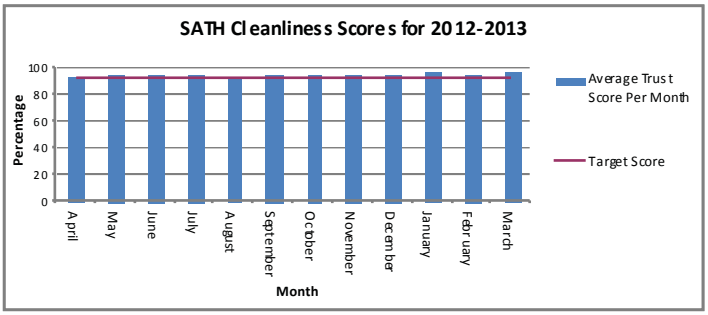
From 2013 the PEAT assessment programme has been replaced with the Patient Led Assessment of the Care Environment (PLACE) programme. The key change to the assessment format being to give patients a real voice in assessing the quality of the healthcare environment.

The assessments will be carried out between April and June and the results will be announced to Trusts and available from the Health and Social Care Information Centre from September 2013.

Cleanliness, food and general maintenance and décor will continue to be monitored via our Patient Environment Team. Feedback from these inspections will be presented to the Patient Environment Group which includes a representative from the Patient Experience and Involvement Panel.

Cleanliness

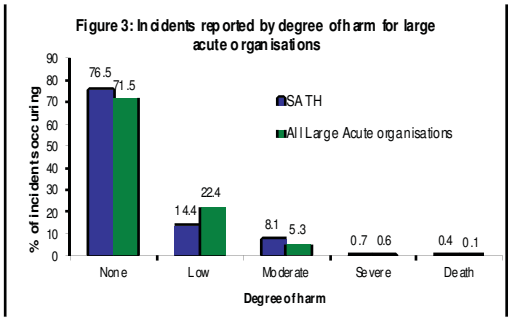
Audits of environmental cleanliness standards in wards and other hospital areas are undertaken by the Domestic Services Monitoring Team. Our cleanliness scores are measured against the National Standards of Cleanliness and have remained high at 96% for the year from April 2012 to March 2013. A breakdown of the scores can be found below:-



Patient Safety

The Trust recognises and values the importance of a culture where staff understand the need to report any incident affecting either patients, staff or environment. By investigating each incident, the organisation can see what they need to do to improve and also identify trends and themes that need particular focus and development of action plans

Nationally across the NHS, 67% of incidents are reported as no harm and just under 1% as severe harm or death, for Large Acute Trusts, 71% 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 unreliable. SaTH has a reporting rate of 76% of incidents being reported as 'no harm'.



In 2012/13 reporting to the National Patient Safety Agency (NPSA—via the NRLS) is a voluntary system (except for certain categories of very serious incidents), but is considered good practice. The Trust reports 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 has increased slightly from the previous report. The Trust has overall, a slightly deteriorated performance in reporting compared to other large Acute Trusts shifting from the top third of reporters to the middle third.

Serious Incidents

Since January 2011 the Trust has encouraged the reporting all incidents using the Datix system and emphasised the importance of reporting Serious Incidents (SI). This has been reflected in an increase in the number of SI's reported year-on-year. Trends and themes within the Serious Incidents are monitored and offer opportunities for targeted improvements, such as pressure ulcers and falls prevention.

In 2012/13 the Trust reported 174 Serious Incidents of which 2 were categorised as Never Events. While this is an increase in the number of Serious Incidents from 2011/12 it has not incorporated a Trust ratified total of 10 unavoidable pressure ulcers, and a possible further 6 that are still in the process of being ratified by our commissioners. Following ratification unavoidable pressure ulcers can be subtracted from the Trust's overall total of Serious Incidents as well as the hospital acquired pressure ulcer total.

The decrease in the number of Never Events, particularly in the Ophthalmology service, evidences the improvements in clinical process and practice supported by a robust auditing process.

In line with policy each Serious Incident is investigated fully with an Root Cause Analysis and action plan for improvement developed. Action plans belong to the appropriate Centres and are monitored for completion within the designated time frames through centre governance meetings and the High Risk Scrutiny Group.

Safeguarding Vulnerable Adults

The Trust continues to provide safeguarding adult protection training for all patient handlers and has achieved 70% overall compliance with training attendance across all relevant staff groups.

The Trust has instigated one hundred and eleven referrals against external agencies including individual relatives and carers from April 2012 to March 2013.

From April 2012 to March 2013 there have been seventy seven adult protection referrals raised against the Trust, this included a significant increase in referrals in March 2013 (seventeen in total), the majority of referrals cited the allegation of neglect with regard to the discharge of the patient. Over half of the referrals were not substantiated however the initial concerns were important enough to raise a referral.

The Trust has welcomed working with our partners in the community including the safeguarding teams of both Shropshire and Telford and Wrekin Councils and also the Clinical Commissioning Groups. A task and finish group has been established to examine the referrals, actions that have been taken and lessons learned. It will also look at the appropriateness of the referrals.

In response to the concerns relating to discharge, a letter from the Chief Nurse has been sent to all Ward Managers, Senior Nurses and Matrons to emphasise that all staff are supported to say no if they feel a patient is not ready to be safely discharged despite the pressures within the Trust around patient flow. This

letter implements the "Safety Pause" which allows and encourages clinical staff to stop and protect time to ensure that patients are discharged or transferred safely.

Patient Services

The Patient Services team consists of staff handling complaints, comments, concerns and compliments, as well as providing bereavement services and overseas visitors assessments.

In addition to offering meetings to discuss the outcome of complaints, more cases are being identified as likely to benefit from an early meeting, pre-dating a written reply. These cases are picked up at the point of triage and include cases where there is a recent bereavement, on-going inpatient care, post-natal issues and complex admissions.

Feedback also continues to be received via a number of avenues, including the Trust's website, patient feedback websites, the complaints email address and via the PALS team (Patient Advice and Liaison Service). Feedback consists of not only complaints but also comments and suggestions, concerns and compliments. All feedback is disseminated to the relevant staff for their information and action as required and is acknowledged by either the Patient Services team or the Chief Executive.

The complaints team continues to be a key part of the Patient Services Team. In 2012, we increased the number of staff supporting complaints, and also recruited to a new position of Complaints Manager. In order to provide a better service to our patients and relatives, the team have relocated to the ward block, to place them in an easily accessible location. This also places them closer to the PALS team, which has improved communication and joint working.

Complaints, Comments and Compliments

In 2012/13 2,505 contacts were handled by the PALS staff and between 800- 1200 compliments were received during each Quarter.

	2011/12	2012/13
Total number of complaints	737	671
Response within 6 months (26 weeks)***	99%* (96.8%)**	91.65%* (89.12%)**
Cases referred to PHSO	47	21
For (on-going/further) local resolution	14	4
No Further Action – confirmed	24	17
Referrals resolved with intervention	0	0
Referrals accepted for investigation	0	0
PHSO referrals upheld against the Trust	1 (2010 investigation)	0

* This relates to cases where the first and only response took over 26 weeks.
**This includes cases that received more than one response, the final response being later than 26 weeks.
***The NHS Complaints Regulations 2009, require at section 14 that if a response is not provided within six months of the date of receipt of a complaint, the Trust must notify the complainant in writing accordingly to explain why and provide a response as soon as reasonably practicable after that time.

An area which has seen a drop in performance is our response to complaints within 6 months. There are a number of reasons why a complaint may not result in a substantive response within six months of receipt, however we recognise that we need to return performance to 2011/12 levels. It is expected that in strengthening the team, and the appointment of a Complaints Manager, we will see the necessary improvements.

In respect of timescales in general, there needs to be a scale that allows for prompt turnaround of straightforward concerns and longer more detailed investigation for complex cases.

Top 3 Complaint Categories

	2011/12		2012/13
Care, monitoring, review delays	153	Care, monitoring, review delays	119
Appointment problems	126	Appointment problems	105
Communication with patients/carers	80	Communication with patients/carers	102

Top 3 Areas for Complaint

	2011/12		2012/13
Outpatients	190	Outpatients	143
A&E	78	A&E	56
Car Park	25	MEC/MAU	29

Ratio of Complaints to Activity

Quarter 1	2011/12*	2012/13
Patient Activity	134,099	138,894
Number of Complaints	164	173
Rate per 1,000 spells	1.22	1.25
Quarter 2		
Patient Activity	138,723	140,694
Number of Complaints	171	165
Rate per 1,000 spells	1.23	1.17
Quarter 3		
Patient Activity	143,041	141,826
Number of Complaints	200	147
Rate per 1,000 spells	1.40	1.04
Quarter 4		
Patient Activity	137,808	136,576
Number of Complaints	202	186
Rate per 1,000 spells	1.47	1.36

**Following a review of the information collected and reported in last year's Quality Account for this section, an improved method of data collection was identified. This new method revised the overall figures*

CQC Annual Inpatient Survey

The Annual Inpatient survey (published on the 16th April 2013) provides some disappointing results for the organisation.

