The Shrewsbury and Telford Hospital NHS
NHS Trust

Quality Account

2013-14

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Contents

Chief Executive statement

Shrewsbury & Telford Hospital NHS Trust aims to be a safe organisation that provides the best possible clinical outcomes and experience of care to our patients. This means that patient safety and quality are at the heart of everything that we do. As Chief Executive I am proud of what we, at the Trust have achieved and with the Board, have committed to delivering further improvements. To deliver these improvements, the Quality Account sets out a number of areas that we need to focus on. These have been influenced and identified by our patients, staff and partner organisations by listening to their views and comparing ourselves with how other organisations across the NHS and beyond are delivering consistent quality standards of care. The Quality Account is a vital snapshot of our achievements and whilst it shows areas of where we have progressed well; there are clearly things that we need to build on and areas where further improvement is still needed. We hope that you find that this Quality Account for 2013/2014 describes our achievements to date and our plans for the future.

Key to the Trust's success and achievement are our people; particularly as we continuously respond to the changing needs of the health of our community, the remarkable and welcome improvement in the life expectancy of older people along with a changing social and financial landscape. We recognise that the main part of the organisation that directly impacts on the quality and safety of patients is the contribution of the people we employ. It is our workforce that make a difference to patient care through their roles in providing direct and indirect care to our patients.

Feedback from our staff has told us that we need to improve their employment experience and this is why we set out a mission to make our organisation a great place to work and ensure that we are an engaging and listening organisation to work for. Through our values based recruitment we aim to recruit and keep people who believe and live our values to ensure that patients receive and experience the best care. We aim to not only employ an engaged, enabled and empowered workforce but also to develop great leaders who put patients first and drive our organisation to achieve.

The largest part of our workforce is within our nursing staff and we know that safe nursing levels on our wards will mean good standards of care. This was highlighted as being of critical importance in delivering high quality, safe and effective care following the Francis and Keogh reviews during 2013. You will see that our quality account reflects this as a priority for 2014 and follows a review of the nursing workforce in November 2013 where we identified by ward both current and proposed nurse to patient ratios leading to planned increases in nursing staffing from April 2014. We have made a commitment to continuously review our nursing staffing levels through 2014 to sustain safe levels based on the dependency of patients on our wards.

We know that providing health care is not without risk and that sometimes we unintentionally harm patients whilst they are in our care. We will strive to reduce harm to patients and continue to learn from examples of where the care we provided could have been better. That is why, despite reducing the overall number of falls and avoidable pressure ulcers and improving timely completion of venous thromboembolism (VTE) risk assessments in 2013/14; we will continue to sustain these quality priorities next year.

As a Trust, we are committed to putting patients first in everything that we do. This is reflected in the development of our patient experience strategy which is being designed to encompass all elements of the patient journey. To support the strategy there are a number of methods that we use to collect data on patient satisfaction and experience such as surveys, patient stories and patient experience audits on our wards. This provides us with valuable feedback on how we are doing when we provide care to patients.

During 2013/14, our patients told us that more work is needed in a number of areas and these will be a priority for next year. The specific areas that we need to improve include how we communicate with patients and their relatives and carers when explaining about when they are going home, helping patients to understand the medicines that they receive when they go home, understanding the experience of patients receiving cancer services and also understanding the experience of patients receiving care who suffer with dementia. We aim to deliver a wider and increased patient experience programme across non-inpatient areas such as the renal unit and out patient departments.

Finally, the Trust will be proud to open the new Women and Children's Centre later in 2014 at the Princess Royal Hospital site. This major redevelopment will provide state of the art facilities and provide care to our patients in comfortable and modern surroundings.

I hope that you will recognise the examples of the improvement work that teams across the organisation are pursuing. We will continue to strive to provide the best possible care that meets the standards that our patients deserve and should expect.

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

Statement of directors' responsibilities in respect of the Quality Account

The Trust Board 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, the Board are required to take steps to satisfy themselves that:

- The Quality Accounts presents an open and 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 Board of Directors confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the Quality Account.

By order of the Board:

Date: 2nd June 2014 Chair:.....

Date: 2nd June 2014 Chief Executive:.....



Part 1

Quality Review - A Look Back at 2013 and 2014

1.1 A Review of Quality Performance in 2013 - 2014

In last year's Quality Account we outlined 5 key quality priorities for 2013/14. For each priority we have provided a report outlining the detailed work undertaken within the Trust to underpin the improvements required.

Quality Priority 2013/14	Current Status of Priority	Comment	Further Details on Page
Reducing inpatient falls resulting in serious harm		Despite our best efforts we have not achieved a reduction of inpatient falls that resulted in harm during 2013/14; which is why this will continue to be a priority next year. We have recruited a falls prevention practitioner who has implemented the falls prevention action plan and standardise best practice across the Trust and there continues to be a decrease of just over 12% in the overall total number of falls.	11
Preventing avoidable pressure ulcers		Much progress has been made in the reduction of avoidable Grades 3 and 4 pressure ulcers. There have been no avoidable Grade 4 pressure ulcers this year and a 34% decrease in avoidable grade 3 pressure ulcers. Overall across all pressure ulcer grades 2-4; 2013/14 has seen a 50% reduction .	12
Safe and effective discharge every time		To support patient flow within the hospital at times of pressure; there has been extensive work to support safe and effective discharge. Successful projects focussing on discharge includes implementation of new nursing documentation that enables planning for discharge at admission, a Home for Coffee initiative that supports planning discharges before 10am and a discharge patient information booklet to support patients understanding of when they go home.	13
Communication with relatives and carers		Improving communication with relatives and carers has progressed well this year. We have expanded our patient experience work through a revised survey used on every ward that evaluates how well we are communicating with relatives and carers. In addition, our Patient Experience and Involvement Panel has developed this year and includes 26 members with broad experience who attend and challenge our performance on a number of groups that focus on quality & patient safety.	14
Non inpatient patient experience		Improvement in the experience of care for our patients has been continuously reviewed this year to ensure that we understand and act on the reliability of care received by patients. In practical terms this means that we have extended our patient experience measures into non-inpatient areas such as outpatients and emergency departments.	15

Update on Quality Priorities in 2013/14

1. Reducing inpatient falls resulting in serious harm

Why was this a priority?