The Inpatient survey reviewed the experience of 850 Individuals who attended for an Inpatient during August 2012.

These survey results need comprehensive consideration to ensure that improvements are made and that patients report those improvements through our monthly patient experience metrics as well as through other patient experience feedback processes.

The results need consideration alongside our operational performance and capacity action plans, as many of the areas demonstrate the impact that the flow of patients though our hospitals is having on the patients waiting within A&E and awaiting a bed. However, the core of this survey is about our support and communication with patients which we need to review and be clear about how we will improve.

Overall the patient experience survey demonstrates that the trust has scored poorly in comparison the previous year's results in the following sections

- The Emergency Department
- Doctors
- Leaving hospital
- Overall experience

Within the other six sections we scored about the same as the other trusts. In no section did the trust perform better than the other trusts.

	CQC Inpatient Survey 2011	CQC Inpatient Survey 2012
	Published April 2012	Published April 2013
	502 patients who were inpatients in June, July or August 2011	516 patients who were inpatients in August 2012
	Comparison with other Trusts in England	Comparison with other Trusts in England
The Emergency/ A&E Department	About the same	Worse
Waiting lists and planned admissions	About the same	About the same
Waiting to get a bed on a ward	About the same	About the same
The hospital and ward	About the same	About the same
Doctors	About the same	Worse
Nurses	About the same	About the same
Care and treatment	About the same	About the same
Operations and procedures	About the same	About the same
Leaving hospital	About the same	Worse
Overall views and experiences	About the same	Worse

Following the publication of the 2011 survey, the corporate nursing team working with the bed holding clinical centres developed an action plan to address the areas highlighted for improvement.

Key areas identified previously

- Wait time in A&E department
- Access to the waiting list
- Patient experience on the ward
- Information given to patients
- Leaving the hospital and the discharge process

The 2012 survey has highlighted similar areas for improvement and demonstrates the need for a different approach to improvements and also a review of this feedback in conjunction with the staff survey results and the operational performance with patient flow and particularly the consistently highlighted area of experience with patient discharge, hence why this is a priority for the year ahead.

The results of the survey are currently being disseminated to the clinical centres and our Patient Experience and Involvement Panel. Actions are being identified and will form part of the plans for 2013/14.

Patient Flow – Right Patient, Right Place

Right Patient, Right Place is the number one priority for the Trust as getting this right for patients has a positive impact across a broad range of quality and experience indicators. Increased levels of A&E attendances have put significant pressure on the hospitals, which has sometimes resulted in longer than expected waits in A&E, delays in patient flow and cancelled operations. This has also been exacerbated by delays in discharging patients with complex care needs and we have been working with the local health and social care economy to make improvements across this issue.

The key issues we face are managing the volume of emergency admissions, discharging those patients who need additional support to leave hospital in a timely fashion and ensuring that we do not cancel operations unnecessarily.

At the Trust a group of senior doctors, nurses and managers have met to get a better understanding of the difficulties we have faced in getting planned surgical patients in to hospital during the winter while managing the overall increase in demand for emergency care. It was acknowledged that the Trust did not have enough beds to manage both emergency and elective demand. We then developed a number of ideas that would help to release acute hospital beds for acutely ill patients.

- Utilising beds in the community for patients waiting for their packages of care or for their home of choice to become available
- Continuing to monitor the number of 'Fit for Discharge' patients and work with others to reduce.
- Ensuring elective day case medical patients do not come into inpatient beds, but are placed in day case beds instead
- Changing the use of Day Surgery to provide short stay surgery beds
- Swapping the locations of AMU and SAU at RSH to improve the configuration of these services.
- Making Ward 22E at RSH and Ward 12 at PRH permanent wards rather than escalation areas to increase the Trust's permanent bed capacity
- Establish a Clinical Decision Unit at the Royal Shrewsbury Hospital to manage patients who do not need to be admitted to hospital, but still need further investigation before being discharged
- Improving discharge skills and competencies to support timely discharge

In the coming year, we will continue to review and assess the benefit of the changes that have been made, and strive to make further improvements to patient flow. The Trust continues to adapt its services and configuration in order to meet the needs of our patients through the on-going Future Configuration of Hospital Services plan.

Reconfiguration of Services

Our goal in 2012/13 was to ensure we gained the final stage of approval and funding for our plans to keep services in the county. This was achieved with the formal approval of our Full Business Case for the Future Configuration of Hospital Services by the then emerging Clinical Commissioning Groups, the PCT Cluster and NHS Midlands and East.

Key to this approval was the continued involvement and engagement of clinicians, staff and managers in the development of the new models of cares, patient pathways, workforce models and new ways of working as well as the design and development of the new facilities at both sites.

On achieving this goal, our aim of consolidating Surgery at Shrewsbury ahead of our original timescales could be implemented and in order to maintain the 'balance' between our hospital sites we were also able to accelerate the move of Head and Neck Services to Telford.

Our goal and commitment of involving, engaging and informing our patients, their families and the public on the changes to our hospital services continued in 2012-2013 and included Focus Groups, attendance at community groups, newsletters, adverts in the local press and radio and television interviews.

In 2012-13 we achieved:

- Final approval of new models of care, patients pathways and new ways of working within Surgery, Head and Neck and Women and Children's Services
- Approval and funding of the Full Business Case for the Future Configuration of Hospital Services
- The consolidation of Surgery at RSH and Head and Neck at PRH
- The creation of a new Surgical Assessment Unit and Surgical Short Stay facility at RSH
- The development of new outpatient and inpatient Head and Neck facilities at PRH, with improved new en-suite facilities for patients with cancer
- Enabling works at PRH to make way for the construction of the new Women and Children's Unit – this involved moving and relocating Medical Records, Hospedia and Children's Outpatients as well as the Helipad a short distance
- A new car park at PRH, increasing car parking spaces at the site and returning the main front car park to patients and visitors only
- The start of the construction of the new Women and Children's Unit which will continue until May 2014
- Progression of the plans for the new facilities at RSH including a new Women's Zone (to include a new Midwife Led Unit, Maternity Outpatients and Scan, Antenatal Day Assessment and Early Pregnancy Assessment) and a new Childrens' Zone (to include a new Children's Assessment Unit and Children's Outpatients)
- Progression of plans to refurbish areas at both sites associated with the move of Women and Children's Services

In the coming months, we will continue to progress the implementation of the changes to Women and Children's Services. This will include:

- Detailed operational planning within Women and Children's Services and across the Trust to deliver a reconfigured service including delivery of our workforce and training plans
- Ongoing engagement and involvement with staff, patients and the public in all areas of change from patient pathways and public information to the design of new patient areas and artwork
- Building works at both sites to create the new facilities associated with the planned changes
- Providing detailed updates to the Joint HOSC and CCGs as part of the ongoing assurance process
- Developing and progressing ideas to help current and ex-staff alongside our patients and their families celebrate the old service and building and welcome the new

Education and Learning

A Fundamentals of Care training day is being launched this year for all ward based registered nurses in order to ensure that we deliver focused education on the direct care issues that really matter to our patients and staff. Staff have fed back to us that they would find this training highly valuable and we have made every effort to ensure that it is interactive, interesting and above all relevant to clinical practise.

The day will feature a video of examples of good and poor practice which nurses are then required to critique using the 6C's methodology. We look forward to feeding back on the success of this new training in next year's Quality Account.

Staff at all levels and in all roles, clinical and non-clinical, need to be skilled, knowledgeable and up to date about the most effective ways of caring for our patients. Education and learning is a valued and key activity in the organisation as a way of supporting staff to improve the quality of the service they deliver and the outcomes for patients.

During 2012-13 we:

- supported 161 staff to complete vocational qualifications in subjects such as Care, Physiotherapy and Occupational Therapy support, Business and Administration
- Support a second cohort of staff to achieve an accredited coaching qualification that results in honest, open, respectful and challenging conversations which support personal accountability

- increased our focus on leadership and management development with over 182 places being taken up on leadership training programmes or accredited courses of study
- enabled over 100 staff to take up coaching support from an accredited coach
- extended the education services available to staff to ensure evidence based practice
- reviewed our personal and patient safety related training and put an improvement plan into place
- enabled over 80% of staff to take up learning opportunities

During 2013-14 we will:

- Review and further increase our leadership development activity to recognise that high quality leadership needs to be supported at all levels of the organisation
- Introduce a mandatory Essentials of Care programme for all nursing staff
- Increase the take up of e-learning to enable staff to make the most of this resource
- Work with managers to ensure that they are able to access timely data to ensure their staff have undertaken all required learning
- Hold a second SaTH Leadership Conference available to all staff which showcases best practice and evidence-based leadership
- Improve our Appraisal process to ensure that it reflects Trust Values

Workforce

2012 and early 2013 saw us change our approach to Workforce, with very positive results:

- Through the Leadership Academy over 40 people have undertaken Leadership Development thanks to our partnership with Warwick University.
- We have developed an Apprenticeship programme allowing individuals to undertake work-based training programmes throughout the organisation.
- Working with the Princes Trust we have introduced a work experience programme that engages young people in careers in the NHS.
- We have 15 internal qualified coaches, providing support to a range of staff and a further cohort of coaches are due to conclude their training in 2013.
- We have focused efforts on promoting Health and Wellbeing — we held Health and Wellbeing Roadshows, Zumba classes and launched the A Healthier You intranet pages. To support managers we have appointed a Wellbeing and Attendance Advisor.