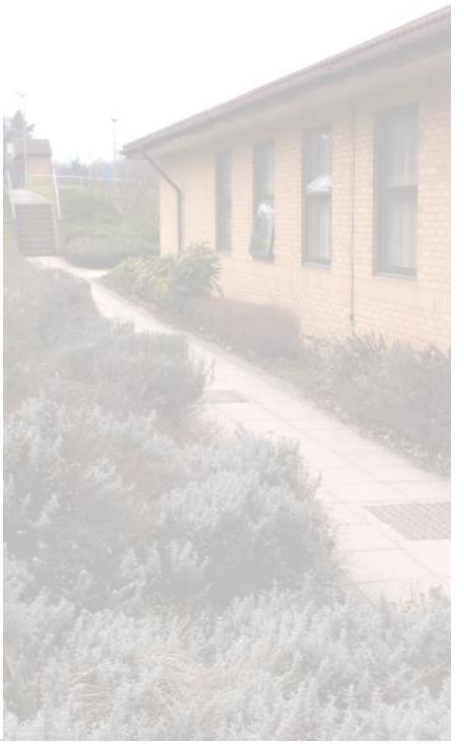
Following a number of incidents resulting in patients being harmed due to a fall within the hospitals, we recognised the need to prioritise reducing falls overall and reducing falls causing harm. This coincided with a level of interest and assurances sought by the Health and Safety Executive into the measures that we were adopting to prevent and reduce falls.

What were our goals for 2013-2014?

- Reduction of overall numbers of falls
- Reduction in severity of falls
- Bench marking of falls with other Trusts in order to better understand our performance
- Appointment of a Falls Prevention Practitioner
- Review of Falls risk assessment and establish best practice
- Develop a remedial action plan with tasks to reduce falls

What have we achieved?

- Recruitment of Falls Prevention Practitioner to deliver education and training
- Internal audit of falls performance by external organisation to test that we are doing everything we can to prevent falls.
- Implementation of actions within the remedial plan to gain assurance that factors that influence falls prevention are being completed.
- Increased awareness among clinical staff of their responsibilities with regards to managing falls risks for our patients.
- Falls Prevention messages incorporated into Fundamentals of Care training
- Trial of new Falls Safe risk assessment
- Review of all falls causing harm to establish key themes and benchmark with other Trusts
- All patient's falls which result in harm reviewed by Senior Nursing Team



What more do we need to do?

We aim to reduce all falls by a further 10% and reduce falls causing harm by 15%. To support this we will continue to implement the Fall Safe risk assessment to all wards, develop a link worker programme that supports the prevention of falls across the Trust and distribute a new updated information leaflet for Staff and Patients.

2. Preventing avoidable pressure ulcers

Why was this a priority?

We know that approximately half a million people in the UK will develop at least one pressure ulcer in any given year. Most commonly this will occur in people with an underlying health condition. For some people pressure ulcers will only require minimal nursing care, whilst with others it can be more serious and have a negative impact on their health and recovery. The Trust remains committed to eliminating acquired avoidable Grade 3 and Grade 4 pressure ulcers and further reducing the occurrence of Grade 2 pressure ulcers year on year.

What were our goals for 2013-2014?

To continue to strive to meet our targets to eliminate acquired avoidable Grade 3 and 4 pressure ulcers and reduce our Grade 2 pressure ulcers by 50%

What have we achieved?

- We have achieved the target of eliminating avoidable grade 4 pressure ulcers
- Our current trajectory for Grade 2 pressure ulcers shows a reduction of 10-15%
- We review all our Grade 2 pressure ulcers to identify further opportunities to reduce Grade 2 pressure ulcers and prevent potential progression to Grade 3
- We have increased capacity within our Tissue Viability team to extend and improve education and training across the Trust
- We have implemented actions within the pressure ulcer prevention plan to improve the recognition and classification of pressure ulcers.
- We have reviewed the quality and specification of our static mattresses and our specialist mattress
- We have tested and evaluated equipment that can contribute to pressure ulcers and introduced a new oxygen mask to reduce the risk pressure ulcers found on ears and noses

What more do we need to do?

The Trust is committed to a further 20% reduction in hospital acquired Grade 2 pressure ulcers and we will continue to strive to make effective changes that will reduce risk to our patients and eliminate avoidable Grade 3 and Grade 4 pressure ulcers.

3. Safe and effective discharge every time

Why was this a priority?

Ensuring that patients know when they're going home and supporting patients to get home safely has a direct effect on our patient's experience. In order to achieve this we know that we need to plan to enable a well delivered discharge process for patients that includes relatives and carers. We also know that with increasing demand on our hospitals we will only achieve this through working with our partner colleagues within primary, community and social care.

What were our goals for 2013-2014?

- Work with our partners to develop an improved and standardised process for discharging patients
- Strengthen our discharge support team
- Introduce discharge training for every registered ward nurse
- Improve information about going home for patients and relatives
- Audit that patients receive discharge information and achieve 80% compliance
- Revise our discharge checklist for every patient being discharged from our wards

What have we achieved?

- During 2013/14 we focussed on improvements to the systems we have available to support and inform us about when patients are ready to go home.
- We implemented a new discharge procedure and also introduced a discharge information leaflet for patients.
- We have implemented a 'Patient Choice' letter for all patients that clearly explains the process from admission to discharge.
- We have recruited to a new role on each site with responsibility for site safety, capacity and improving discharge planning.
- We have established a discharge hub with our partners that provides a centralised control centre which aids communication between the Trust and its external partners.