We held our first Leadership Conference which nearly 200 people attended.

Looking to the year ahead it is important that we focus on building on these achievements to ensure that as an employer we are providing a positive experience for staff ensuring that staff are proud to work with us. This will be achieved through

supporting staff in their roles to deliver or support the delivery of excellent patient care improving the patient experience. In 2012 the Staff Survey was sent to all staff and we saw a 57% response rate — a total of 2,910 individuals.
The results for Staff Engagement demonstrate that overall our scores are worse than the national average; however within this the number of staff reporting that they are able to contribute towards improvements at work has increased from 53% in 2011 to 60% in 2013. Other areas of improvement include Staff Job Satisfaction and the number of staff receiving appraisals.

However there remain key areas of focus for the Trust

Place staff want to work and recommend for treatment – in 2011 the Trust score for this finding was 3.31 (out of 5) but has fallen this year to 3.27 whilst the national average for acute Trust is 3.57.
Develop and enhanced Leadership in line with Trust values – as above the number of staff stating that they are able to contribute towards at work has increased (although the national average is 68%. Unfortunately the percentage of staff reporting good communication between senior management and staff (19%) is significantly less than the national average (27%).

Health and Wellbeing of all staff is a priority – 30% of staff report that they believe the organisation takes positive action on health and well being compared to the national average of 43%.

Having taken the opportunity to survey the whole workforce in 2012 the detailed responses have allowed us to review results by individual Care Group and Centre. Each Centre has identified their top three areas for action in addition to the Trusts key areas above to target and focus developments and enhancements to staff needs.

During 2013 we have an ambitious agenda including:

- Further Leadership and Management Development
- Organisational refocus to support the development of Care Groups and ensure that our Workforce Directorate is appropriate aligned to support these teams.
- Expansion of our Staff Engagement model to ensure that staff are involved in decisions and communicated with effectively.
- A new recruitment process to ensure we have the right person in post at the right time.
- Further training opportunities available on E-Learning.
- Implementing an electronic bank staff system to support our temporary staffing needs.
- More Health and Wellbeing Roadshows.
- A second Leadership Development Conference.

Understanding culture and learning from the Francis Report

Culture

It is so important that we ensure that all staff across the Trust believe in and live to our Trust values. We plan to review our Trust values this year to ensure that they are up to date and meaningful. We will then support and engage with our staff to help them to input to and understand these values which will drive everything we do.

To ensure these values are embedded for the future we will be developing a values based recruitment process in order to ensure that we recruit the "right person" to our roles. For nursing posts this will encompass the 6 C's approach as laid out by Jane Cummins, Chief Nursing Officer for England.

The Francis Report

In 2011 the Board considered the key themes and actions arising from a series of national reports (including the first Francis report) and the recommendations arising from these and in January 2013 updated this to include The Winterbourne view report.
In 2012/13 there have been some key changes in Chief Executive and Executive Director roles and to support the review of the Francis report (2013) and the emerging response and recommendations by the Department of Health, the previous Board paper has been updated again to provide a high level overview of how we will as an organisation progress the key themes of the Francis Report.

The Statement of common purpose reflected in the Department of Health response to the Francis report is one that is core to the principles of the NHS Constitution. The Quality and Safety Committee have signed up to this statement and formally have asked the Board to do the same which responds to the DH request to sign up to the Statement of common purpose.

The Quality and Safety Committee will continue to monitor overall progress against recommendations and provide an overview to the Board on a six monthly basis, with an initial report being made by the Committee in May 2013.

1.4 Looking Ahead

Our fourth Quality Account aims to be honest and open with our performance over the last year and encourage scrutiny of the improvements we have made and those that we must achieve in the year ahead.

Our work with the local health and social care economy towards improving the flow of patients through our hospitals is starting to demonstrate improvements. However, we must continue to focus our efforts in this area and on the priorities we have set ourselves to ensure we achieve these key improvements.

Developing our Quality Accounts is always an ongoing valuable learning experience for the Trust and we view each year's account as an opportunity to improve and inform our stakeholders and the public about the quality of care and services we provide. Last year, our stakeholders told us that we had improved on the previous year in terms of presentation and accessibility and they would like to see us move more in this direction in 2012/13. We have responded to this by including more visual information and grouping it into sections to make it easier to read and understand. We will endeavour to further develop the accounts year on year, and we actively encourage 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 1.2?
- 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?
- What else would like to see in our quality accounts?

Looking further ahead, we welcome your suggestions for our Quality Priorities in 2014/15 – we will select three to six top priority issues across the three dimensions of quality (patient experience, safety, effectiveness).

Part 2

Statutory Requirements

2.1

Key Performance Indicators reported and monitored by the Shrewsbury and Telford Hospital NHS Trust based on national and local priorities. The table below reports performance against these and against the previous year, with national information where it is a mandatory requirement*.

No.	Description of Target	2011/12	2012/13	National Average	Trust Target
Patient Safety Measures					
1	MRSA Bacteraemia (bloodstream) infections	2	1	-	2
2	Clostridium difficile infections	41	45	-	45
3	Clostridium difficile infections per 100,000 bed days*	-	11.86	6.52	-
4	Rate Surgical Site Infections per 10,000 Orthopaedic operations*	-	66.9	88.2	-
5	MRSA Screening Emergency Admissions	96%	92.82%	-	95%
6	MRSA Screening Elective Admissions	91%	93.35%	-	95%
7	Hand Hygiene	98%	99%	-	95%
8	Percentage of admitted patients risk assessed for Venous Thromboembolism (VTE)*	91.48%	90.08%	93.7%	90%
9	Reducing inpatient falls	1590	1538	-	-
10	Safe Surgery checklist compliance	99%	99.96%	-	100%
11	Rate of patient safety incidents per 100 admissions	6.66	6.85	6.81	-
12	Rate of 'serious harm' patient safety incidents reported per 100 admissions*	-	0.62	0.41	-
13	Number of patient safety incidents reported**	7800	7599	-	-
14	Number of patient safety incidents resulting in severe harm/death**	40	89	-	-
15	Percentage of patient safety incidents resulting in severe harm or death as a percentage of the number of patient safety incidents	0.51%	1.17%	0.7%	-
16	Avoiding preventable pressure ulcers (grade 3 & 4)	20	42	-	-
Clinical Outcome Measures					
17	Standard Hospital Mortality Indicator (SHMI)* (lower is better)	-	105.3	100	-
18	Percentage of palliative care deaths which is coded appropriately (at either diagnosis or specialty level)	17.36%	17.02%	-	-
19	2 week wait for cancer referrals	97.86%	96.00%	-	93%
20	18 week GP referral to first treatment - Admitted	94.48%	78.00%	-	90%
21	18 week GP referral to first treatment - Non Admitted	87.31%	95.08%	-	95%
22	Patient Reported Outcome Measure - groin hernia surgery*	-	39.4%	51.6%	-
23	Patient Reported Outcome Measure - varicose vein surgery*	-	56.3%	51.6%	-
24	Patient Reported Outcome Measure - hip replacement surgery*	-	100%	88.4%	-
25	Patient Reported Outcome Measure - knee replacement surgery*	-	66.7%	78.9%	-
26	Percentage or patients aged 0 - 14 readmitted within 28 days of discharge	9.3%	9.9%	-	-
27	Percentage or patients aged 15+ readmitted within 28 days of discharge	5.4%	5.4%	-	-
Patient Experience Measures					
28	A&E 4 hour wait	94.52%	90.62%	-	95%
29	Responsiveness to inpatients personal needs (maintain or improve) - CQUIN Score out of 100	64.3	62.1	68.1	Maintain or improve
30	Staff survey - Percentage of staff who would recommend the Trust to friends or family needing care	-	50.9%	62.8%	-

- Data is not required or is not available *source—Methods Insight quarterly Acute Trust Quality Dashboard
** Oct 10 - Oct 11 & Oct 11 - Oct 12

2.2 Statements of Assurance

Progress and achievement of this year's quality priorities will be reported to the Quality and Safety Committee which is a formal subcommittee of the board, externally to commissioning groups via the Commissioning Quality Review meeting and in the 2013/14 quality account

How will we monitor, measure and report progress to improve quality, including our Quality Priorities?