What more do we need to do?

We know that we have more work to do to ensure that we consistently plan for discharge and communicate with patients, relatives, carers and partner agencies. Listening to our patients and their families tells us that we fall short in sharing enough of the right information when we send patients home and often this relates to their medication. Safe and effective discharge planning therefore is one of the key quality priorities looking forward next year.

4. Communications with Relatives and Carers

Why was this a priority?

From the feedback we get from complaints, PALS enquiries, our patient feedback and from the results of our inpatient surveys we are told that we need to improve the way that we communicate with and provide information to our patients, relatives and carers. This can relate to information about choice of treatment plans, on-going care or plans about being discharged from hospital. We also know that we need to improve the information and signposting for carers particularly those supporting patients living with dementia.

What were our goals for 2013-2014?

- Develop a suite of relevant and clear patient information
- Expand our patient experience feedback processes to include families and carers
- Ensure families and carers are represented on our Patient Experience and Involvement Panel (PEIP)
- Ensure we signpost families and carers of those patients with dementia to where they can access help and support
- Audit and report progress monthly to our Quality and Safety Committee to ensure that we are providing the right support in these areas

What have we achieved?

- We now include feedback from patients, relatives and carers on our 'ward to board' patient surveys
- We have audited our Emergency Department patient experience on a regular basis and increased the number of patients taking part in the survey
- We have developed networks with groups representing carers and have increased their representation on our PEIP panel
- We have implemented a scheme to identify carers for those patients with dementia and signpost them to help and support
- We have worked with the Patient Carers Hospital Liaison worker to support families and carers
- We have listened to carers groups and implemented a carers passport scheme which enables carers to support a patients stay in hospital
- We have implemented an information booklet to support the safe, effective and timely discharge of all our inpatients

What more do we need to do?

We need to continue to listen and learn from what patients, relatives and carers tell us in their feedback to us. We also need to act on the information that they give us and share this across the organisation to improve patient experiences. We will continue to develop and strengthen the relationship between our PEIP panel and our Trust so that the patient experience is central to our work.

5. Non inpatient patient experience

Why was this a priority?

Whilst much of our patient experience work involves inpatient areas such as wards; the Trust recognises the importance and value of continuing this work in non-inpatient areas attended by patients within the hospital. We need to consider patients in all our areas throughout the Trust to ensure that we are listening to their experiences and identify opportunities for improvement to quality and safety.

What were our goals for 2013-2014?

- To continue to listen to patients in non-inpatient areas and include in our monthly report to the Quality and Safety Committee by October 2013
- Gain feedback from patients in our Outpatients department, fertility Clinic, Paediatric wards, renal and Neo-natal unit
- Improve the work of our PEIP members in non-inpatient areas and involve the staff in developing patient experience metrics

What have we achieved?

- We have extended the Friends and Family test into Maternity outpatient settings.
- We have expanded the Friends and Family survey into several Outpatient clinics.
- We have implemented a regular Emergency Department patient experience survey.
- Our PEIP members have been part of a Patient Access project which has led to increased responses and improvement in our Outpatient patient experience survey results.
- PEIP members are now part of regular assurance visits to Outpatients areas and conduct observations of care provided
- We have implemented information for patients aimed at helping them get the most from their consultation with doctors and nurses.
- We have extended our ward to board nursing and quality metrics to our Renal and Paediatric wards.

What more do we need to do?

We will continue to extend and improve the Friends and Family test to cover all our Outpatients clinical areas. We will work with our community partners to ensure that we develop patient experience feedback that supports patients with a learning disability to tell us about their experiences of health care. We will also work with our Emergency Department teams to ensure that the views of our patients are listened to and shared through displayed "You said we did" boards.

1.2 Looking Forward to our Quality Priorities for Improvement for 2014 - 2015

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 4 new key 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
	End of Life Care	Dementia Care	Improving Patient Care through Safe and Effective Staffing Levels	Patients, Relatives and Carer Experience
Why is this a priority?	A national review and phasing out of the Liverpool Care Pathway for the dying patient has meant changes are needed to ensure that people with advanced life threatening illnesses and their families receive the best possible end of life care.	Nearly 2 thirds of patients admitted to hospital are over 65 and are frail or suffer with some form of dementia. We know that our hospital buildings, services and staff are not always equipped to provide the best possible care for patients with multiple complex needs associated with dementia.	Our staff play a key part in ensuring the quality and safety of patients in the contribution they make providing care. Feedback from our staff tells us that we need to improve their employment experience. The largest part of our workforce is within our nursing staff and we know that safe nursing levels on our wards enables good standards of care.	We continuously receive feedback from patients and relatives through a variety of national and local surveys as well as local patient stories and experience audits. Our patients, carers and relatives tell us that we need to improve in how we communicate with them and improve their experiences of the care that they are receiving.
Where are we now?	• Developed a health economy wide end of life care plan • Multi-disciplinary and partnership approach to patient choices • Lead clinicians, patient representatives and palliative care leads involved organisations working together to support early identification and choices provided for end of life care to patients.	• Improving the quality of care provided to patients with dementia. • Engagement and inclusion of carers and relatives, using a Friday lunchtime club • Socialisation and diversion therapies for patients with dementia • Revised tool for the identification and screening of patients. • Introduced a dementia/ delirium care bundle across the Trust.	• Review of the nursing workforce; identifying by ward current and proposed nurse to patient ratios. • We are recruiting to an increased number of nursing staff. • Integrated education plan sets out a commitment to learning through education. • Revised appraisal process • A focus on clinical training and leadership development for all disciplines.	• Understanding the patient experience via our monthly quality reviews on the wards. • Reviewed and implemented changes through listening to what patients are telling us from PALs and complaints feedback. • Patient Experience and Involvement Panel has progressed in delivering a range of inspection programmes.
What are our plans for 2014-2015?	A system wide approach to improving the quality of care at the end of life by: • Appointing a End of Life Facilitator. • Reviewing care recording and decision making at the end of life stage. • Implement care planning to extend choice and to support rapid discharge home. • Implement the Amber Care Bundle that promotes early identification and advance care planning.	A person centred planned approach to care and services to patients with dementia that includes: • An integrated patient pathway using best practice working across primary, community and secondary care. • Identifying and training dementia champions across the Trust • Improved signage and labelling on key wards following a pilot on the care of the elderly/ rehabilitation ward. • Continuing focus on improving engagement and communication with relatives and carers.	Review our nursing staffing levels to ensure on-going quality and safety and update the Trust board on a quarterly basis. • Nurse staffing ratios will be reported by inpatient ward. • Implement our People Strategy that aims to make the organisation a great place to work and makes clear that this will happen by ensuring that we have engaged, enabled and empowered leaders who believe in the values of the Trust.	Through communication with patients relatives and carers we know that we need to improve in a number of areas. These are: • Understanding the experience of patients with dementia and cancer. • The experience of patients with mental health needs. • Improving how we communicate with patients and their relatives and carers when explaining about when they are going home.