Patient Experience

Our improvements against the priorities will be monitored by our Patient Experience and Involvement Panel who will receive reports on progress and results of patient experience surveys and audits throughout the year. The Quality and Safety Committee will receive a summary of progress and will hold us to account for delivery of the priorities relating to patient experience.

Our performance against measuring and improving patient experience will also be reported to our commissioners through the Commissioning Quality Review meeting on a monthly basis.

Patient Safety

Our 2 key safety priorities of pressure ulcer elimination and falls reduction will be monitored by the specific task group for each which will also support the delivery of the work that needs to be done. These and a range of safety metrics are presented and discussed by clinical centre senior nurses at the Nursing and Midwifery Forum where peer and corporate challenge is given and actions for improvement agreed. The Quality and Safety Committee will receive information regarding to performance and progress in the monthly quality report. The quality report contains a variety of metrics relating to patient safety which are carefully monitored and challenged by the committee who conduct a visit to a clinical area to gain further assurance on a monthly basis. Our quality report is also shared with commissioning groups and forms the basis of discussion at the Commissioning Quality Review meeting.

Clinical effectiveness and outcomes

We recognise that the priority to improve discharge really matters to patients and their relatives or carers. We will monitor our progress in this area closely and ensure that we foster a partnership working approach to ensure that we make improvements in this area. Reporting against our performance in this area will be at many levels throughout the Trust from Ward to Board level and externally to the Trust through commissioners and other stakeholders.

Progress and outcomes of clinical audit continue to be shared across the Trust and compliance with NICE guidelines and Technology Appraisals (TAG) is reported both internally and externally to commissioning groups.

Review of Services

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

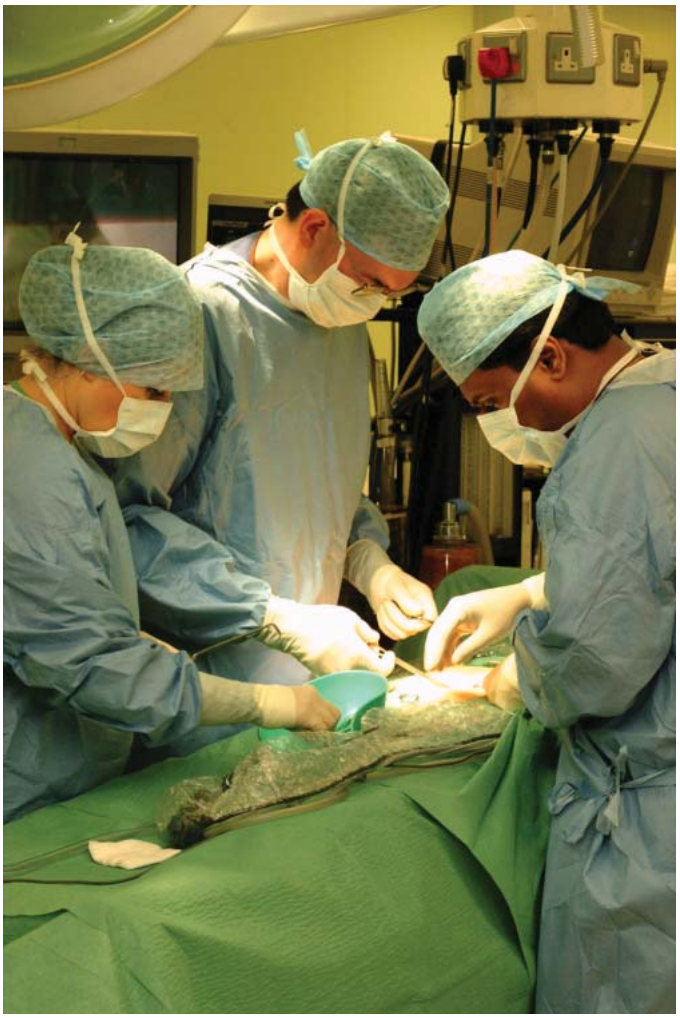
- Daycases
- Elective care
- Emergency care, including A&E services
- Maternity care
- Outpatients

During 2012/13 the Shrewsbury and Telford Hospital NHS Trust provided and/or subcontracted the full range of services for which it is registered NHS Services (these are detailed in the Trust's Annual Report 2012/13 or via our web site).

The Trust supported a number of reviews of its services during 2012 and 2013. These were undertaken by external organisations and included:

- *The Care Quality Commission*
- *Annual Cancer Peer review*
- *Royal College of Ophthalmology: Cataract pathway review*
- *Ofsted/CQC review of children's safeguarding services*

The Trust did not formally review any of its own services however, did review and support individual wards on a quality improvement framework, reviewed patient flow processes and supported the Royal College of Opthalmology review by sharing trust investigation findings. The Trust has reviewed all of the information available in relation to the services provided.



The following internal and external reviews tool place during 2012—2013

Trust Wide Inspections CQC		Unannounced inspections were carried out on the Princess Royal Hospital site in May 2012 and at the Royal Shrewsbury Hospital site in August 2012. Reasons for the visits were; Princess Royal Hospital—part of the CQC routine schedule of planned reviews. Royal Shrewsbury Hospital—part of a follow up schedule of visits to the previous Dignity and Nutrition scheme commissioned by the Secretary of State. Both visits concluded that there were no longer any concerns regarding the care delivered against the assessed standards and all previous concerns were lifted. However, a further unannounced visit was carried out at the Princess Royal Hospital in April 2013 and the Trust is awaiting the formal report in relation to this.
Trust Wide NPSA PEAT Assessment		Formal annual assessment undertaken across both sites with an outcome of "excellent" rating
Medical Engineering Services		The department maintained its external audit success and compliance with the requirements of ISO 9001:2008 and on-going ISO 13485:2008
Trust Wide Pharmacy		Our pharmacy department was subject to a routine review by the British Pharmaceutical Society of Great Britain. The outcome of the review was that the services provided were satisfactory and no concerns were raised regarding the outcome of the visit.
Maternity		Assurance Visit (undertaken by Commissioners) took place in January 2012 with a particular focus on clinical governance arrangements, process for undertaking root cause analysis following serious incidents. The Trust received positive feedback.
Midwifery		Midwifery services are reviewed annually by the West Midlands Local Supervising Authority Maternity Officer (WM LSAMO) to ensure that the arrangements for and the execution of Supervision of Midwives are satisfactory. The Trust again received positive feedback highlighting the proactive approach to supervision within SaTH. SaTH will be exploring how to meet the recommended ratio of 1 Supervisor of Midwives to 15 practising midwives.
Paediatric Oncology		A Peer Review was undertaken in August 2012. SaTH scored 94.2% for core measures and 94.7% for MDT measures.
Paediatric Diabetic		A Peer Review was undertaken during 2012/13. Information for children, young people and their families was good. The information was comprehensive, clear and well-presented. No immediate risks were identified
Paediatric Cystic Fibrosis		A Peer Review was undertaken in March 2013. A number of areas of good practice identified as well as a 1 area for development.
Gynaecology Oncology		A Peer Review was undertaken during 2012/13. A number of significant achievements identified. No immediate risks or serious concerns raised, with a small number of areas for development identified.
Fertility		A HFEA visit was undertaken during 2012/13 with a full review scheduled for May 2013
Laboratory Services		There was a RSH Blood Transfusion laboratory inspection by the MHRA following the annual self-assessment return. The inspector was satisfied that the department was fully compliant with the Blood Safety and Quality Regulations 2005.
Ophthalmology		Royal College of Ophthalmology visit – 17th September 2012 – review Cataract pathway, procedures and processes by external clinical advisory team following series of Never Events being reported. Very positive report highlighting improvements made and areas of good practice
NHS Bowel Cancer Screening Programme (BCSP) Regional Quality Assurance visit		NHS Bowel Cancer Screening Programme (BCSP) Regional Quality Assurance visit Shropshire Bowel Cancer Screening Centre underwent its first 3 yearly visit. The purpose was to examine the performance of all aspects of the programme at screening centre and professional level as well as verification of achievement of national BCSP standards. All stakeholders involved with the service were reviewed. Excellent feedback overall with 13 points of good practice identified. The main recommendations focussed on elements to enable the implementation of the age extension.