1.3 Other Quality Measures Which Remain a High Priority

In addition to our new priorities, we maintain focus on a number of other quality measures which are important to us

1. Reducing Harms

Despite our best efforts; we know that sometimes we unintentionally harm patients whilst they are in our care. Harm is described as suboptimal care which reaches the patient either because of something we shouldn't have done or something we didn't do that we should have done. Hospital acquired infections, medication errors, surgical infections, pressure sores and other complications are examples of harm which can occur within a healthcare setting. It is therefore important that we continue to try and reduce harm to patients and to learn from the examples of where the care we provided could have been better.

Current position within the Trust

In the last 12 months, we have reduced the number of overall falls, avoidable Grade 3 and 4 pressure ulcers and improved the timely completion of venous thromboembolism (VTE) risk assessments within the Trust. To maintain improvements the Trust is part of a local health economy group that promotes harm free care across the County. This group looks at initiatives that will help to improve the prevention of key harms sustained as a result of falls, pressure ulcers, VTE risk assessment and catheter acquired urinary tract infections. Each safety initiative is led by a senior nurse or doctor within the Trust to monitor and review any harms caused.

Our aims for 2014/15

During 2014/15, we will continue to use the "Safety Thermometer" to understand the extent to which the care received within our Trust is harm free. Although we are proud of our work on pressure ulcers and falls we will continue to implement our plans to further reduce Grade 3 and 4 pressure ulcers and develop improved changes across the hospital that prevent falls.

At Shrewsbury and Telford Hospital we aim to reduce harm and measure the outcomes of many individual harms to identify the impact of any improvement work we undertake in order to:

- Reduce the number of avoidable Grade 2, 3 and 4 pressure ulcers
- Reduce the number of falls causing harm
- Increase the number of timely VTE risk assessments
- Reduce the number of hospital acquired infections

Each harm will be measured by the Safety Thermometer where relevant and looked at in a more in depth way by dedicated groups to focus on learning and improvement.

2. Fractured Neck of Femur

Patients who suffer a Fractured Neck of Femur have a high mortality and morbidity rate with up to 20% needing long term care post fracture and a further 30% not returning to their pre fracture functioning. Hip fracture accounts for 87% of total fragility fractures.

We know that care varies throughout the country with the length of stay varying between 17 to 40 days between Trusts. Longer lengths of stay also lead to a high rate of healthcare associated infections.

Current position within the Trust

The Centre specialty has successfully submitted a Fractured Neck of Femur business case to the Trust board in order to increase capacity and enable compliance with best practice standards in the treatment of fractured neck of femur. The Trust has also recruited to one Orthogeriatrician at the Royal Shrewsbury Hospital who is beginning to improve the current compliance rate for best practice.

The journey for patients with fractured neck of femur has also been scoped and audited in order to identify areas where the service is challenged to meet best practice standards and key issues identified are being resolved.

Our aims for 2014/15

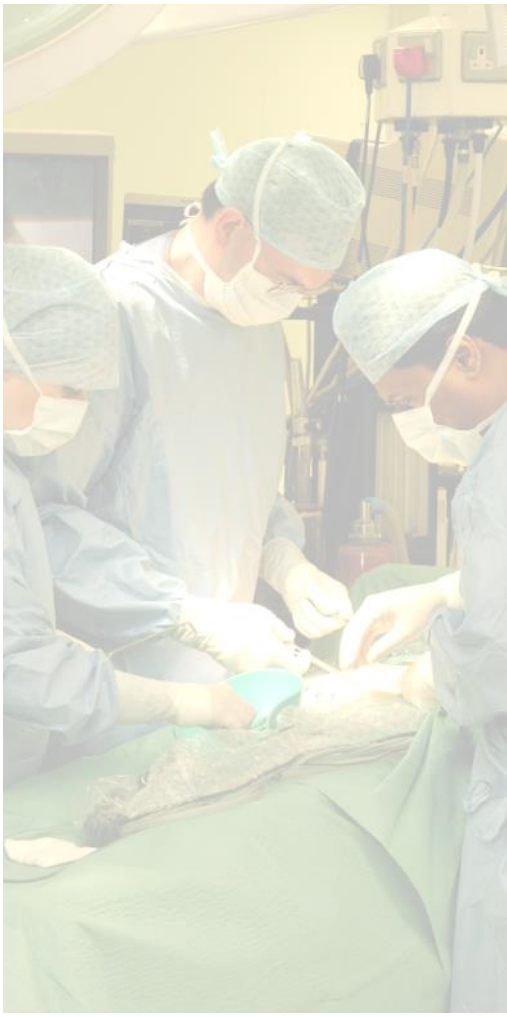
The Trust aims to improve the clinical outcomes for patients treated with a Fractured Neck of Femur by ensuring an effective care pathway that is:

- Recruitment of a further Orthogeriatrician and Trauma Nurse Specialist for Princess Royal Hospital site in order that appropriate, medically fit patients receive surgery within 24 hours across both sites.

- Services to be co-ordinated and designed to reduce variation in length of stay, reduce mortality and re-admissions.

- Patients are mobilised within 12-18 hours post op and receive needed therapy input.

- Patients are assessed and supported to be discharged back to their home.



3. Caring for our Patients with Mental Health Needs and Learning Disabilities

Patients with Mental Health Needs

Many people with mental health needs are brought to Emergency Departments in distress or are seriously disturbed. Some can become more distressed as a consequence of the illness or injury that has brought them to hospital. 60% of acute hospital inpatients over 65 years of age will have a mental health problem and will require additional skills to support them in the hospital environment.

What do we want to improve in 2014/15

Working together with our partner agencies we want to improve the outcomes for patients with mental health problems and deliver a high quality response when people with mental health problems urgently need help. We want to achieve this by:

Patients with Learning Disability Needs

People with learning disabilities are often vulnerable in acute hospital settings and at greater risk of adverse incidents. Illness can be missed particularly where staff have little knowledge of the healthcare needs of this patient group or where specialist knowledge is unavailable to support them.

- Improving communication and work closely with our colleagues in mental health teams, out of hours services, police and social care to improve the patient experience.

- Improve knowledge through joint training with acute and mental health staff so that they can readily identify the needs of and risks to patients with mental health needs who come into our emergency departments.

What do we want to improve in 2014/15

With our colleagues we want to implement a number of initiatives that help patients with learning disability to be better supported when they have to come into hospital. The key areas for improvement are:

- Improving the knowledge and skills among staff in communicating with people with learning disabilities.
- Recognising, identifying and flagging patients with learning disability.
- Improving information and making reasonable adjustments in hospital for people with learning disability.
- Improving the transfer of information between health services by embedding the “who I am” passport and work with Carers groups to implement a carers passport scheme.

4. Cleanliness and Hygiene

The Patient Environmental Action Team (PEAT) assessments were replaced this year by the Patient Led Assessment of the Care Environment (PLACE) programme.

The programme offers a non-technical view of the buildings and non-clinical services provided across hospitals, hospices and independent treatment centres providing NHS-funded care. A crucial change to the assessment process is the involvement of patient assessors.

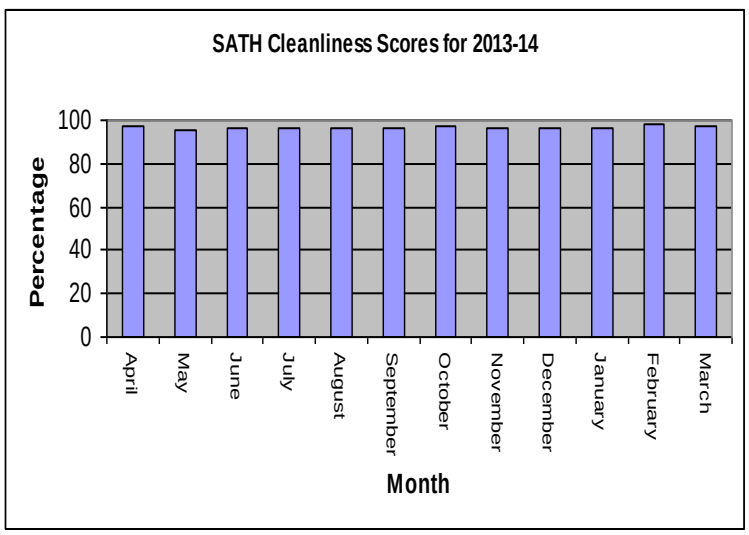
The results of the assessment are shown in the table below.

	Cleanliness	Food	Privacy & Dignity and Well Being	Condition Appearance and Maintenance
	%	%	%	%
Princess Royal Hospital	99.02	76.27	89.07	87.70
Royal Shrewsbury Hospital	98.94	69.66	86.24	84.67
Bridgnorth Maternity Unit	100.00	92.42	93.00	93.10
Ludlow Maternity Unit	74.48	87.50	60.00	49.14
Oswestry Maternity Unit	100.00	86.53	77.14	83.33
National Average	95.74	94.98	88.87	88.75

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

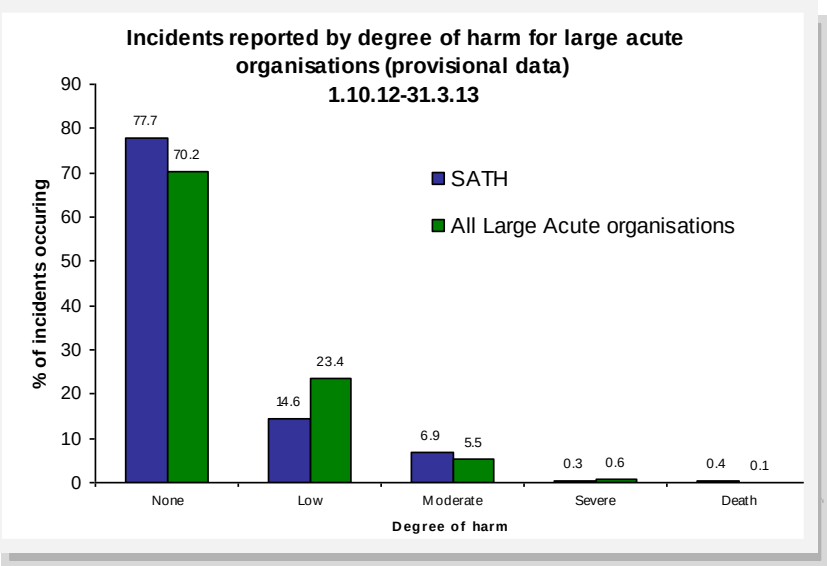
Audits of Environmental Cleanliness standards in wards and other hospital areas are undertaken by the Domestic Services Monitoring Team. Our cleanliness scores are measured against the national Standards of Cleanliness and have remained high at 96.74% for the year from April 2013 to March 2014.