WHO Safe Surgery Checklist		As part of the World Health Organisation drive and in response to the Who Surgical Safety Checklist, theatres within SaTH undertake a monthly audit assessing theatre staff compliance for completing the Who Safer Surgery Checklist. This audit is undertaken in each theatre, 19 in total and includes a minimum of 10 patients per theatre per month. The audit is very specific and looks at staff undertaking the following tasks, prior to each patients operation: • Team Brief • Time Out • Sign Out The Trust consistently achieves 100% compliance with this audit.
Telford & Wrekin Ofsted Inspection for Safeguarding Children		As part of this inspection the CQC visited the Emergency Department at PRH and Wrekin Maternity In June 2012. Issues reported were inadequate safeguarding supervision for Emergency Care staff and reassurance that medical staff were all completing Safeguarding training. This has been addressed by ensuring that Safeguarding Supervision is in place for 2013 and all medical staff have been encouraged to undertake online safeguarding training.
Cancer Centre Quality Management System		The Radiotherapy Department has had BSI ISO 9000 certification since 1999 however this has been extended to include Chemotherapy. The Chemotherapy and Radiotherapy services were jointly certificated for ISO 9001:2008 in March 2012 and since then have had two further BSI assessment visits. The Jan 2013 visit offered particularly positive commentary and closed two minor non conformities so there are now no existing non conformities within the Centre. A comprehensive internal audit schedule is maintained as per BSI framework and results fed in to appropriate governance groups/sub groups for actions and quarterly reports provided for the SaTH clinical audit department. Off procedure events are reported/ actioned via the Quality Management System, thus maintaining an open and transparent system of clinical work. Work has now begun to construct a QMS for haematology with a view to BSI certification in 2014.
2012/13 Annual Cancer Peer Review		3 clinical teams have undergone external review in March 2013 as part of the Peer Review cycle of 2012/13. The final reports from which will follow on thereafter. 9 clinical teams underwent self assessment and 8 clinical teams underwent self assessment and internal validation. There were a considerable number of examples of good practice and significant achievements noted in the reports. These included recognition about recruiting into key vacant posts, ISO accreditation for the Oncology Chemotherapy service, undertaking audits, participating in clinical trials, improved data collection, developing new services e.g. one-stop and fast track clinics, improved patient outcomes and excellent patient information. There was only 1 serious concern noted by the Breast team in relation to the reconfiguration of the middle grade position as failure to replace these posts would restrict the ability of the Consultants to deliver an effective service. All concerns and serious concerns were discussed with the relevant Centre Chiefs and Centre Managers for their consideration and action. The serious concern was escalated to Executive level. A new process of ratification, communication and escalation was implemented for this cycle of Peer Review. The Cancer Value Stream meets with the clinical teams quarterly to discuss their Peer Review compliance and cancer target performance.
Environmental Health Food Hygiene Inspection		Environmental Health Inspections were carried out for both sites. We achieved a score of '4' for our Food Hygiene rating at the Royal Shrewsbury Hospital and '5' at the Princess Royal Hospital.
Cleanliness and Patient Environment Audits		Review of cleanliness assessed against the National Standards of Cleanliness carried out monthly Internal Patient Environment audits are carried out monthly
Quality & Safety Committee		Continue to support and receive feedback from quality and safety walkabouts and to receive and gain assurance relating to quality improvement frameworks.

2.3 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.

Clinical Audits

Section 2

During 1st April 2012 to 31st March 2013, 68 national clinical audits and 5 National Confidential Enquiries (NCEPOD) covered NHS services that the Shrewsbury and Telford Hospital NHS Trust provides.

Section 2.1

During that period the Shrewsbury and Telford Hospital NHS Trust participated in 63 / 68 [93%] of the national clinical audits and 5/5 [100%] national confidential enquiries which it was eligible to participate in.

Section 2.2

The national clinical audits and national confidential enquiries that the Shrewsbury and Telford Hospital NHS Trust was eligible to participate in during 1st April 2012 to 31st March 2013 [73] are listed at
http://www.sath.nhs.uk/Library/Documents/Clinical_Audit/QA%202012%2013%20TABLE%201.pdf

Section 2.3

The national clinical audits and national confidential enquiries that the Shrewsbury and Telford Hospital NHS Trust participated in between April 2012 and 31st March 2013 are listed at:
http://www.sath.nhs.uk/Library/Documents/Clinical_Audit/QA%202012%2013%20TABLE%202.pdf

Section 2.4

The national clinical audits and national confidential enquiries that the Shrewsbury and Telford Hospital NHS Trust participated in, and for which data collection was completed during 1st April 2012 and 31st March 2013 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 are listed at:
http://www.sath.nhs.uk/Library/Documents/Clinical_Audit/QA%202012%2013%20TABLE%203.pdf

Section 2.5

The reports of [5] national audits were reviewed by the provider during 1st April 2012 and 31st March 2013.

Section 2.6

The Shrewsbury and Telford Hospital NHS Trust intends to take the actions listed to improve the quality of healthcare provided:
http://www.sath.nhs.uk/Library/Documents/Clinical_Audit/QA%202012%2013%20TABLE%204.pdf

Section 2.7

The reports of [93] local clinical audits were reviewed by the provider during 1st April 2012 and 31st March 2013

Section 2.8

The actions which the Shrewsbury and Telford Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided are listed at:
http://www.sath.nhs.uk/Library/Documents/Clinical_Audit/QA%202012%2013%20TABLE%205.pdf
Brief highlights include:

- Nursing documentation reviewed and implemented
- Radiographers training programme devised to ensure competency standards
- Role of Designated Professionals for safeguarding children and young people included in training presentations
- A new chest pain pathway has been introduced to enhance the treatment of these patients

2.4 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 we serve.

What have we done?

The Shrewsbury and Telford Hospital NHS Trust works closely with the West Midlands North CLRN (Comprehensive Local Research Network) and the Topic Specific Networks to promote a robust research culture. We continue to be active offering patients opportunities to participate in studies in a wide variety of specialties. Overall recruitment is slightly lower than 2011/12 as a result of the national closure of several large cancer genetics studies which reached their required numbers.

We have improved our Trust approval process so that by the second half of 2012/13 all new studies completed the process within 30 days.

Processes have been put in place to facilitate recruiting the first patient within 30 days of opening a new study and work continues to improve on this.

Work has started on increasing engagement at all levels within the Trust and the public by promotional events, activity report to the Board and appointment of 2 lay members to the R&D Committee.

The number of patients receiving NHS services provided or sub-contracted by The Shrewsbury and Telford Hospital NHS Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 1273

Specialty	Total no of studies 2011/12	Recruitment 2011/12	Total no of studies 2012/13	Recruitment 2012/13
Cancer	33	624	24	301
Cardiovascular	2	47	3	137
Gastro-Intestinal	14	467	16	443
Stroke	3	62	2	32
Respiratory	3	19	1	1
Reproductive Health	3	10	3	30
Medicines for Children (inc non drug studies)	5	16	5	63
Renal	4	16		23
Surgical	2	7	1	6
Dementia	1	62		189
Dermatology	1	4	1	6
Other	1	54	4	42
Totals	71	1389	60	1273

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

A full list of recruiting studies is available from the Trust: research@sath.nhs.uk

The Shrewsbury and Telford Hospital NHS Trust also acts as a Continuing Care site for local children recruited into cancer studies at Birmingham, delivering all the treatment and follow up care.

Active participation in clinical research demonstrates The Shrewsbury and Telford Hospital NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

The Shrewsbury and Telford Hospital NHS Trust employs 25 dedicated research nurses, allied health professionals, assistant research practitioners, data and administrative staff supporting the 32 Principle Investigators and many co-investigators.

What we will do in the coming year?

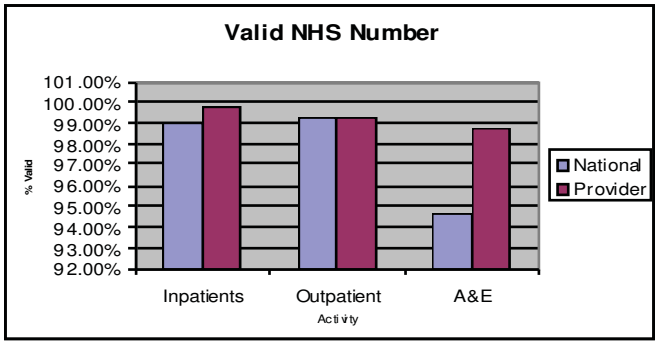
- Meet national target for study approval process time lines of > 80% gaining local approval within 30 days.
- Work towards > 80% of studies where annual recruitment target is 12 or more recruiting first patient within 30 days of approval.
- Support local Principle Investigators in becoming Chief Investigators for 2 or more multicentre studies
- Increase the number of commercial studies recruiting during the year from 7 in 2012/13 to10 in 2013/14
- Open drug studies in haematological cancer and in emergency medicine.
- Increase engagement at all levels to promote research activity within the Trust

2.5 Data Quality

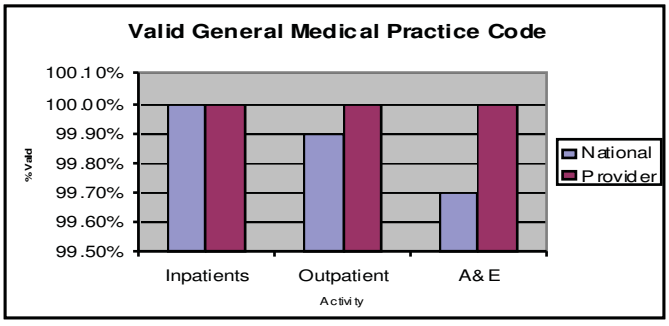
This section of our Quality Account provides information about data quality. Good quality information underpins the delivery of effective patient care and is essential if improvements in quality of care are to be made.