5. Patient Safety

Improving patient safety is central to the Trust's approach to delivering high quality and safe care for our patients. We recognise the value and importance of an open reporting culture when reporting incidents and actively encourage staff to speak out safely on all patient safety incidents.

By investigating each incident, the Trust assesses what actions need to be taken to reduce future risks. We also identify trends and themes that may require a particular focus for learning or improvement. Any serious incident is communicated with the complaints department to ensure that all lessons are learned and shared openly.



Incidents are classified by the 'degree of harm' they cause and by uploading our patient safety incidents to the NRLS (National Reporting and Learning System) a degree of benchmarking can take place. While reporting to the NRLS is a voluntary system, it is considered good practice to report and enables the Trust to a degree of measured comparison against similar sized Trusts. However, NHS England has identified that Trusts apply the degree of harm inconsistently, making comparisons difficult and often unreliable.

Serious Incidents (SIs)

Within the open reporting culture of the Trust, staff are encouraged to identify and escalate any Serious Incidents (SIs) and as with any other incident the Trust reviews SIs for trends and themes to look for opportunities for improvement.

In 2013/14 the Trust reported 145 SIs, none of which have been categorised as Never Events. This is a decrease of 19 incidents reported in 2012/13. The absence of Never Event reporting demonstrates a continued commitment to high standards in clinical processes and practice.

The Trust investigates every SI through a Root Cause Analysis (RCA) and an action plan for improvement is developed. Action plans are implemented by the appropriate Care Groups and monitored for completion within identified time frames through Governance groups. Trust wide learning is shared through the Clinical Governance Executive Committee.

6. Safeguarding Adults and Children

The Trust is committed to ensuring that all children and adults at risk have a right to be protected for their safety and well-being and that all staff within our hospital have a responsibility to protect them from harm. The principles of Safeguarding guides the Trust to make sure that:

- We effectively respond to allegations of harm and abuse and that the responses are in line with local multiagency procedures.
- We maintain integrated governance processes when reporting concerns or issues.
- We work in partnership with Local Safeguarding Boards (Child and Adult), patients, families and community partners to create safeguards for children and vulnerable adults.
- We prevent harm and abuse through the provision and delivery of high quality care.

Safeguarding Adults

From April 2013 to March 2014 there have been 72 safeguarding adult alerts raised against the Trust. In the main, these alerts related to allegations of neglect with regard to the discharge of the patient. The majority of alerts were closed at the strategy phase of the process and did not meet the threshold guidance of significant harm. As part of the Safeguarding Board the Trust has agreed to adopt the West Midlands Safeguarding Policy. This commenced in April 2013 and provides continuity for all agencies throughout the West Midlands.

Safeguarding Children

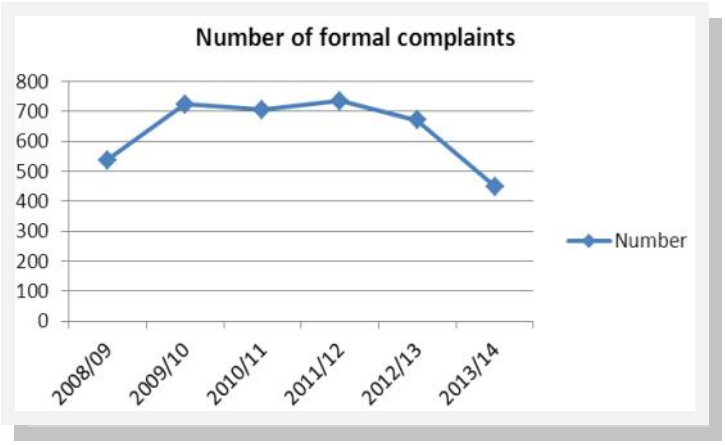
The Trust supports and contributes to both Shropshire, Telford & Wrekin Local Safeguarding children's boards and is committed to the principle that safeguarding children is everyone's business. Following changes to the Working Together to Safeguard Children guidance in 2013 the Trust is working with the national Child Protection Information System to improve communication and information sharing and to increase safeguards for vulnerable children at risk.

7. Patient Feedback and Complaints

The Trust welcomes feedback from patients and relatives, both positive and negative about the care and services we provide. During the year the Trust has focussed on improving the way in which it responds to concerns and complaints made by patients and their families with the aim of being much more patient focused, responsive, open and transparent.

PALS

PALS is often the first point of contact for patients and relatives wishing to raise concerns. The PALS team can assist with any problems or concerns that patients and the public may have about the Trust's services and listen to their views and comments. This year, PALS have seen a reducing trend in the number of concerns being raised with 2,055 received this year compared to 2,454 during 2012-13.



Complaints

The Trust has seen a downward trend in the number of formal complaints received this year. In previous years all concerns raised in writing or via the Trust's website were handled as a formal complaint with many issues relating to appointment or admission problems that could have been resolved earlier. Since July 2013, all concerns are assessed and where appropriate with agreement with the complainant, these issues are handled by the PALS team, thereby ensuring a timely response. This has led to a decrease in the number of formal complaints received by the Trust.

In 2013/14 the Trust received 444 formal complaints showing a 34% decrease from the previous year (671 in 2012/13). Following changes made within the complaints department early contact is made with each complainant and a timescale for response is agreed, based upon the complexity of the complaint. The Trust now achieves a response rate of over 90% within the timescale for response agreed with the complainant.

Positive changes made by the Trust as a result of feedback from patients via PALS and complaints include:

- Staff attend Dementia Care Awareness training.
- Posters displayed on the ward giving details of the nurse in charge and how appointments can be arranged with clinical staff.
- Changes to policies and procedures.
- Staff attending training to improve their communication skills.

CQC Inpatient Survey 2013

The CQC Inpatient survey reviews the care of 850 patients who were admitted as inpatients during July and August 2013. The results will be carefully considered within our Care Group teams to ensure that rapid and sustainable improvements are made to the overall experience we offer to our patients and that improvements are made and evidenced.

The survey shows that we have made significant improvements in a number of important areas and demonstrate that we have delivered improvements in three of the ten sections surveyed.

- The Emergency Department
- Doctors
- Leaving Hospital

Section	Change from 2012*	How does The Shrewsbury and Telford Hospital NHS Trust compare with other Trusts across England?
Section 1: The Emergency / A&E Department	↑	About The Same
Section 2: Waiting list and planned admissions	=	About The Same
Section 3: Waiting to get a bed on a ward	=	About The Same
Section 4: The hospital and ward	=	About The Same
Section 5: Doctors	↑	About The Same
Section 6: Nurses	=	About The Same
Section 7: Care and treatment	=	About The Same
Section 8: Operations and procedures	=	About The Same
Section 9: Leaving Hospital	↑	About The Same
Section 10: Overall views and experiences	=	Worse

* The National Inpatient Survey is conducted annually. Every participating Trust is required to send the survey to 850 patients who spent one night or more in hospital during Summer 2013. The Shrewsbury and Telford Hospital NHS Trust sent the National Inpatient Survey 2013 to 850 patients with an overnight stay during August 2013. 502 completed usable questionnaires were returned. The 78 core questions are divided into the ten sections above. The "Change" score indicates whether our comparison with Trusts nationally (Better, About the Same, Worse) has improved, remained the same or declined compared with the National Inpatient Survey 2012.

Last year's survey showed that the trust was scored as performing worse than other trusts in these three sections. We have improved that position to a score which rates us on a par with the national score. Whilst it is a positive to see an improvement the trust aspires to be better than average and will strive to improve next year.

One particular area where we have performed worse than last year is in relation to overall views and experience. Although this is disappointing; we know from our local intelligence and feedback that we need to improve on how we communicate with patients and ask for their views on the care they have received.

The collection of patient feedback is of paramount importance to the Trust and enables us to be an organisation that *listens and learns* from what our patients tell us.

This year a number of patient feedback processes have been implemented and a focus next year is placed on the collection of real-time feedback collected by our Trust patient representative panel (PEIP). The ward teams will have access to a designated PEIP member so that they can identify areas where they need to improve the patient experience.

8. Women and Children's Services

The Maternity Services Review was commissioned by Telford & Wrekin and Shropshire Clinical Commissioning Groups in September 2013. The overarching aim of the Review was to ensure the Maternity Service were providing the highest quality and safest care during and after pregnancy for mother and baby. The Review focused on the quality and safety of Maternity Services, through five work streams:

1. Service user experience
2. Clinical outcomes indicators and activity data
3. Hub and spoke model
4. Workforce
5. Risk management.

The overall findings of the review demonstrated that the Shropshire Maternity Service is a safe and good quality service which is delivered in a 'learning organisation'. A complete copy of the Maternity Services Review can be downloaded from www.telfordccg.nhs.uk

Midwifery-Led Units

Shropshire has five Midwife Led Units (MLUs), which are situated in Oswestry, Ludlow, Bridgnorth, Shrewsbury and Telford.
The MLUs are designed to provide a homely atmosphere for low-risk pregnancy, labour and birth and are run by highly trained and experienced midwives. Women with low risk pregnancies are encouraged to consider having their baby at their local MLU.
All units contain a chair-bed for partners, birthing aids such as mats and bean bags or a conventional bed if preferred. Birth rooms have dimmable or mood lighting, CD players or televisions to promote a calm and relaxing environment.
Shrewsbury and Wrekin MLUs contain birthing pools and now the latest addition is a state-of-the-art pool installed in the Oswestry MLU in late 2013. (Pictured)
Across the County, some MLU midwives are qualified to offer an aromatherapy service, hypnobirthing or aqua-natal sessions.

9. Mortality

Understanding mortality and how we measure it

With the type of acute care that hospitals such as ours provide it is expected that some patients will die.

We actively monitor our mortality rates using four measures:

- The Hospital Standardised Mortality Ratio (HSMR) (1). This is a national measure and an important means of comparing our mortality against other similar hospitals
- The Summary Hospital-level Mortality Indicator (SHMI). This is similar, in many ways, to the HSMR but also includes patients who die within 30 days of being discharged from our hospital
- Risk Adjusted Mortality Index (RAMI) is similar to HSMR but compares us with a different group of hospitals
- Crude Mortality. This includes all deaths in our hospital

We report on these to the Trust Board and to the Quality and Safety Committee on a monthly basis.

What were our goals during 2013/14?