During the reporting period April 2012 to March 2013, the Trust submitted records to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics.

The percentage of records in the published data (based on April-Jan 12/13) SUS data at the month 10 inclusion date) which included the patient's valid NHS number was:



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



2013 will see some further investment in the Data Quality Team to continue with the existing programme of work. There have already been significant improvements in some key areas for example duplicate registrations have been reduced by 75%. All front line service areas have received training on how to validate patient demographics using the national spine, for data collection requirements.

Data Quality: Clinical Coding

The Shrewsbury and Telford Hospitals was subject to the Payment by Results clinical coding audit during the reporting period April 2012 to March 2013 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

Primary Diagnosis incorrect	4.5%
Secondary Diagnosis incorrect	11.4%
Primary Procedure incorrect	14.3%
Secondary Procedure incorrect	4.1%

The performance of the Trust, measured against the number of spells with an incorrect payment, places the trust better than average, compared to last year's national performance.

Information Governance

Information Governance is the framework for handling information in a confidential and secure manner to the appropriate ethical and quality standards in a modern health service. It brings together interdependent requirements and standards of practice in relation to the IG initiatives

The IG Toolkit (IGT) is a self-assessment tool that sets the requirements and standards that NHS organisations need to achieve to ensure it fulfils its obligations to ensure that information about patients and staff 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 provide assurance to its stakeholders. This in-turn increases public confidence that 'the NHS' and its partners can be trusted with personal data.

The current assessment has been submitted for March 31st 2013. The Trust has achieved a 'satisfactory' result as all the categories have at least a level 2 compliance score.

Initiative	Level achieved 2012	Grade
Information Governance Management	86%	Satisfactory
Confidentiality and Data Protection Assurance	87%	Satisfactory
Information Security Assurance	75%	Satisfactory
Clinical Information Assurance	80%	Satisfactory
Secondary Use Assurance	70%	Satisfactory
Corporate Information Assurance	77%	Satisfactory

Information Governance Training and awareness is ultimately about changing the way people behave: that is, about changing the way people think and act. To achieve that change in behaviour, all Trust staff are provided with regular IG training.

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

A proportion of Shrewsbury and Telford Hospital NHS Trust income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Shrewsbury and Telford Hospital NHS Trust and any person or body they entered into contract, agreement of 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 2012/13 and for the following 12 month period are available electronically at:

http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

No	CQUIN Goal	
1	VTE. Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE). 90% of admitted patients to have a VTE assessment every month.	Met
2	Patient Experience. Improve responsiveness to personal needs of patients. Maintain or improve upon 2011/12 survey results (64.3).	Not met
3	NHS Safety Thermometer. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE.	Met
4	Improving Diagnosis of Dementia in Hospital. The use of a screening tool, a screening questionnaire and referrals to specialist dementia service.	Partially met
5	Medicines Management. Drug regime changes y/n (and reasons why), renal function and allergy status recording.	Partially met
6	Nutrition. Nutritional screening, assessment and delivery of an agreed individual action plan to maintain or improve an 'at risk' inpatients nutritional intake, protected mealtimes and red tray scheme.	Met
7	Pressure Ulcers. 2hr assessments, care plans, 0 grade 3 and 4 ulcers and compliance to pressure sore handbook.	Partially met
8	Net Promoter Question. Real time feedback to support the Patient Revolution work as embodied in the SHA Ambitions.	Met
9	Maternity. To achieve Baby Friendly accreditation for SaTH Maternity Service at level 2 by April 2014	Met
10	Making Every Contact Count. Development of MECC action plan with named implementation lead, training and increasing referrals to the 'stop smoking' service.	Met
11	VTE Prophylaxis. Percentage of adult inpatients assessed to be at increased risk of VTE who receive appropriate prophylaxis in line with the prescribed prophylaxis regime based on national guidance (NICE)	Met

There were goals relating to renal dialysis, neonatal care and organ transplants for our contract with Specialised Services, summarised in table below:-

No	CQUIN Goal	
1	VTE. Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE). 90% of admitted patients to have a VTE assessment every month.	Met
2	Patient Experience. Improve responsiveness to personal needs of patients. Maintain or improve upon 2011/12 survey results (64.4).	Not met
3	NHS Safety Thermometer. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter, and VTE.	Met
4	Improving Diagnosis of Dementia in Hospital. The use of a screening tool, a screening questionnaire and referrals to specialist dementia service.	Partially met
5	Implementation of clinical dashboards for specialised services. Ensuring that Providers implement and routinely use the required clinical dashboards for specialised services	Partially met
6	Increasing use of home renal dialysis. To ensure patients are offered choice in their renal replacement therapy. Increase number of patients receiving dialysis at home.	Partially met
7	(Neonatal) Increase effectiveness of hypothermia treatment	Met
8	(Neonatal) Discharge planning/family experience and confidence	Met

During 2012/13 2.5% of our contract values with PCTs in England will be based on achievement of 11 CQUIN goals. As in 2011/12, VTE and Improving Responsiveness to personal needs of patients remain national CQUIN goals and are joined by national Safety Thermometer and Dementia goals. Local CQUIN goals are currently under discussion for inclusion in the 2013/14 contract. These are summarised in table below:

No	CQUIN Goal
1	Friends and Family. Phased expansion to include the Emergency Department and Maternity Services *National requirement.*
2	VTE screening performance target increased to 95%. *National requirement.*
3	NHS Safety Thermometer—using this prevalence audit to demonstrate a reduction in catheter associated urinary tract infections.
4	Dementia. 90% of patients over 75 to be screened, risk assessed and referred on where appropriate, plus signposting to support for carers of people with Dementia. *National requirement.*
5	Medicines Management. Improved monitoring of antimicrobial use to contribute to C. Diff reduction and continuation of an element from 2012/13 schedule relating to discharge communication with GP's regarding the starting or stopping of medications.
6	Patient flow. To facilitate safe discharge and early transfer.
7	Organisational culture. Values based recruitment across agreed staff groups
8	Falls reduction. Reduction in falls resulting in serious harm.
9	Maternity. Continuation of 12/13 Baby Friendly initiative.

There are goals relating to renal dialysis and for our contract with Specialised Services, summarised in the table below.

No	CQUIN Goal
1	Friends and Family. Phased expansion
2	VTE screening. Phased expansion. Target increased to 95%.
3	NHS Safety Thermometer. Moved from local to a national requirement.
4	Dementia. Phased expansion.
5	Clinical Quality Dashboards across specified clinical specialities
6	Neonatal retinopathy
7	Radiotherapy IGRT
8	Renal patient view & Acute Kidney Injury

Further details are available on http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html.

2.7 Care Quality Commission (CQC) registration and compliance

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 2012-2013 and the Trust is not subject to periodic review by the Care Quality Commission

The Shrewsbury and Telford Hospital NHS Trust has not taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during 2012-13.

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 on-going basis by the Care Quality Commission.

Care Quality Commission Reviews

The Trust was reviewed by the CQC during unannounced inspections in May 2012 (PRH) and August 2012 (RSH). The reasons for the visits were; Princess Royal Hospital—part of the CQC routine schedule of planned reviews. Royal Shrewsbury Hospital—part of a follow up schedule of visits to the previous Dignity and Nutrition scheme commissioned by the Secretary of State. Both visits concluded that there were no longer any concerns regarding the care delivered against the assessed standards and all previous concerns were lifted. However, a further unannounced visit was carried out at the Princess Royal Hospital in April 2013 and the Trust is awaiting the formal report in relation to this.

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Outcome	CQC Judgement	
	RSH	PRH
1: Respecting and involving people who use services	Compliant	Compliant
4: Care and welfare of people who use services	Compliant	Compliant
5: Meeting nutritional needs	Compliant	Compliant
7: Safeguarding people who use services from abuse	Compliant	Compliant
13: Staffing	Compliant	Compliant
16: Assessing and monitoring the quality of service provision	Compliant	Compliant

Annex 1

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

Telford and Wrekin Local Involvement Network

During the past year much has improved in the quality and care of the patients, this has been achieved under difficult operating circumstances.

We agree with the priorities & objectives for the coming year as outlined in the quality report. Working with all agencies within the NHS will help with the flow of Patients within the Trust

It has been disappointing that pressure sores, falls, and mortality rates, whilst they have fallen slightly have not made significant improvements

We would like to see a greater improvement in outpatient waiting times as it is a cause of concern for many people. We would like the Trust to implement mandatory training for all Nursing Staff in the areas of Dementia, Nutrition and the care of Patients with Frail and complex conditions. We would also like to see a more robust approach for dealing more swiftly with complaints.

We congratulate the Trust in making the quality accounts more user friendly

Shropshire Council Health Overview and Scrutiny Committee

The Committee was satisfied with the content of the Quality Account document, and agreed with the priorities set by the Trust, which mirror national health priorities in general. Members would like to commend the efforts taken by SaTH to engage with Shropshire's Healthy Communities Scrutiny Committee over the past 12 months, and were assured that this would continue to develop in the future.

The development of partnership working and integrated thinking is seen as key to the success for not just the Trust, but the whole health economy. With sustained high demand for unscheduled care, more and more pressures are being put on acute providers, but the developments being put in place by the Trust through its priorities will go some way to improving patient outcomes, developing servicing, and creating more efficient processes and protocols.

The Committee was reassured that the Trust was investing in staff training and that the 'Fundamentals of Care' were addressed for all ward staff to ensure improvements in patient experience, but also to enable staff to understand how their role impacts on patient outcomes. The Committee was disappointed with the outcomes of the Staff Survey and would request that Trust take on board the concerns raised through this document and work with staff to improve.

Following the Francis Report, the Trust has undertaken to improve its services and staffing to ensure patients are treated with dignity and care, and are assured a safe clinical pathway throughout their journey.

The Committee was satisfied with the content of the Quality Account, but stressed the need to provide an easy read version to engage with the public and raise the profile of the document for the future.

The Committee welcomed continued engagement with Healthy Communities Scrutiny Committee in the coming year.

Telford & Wrekin Council Overview and Scrutiny Committee

Reconfiguration

The Joint HOSC supported the Full Business Case for the reconfiguration subject to further approvals and assurances from the PCT Cluster and Strategic Health Authority.

The Joint HOSC focussed on the Travel and Transport Plan. The Committee had initial concerns but has been assured that the local authority and other partners are now fully involved.

Accident and Emergency Service and Capacity

The Committee expressed concern about A&E services in August 2012 and there were further discussions with the Joint HOSC. The Committee remains extremely concerned that the Trust is failing to meet national waiting time targets and has declared a Level 4 on three occasions, and about the cancellation of non-emergency operations due to lack of A&E capacity. The Committee recognises that pressure on A&E is a national issue, but will continue to scrutinise issues through the Joint HOSC to ensure services are accessible, safe and sustainable and awaits the outcome of the urgent care review.

The Joint HOSC considered the impact of delayed admission to A&E on ambulance availability for emergency calls. The Committee suggests the quality account shows how the Trust is working with the ambulance service to address this.

Reduction of Inpatient Falls

The Committee supports the continued focus on falls prevention. The Joint HOSC heard that lessons would be learnt from the coroner's reports into the falls-related deaths.

Preventing Avoidable Pressure Ulcers

The Committee is concerned by the increase in reported Grade 3 and 4 pressure ulcers despite prevention being a priority.

Views of Patients and Staff

The Committee is concerned about the results of the patient satisfaction survey and low staff morale and will continue to scrutinise issues through the Joint HOSC.

Communication

The Committee is pleased to see communication with family and carers as a priority. The Committee's review of Continuing Healthcare (CHC) highlighted issues with this, although the Clinical Commissioning Group is responsible for CHC. The Committee also wants to ensure that family and carers are provided with information about medication and follow-up procedures.

The Committee is concerned the appointment system is not working effectively. Members heard of patients receiving confirmation and reminder letters at the same time which is an unnecessary cost.

Commissioning for Quality and Innovation (CQUIN)

The Committee recognises further work is necessary to meet CQUIN targets and would like to see more information included, particularly on CQUIN Goal 4 (dementia care) to ensure all Trust front-line staff receive dementia training.

Blood Tests

The Committee was concerned about long waits for blood tests (without food) and would like to see how this will be improved especially for diabetic/frail patients.

Stroke Review

The Committee will continue to monitor the outcome of the stroke services review through the Joint HOSC. The Committee wants to ensure that acute and hyper-acute stroke services remain within the county and are sustainable and accessible.

Shropshire Clinical Commissioning Group & Telford and Wrekin Clinical Commissioning Group Joint Statement

Shropshire Clinical Commissioning Group (SCCG) as the local Lead Commissioning Organisation monitors the quality of the services delivered by the Trust in conjunction with Telford & Wrekin Clinical Commissioning Group (TWCCG). This includes monthly reviews of performance and governance data, patient safety and experience metrics via Clinical Quality Review (CQR) meetings, announced and unannounced quality and safety review visits.

We believe that the Quality Account is reflective of the Trusts achievements and also outlines the challenges it has faced in the year in relation to the sustained delivery of both urgent and planned care; and a lack of achievement against both its own and national priorities for 2012-13 including the elimination of avoidable grade 2, 3 and 4 pressure ulcers and only partial achievement of several Commissioning for Quality and Innovation (CQUIN) goals.

This Quality Account is the Trust's annual report to the public about the quality of services that are delivered. While the document provides lots of helpful information, it is generally presented from the points-of-view of the Trust's internal processes (patient safety, clinical effectiveness, patient experience etc.). It is however worth note the Trust commitment for 2013/14 to continue to strive for best practice in improving the patient journey and patient experience by continuing to strengthen both patient and public involvement.

"SCCG is fully supportive of the Trust's quality priorities for improvement that are identified for 2013/14 and commend its commitment to focus on the culture of the organisation " To ensure that it is founded on the values of the Six C's – **Care, Compassion, Courage, Communication** and **Competence**.." and to be " A **caring** organisation that always Puts Patients first.

Accuracy of Information

SCCG in line with its responsibilities has taken appropriate steps to assure the accuracy of data presented in the Trusts quality in relation to the locally commissioned services and is satisfied that the SaTH NHS Trust Draft Quality Account 2012/13 provides a level of assurance on a range of its services.

Montgomeryshire Community Health Council

Community Health Councils (CHCs) in Wales have a statutory responsibility to represent the patients' and general public's perspective of health services, to keep under review the operation of the health service in its district and to make recommendations for the improvement of that service. Hospital monitoring and inspection are two of the core functions of the CHC's 'quality monitoring' programme of local health services on behalf of patients and the public.

During 2011/12 Montgomeryshire Community Health Council has continued to review the Trust's health service provision to Powys residents through CHC monitoring visits; inspections; and feedback from patients. The Trust has continued to send a senior representative to CHC Full Council meetings to respond to questions raised by CHC members and to engage with, consult and advise CHC members of the Trust's plans and proposals. The Trust has responded to CHC concerns and recommendations. These have influenced its plans and priorities for improvement, including the Quality Improvement Strategy; Quality monitoring and improvement measures; and Quality Priorities for 2012/13.

Montgomeryshire CHC has welcomed the opportunity to be part of the Trust's Patient Experience Involvement Panel, and the development of the work programme to support the review of patient care.

We also welcome the approach taken by the Trust to act on both positive and negative feedback from our members and from Powys patients. The CHC will continue to offer advice encouragement and support to the Trust where appropriate to enable it to achieve its aims on quality, safety, and patient experience.

Shropshire Healthwatch

Healthwatch Shropshire was established on 1st April 2013 to act as the independent consumer champion for health and social care for the people of Shropshire. We are grateful for the opportunity to consider and comment on the Quality Account.
Healthwatch Shropshire has read the Quality Account carefully and can see the effort the Trust has put in to improving its services. However, we would welcome more benchmarking of services against national data and also additional comments from the Trust to give more context to the data especially where objectives are only partially met.
Healthwatch Shropshire recognises that the Trust has a large volume of information which it is required to include in the Quality Account but is concerned that it is not easy to read and assimilate the information. We would like to see a "summary" document highlighting the key issues for patients, service users and carers that is in a more accessible format.
Healthwatch Shropshire welcomes the proposed quality priorities for 2013-14 and looks forward to developing its relationship with the Trust during the year.

The feedback from our external stakeholders has been replicated in its entirety without edit.

Trusts response to feedback from stakeholders

In response to comments from external stakeholders, the Trust has made a small number of amendments to this year's Quality Account.
We have strived to make this year's Quality Account more readable and clearer. We plan to distribute to a greater number of public areas such as Leisure Centres, GP surgeries and civic buildings.
We have updated the glossary to reflect additional abbreviations used within the Quality Account and removed unnecessary ones.
We have produced a summary version of the Quality Account, which is available on request.

As in previous years, the Trust will endeavour to act upon all stakeholder feedback in order to attain year on year improvements to the Quality Account.

Following interim feedback from stakeholder groups, we have made the following amendments to the Quality Account.

- We have expanded on the Workforce section to include an update and response to our Staff Survey, and included information on the role of our Education and Learning team, and their plans for 2013/14.
- We have expanded the section on Patient Services to highlight the development of the team, and also to comment on the complaint response performance levels, and how these would be improved.
- We have provided additional clarity on how we will deliver our quality performance priorities for the coming year and highlighted the key performance measures which will help us deliver them.
- We have made a number of formatting amendments, based on advice from stakeholders, to improve the layout and presentation of the Quality Account.

Annex 2.

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board:

Date: 27.6.13 Chair: .....

Date: 27.6.13 Chief Executive: .....

Annex 3.

KPMG Limited Assurance Audit report

INDEPENDENT AUDITORS' LIMITED ASSURANCE REPORT TO THE DIRECTORS OF THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST ON THE ANNUAL QUALITY ACCOUNT

We are required by the Audit Commission to perform an independent assurance engagement in respect of The Shrewsbury and Telford Hospital NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our work under section 5(1)(e) of the Audit Commission Act 1998 ("the Act"). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death; and
- Percent of all adult inpatients that have had a VTE risk assessment on admission to hospital using the clinical criteria of the national tool.

We refer to these two indicators collectively as "the indicators".

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners dated 17/6/13;
- feedback from Local Overview and Scrutiny Committees;
- the trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- the Head of Internal Audit's annual opinion over the trust's control environment 2012/13;
- the Annual Governance Statement 2012/13; and
- Care Quality Commission quality and risk profiles 2012/13.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of The Shrewsbury and Telford Hospital NHS Trust in accordance with Part II of the Audit

Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Shrewsbury and Telford Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Shrewsbury and Telford Hospital NHS Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP

Chartered Accountants

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Birmingham

B4 6GH

27 June 2013

Glossary

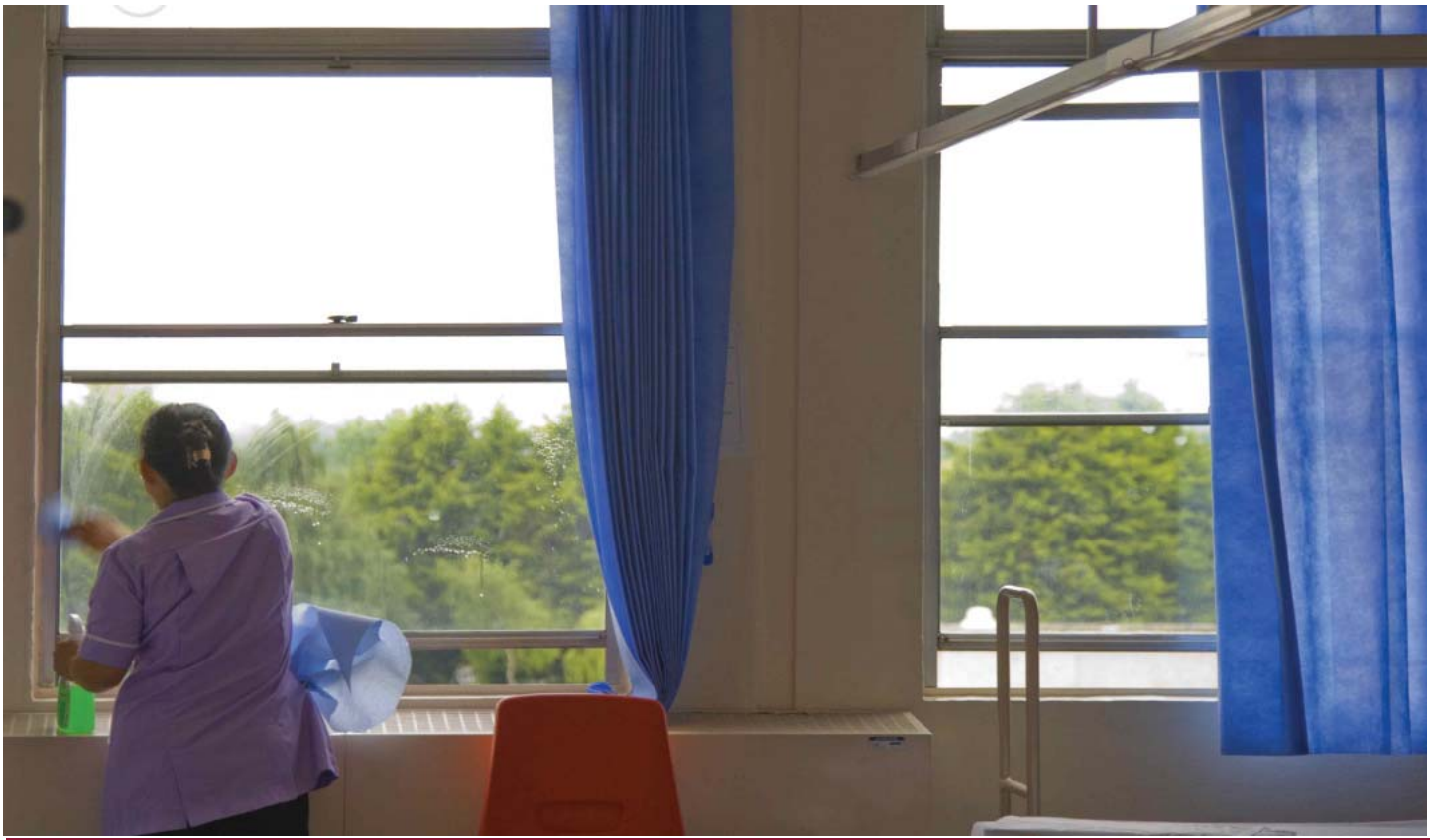
CGE: Clinical Governance Executive	
CHC: Community Health Council	Community Health Councils in Wales have a statutory role to represent the interests of the public in the health services in their district. See www.wales.nhs.uk/chc
Clinical Audit	Information about clinical audit, including a definition, 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 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 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, Telford and Wrekin Primary Care Trust 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
DATIX	The Shrewsbury and Telford Hospital NHS Trust internal incident reporting tool
EDD	An Expected Date of Discharge (EDD) is the date we think a patient will be able to safely leave the hospital. This date is discussed and agreed by the team looking after the patient
HSMR: Hospital Standardised Mortality Ratio	The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect
ISO 9000	The ISO 9000 family of standards is related to quality management systems and designed to help organizations ensure that they meet the needs of customers and other stakeholders while meeting statutory and regulatory requirements
Information Governance Toolkit	This is an tool to support NHS organisations to assess and improve the way they manage information, including patient information See www.igt.connectingforhealth.nhs.uk
KPI: Key Performance Indicators	A set of defined measures which show progress against the target
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 like and dislike 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.
MDT	Multi Disciplinary Team—A group of health care professionals who provide different services for patients in a co-ordinated way

MHRA	The Medicines and Healthcare Products Regulatory Agency (MHRA) is a UK government agency which is responsible for ensuring that medicines and medical devices work and are acceptably safe.
MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections.
NHSLA	The NHS Litigation Authority is a not-for-profit part of the NHS. It manages negligence and other claims against the NHS in England on behalf of member organisations.
NPSA	The NPSA is an arm's length body of the Department of Health. It was established in 2001 with a mandate to identify patient safety issues and find appropriate solutions
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 our own internal surveys and the complaints and compliments we receive from patients and carers.
PEAT	Patient Environment Action Team
PEIP	This stands for Patient Experience and Involvement Panel. This group brings together patients, carers, patient representatives and senior staff to make on-going improvements to patient care and experience.
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
PROMs	Patient Reported Outcome Measures - PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires.
PSAG	Patient Status at a Glance. An SaTH developed electronic patient board which shows clinical teams what interventions the patient requires. Provides basis to manage demand and capacity.
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.
RCA	Root Cause Analysis. An investigation which takes place to find out the cause of a problem which has occurred
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
Safety Thermometer	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care
SHMI	Summary Hospital-Level Mortality Indicator.
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.
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

Acknowledgements

We would like to thank the following people for their contribution and generous feedback which has shaped this year's Quality Account.

- Health and Safety Manager
- Specialist Practitioner in Blood Transfusion
- Associate Director of Quality and Patient Experience
- Centre Manager—Therapies
- Diabetic Clinical Nurse Specialist
- Deputy Chief Nurse
- Medical Performance Manager
- Business Manager—Estates and Facilities
- Patient Safety Team Manager
- Patient Services Manager
- Programme Manager - Future Configuration of Hospital Services
- Chief Information Officer
- Clinical Governance Manager
- R&D/Clinical Trials Manager
- Data Quality Manager
- Information Governance Manager
- Contracts and Performance Manager
- Hygiene and Compliance Officer
- Head of Business Information
- Contracts & Performance Manager
- Senior Human Resources Manager
- Improvement Manager—Corporate Nursing
- Members and contributors from the following groups
    - Shropshire Clinical Commissioning Group
    - Telford and Wrekin Clinical Commissioning Group
    - Telford & Wrekin Local Involvement Networks (LINKs)
    - Shropshire Healthwatch
    - Shropshire and Telford & Wrekin Health Overview and Scrutiny Committees (HOSC)
    - Montgomery Community Health Council (CHC)



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.

www.sath.nhs.uk