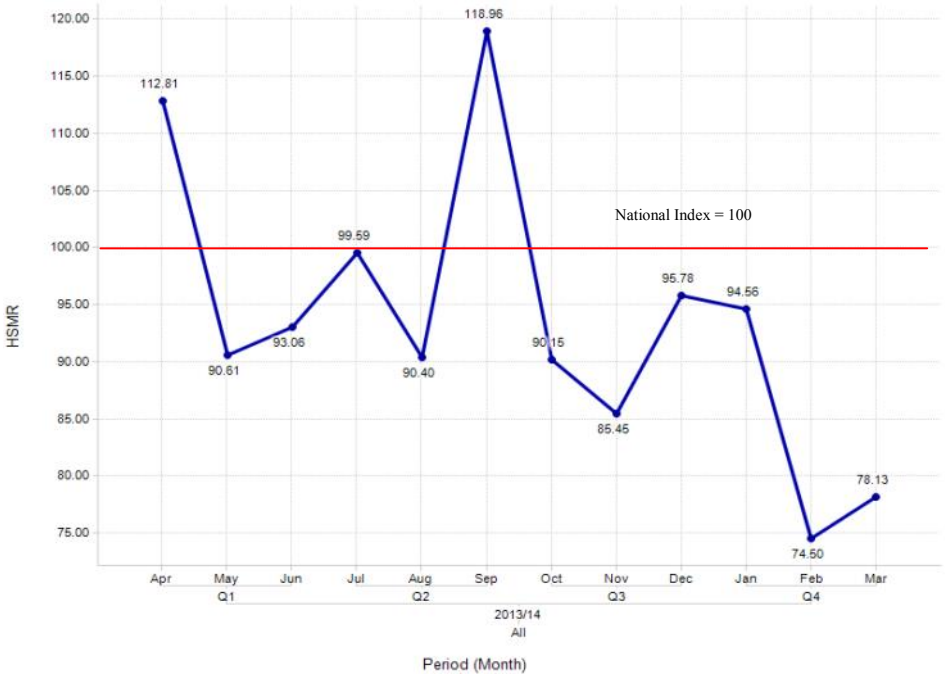
In 2009/10 the Trust was an outlier in the Dr Foster Hospital guide and we knew there were no quick fixes to this problem. We made major improvements and, in this last year, have continued to improve against national measures. Specifically we have:

- worked with the Clinical Commissioning Groups and Community Trust to reduce our mortality further
- improved in-hospital mortality through the implementation of care bundles focused on specific diseases
- sustained our focus on SHMI to improve it in line with the other mortality measures

Where are we now?

We have made significant progress in reducing mortality at the Royal Shrewsbury Hospital and the Princess Royal Hospital and we have shown this in the mortality measures that we report to the board.

The HSMR was reduced to below the national index, to between 95 and 97 in 2012/13. We have continued this good performance in 2013/14 by reducing further to around 93 - 94 for the year. We shall strive to maintain this positive trend.

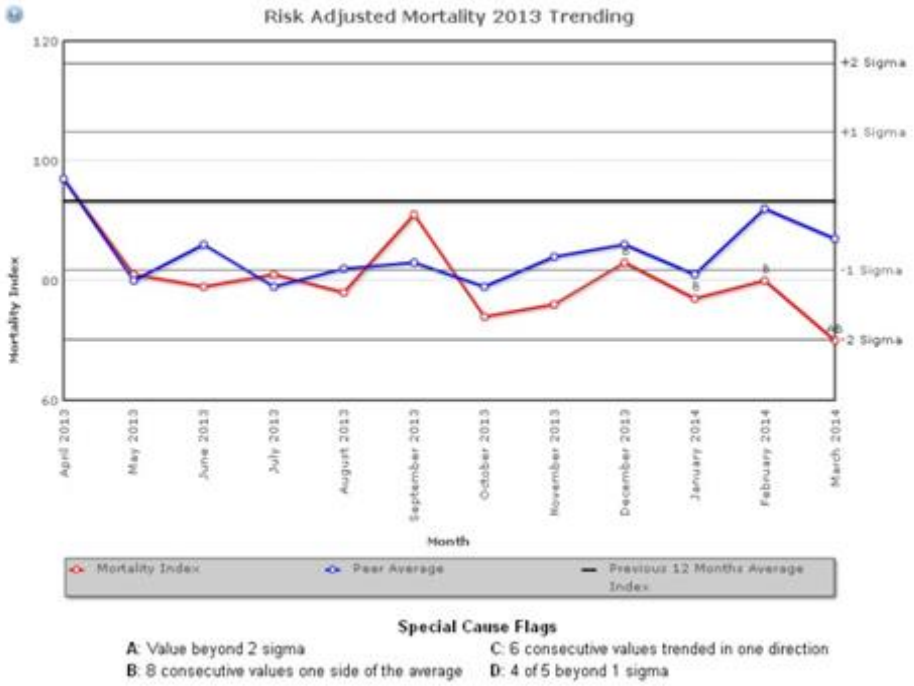


The SHMI remains within "expected range" for mortality, with a reduction in the number of patients who die in hospital, for which we are performing

better than similar hospitals. However, the number of patients who die within 30 days of discharge remains an area for improvement.

Our improvement in performance is also shown in the RAMI, with performance remaining better than similar hospitals for the latter half of the year.

We also continue to make good progress on crude rate of deaths, as we have reduced crude mortality numbers by 6% compared to 2012/13.



The most significant element about all of these measures is that, taken together, they prove that there has been a tangible reduction in mortality achieved by improvements in the care we provide to our patients.

What more can we do?

We aim to continue to improve our mortality rates by setting ourselves even more challenging objectives.

The objectives for 2014/15 are to:

- maintain the improved mortality levels achieved by the Trust over the last three years, and improve further
- implement a system of screening all in-hospital deaths based on nationally recognised criteria
- implement a system of learning from, and acting on, any death in which avoidable factors played a part

These objectives will help us reduce mortality further by improving the way we learn from mortality. We shall enhance our ability to monitor actions and report areas where improvement can be made. We shall increase the focus on mortality through Clinical Governance groups for each speciality, ensuring that lessons are learned from the screening system we shall put in place.

1.4 Looking Ahead

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

Our work with our local health and social care colleagues looking at the quality and safety of the pathway 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

We continue to evaluate the presentation and content of the Quality Account to ensure it remains fresh and accessible. With this in mind, we have included 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

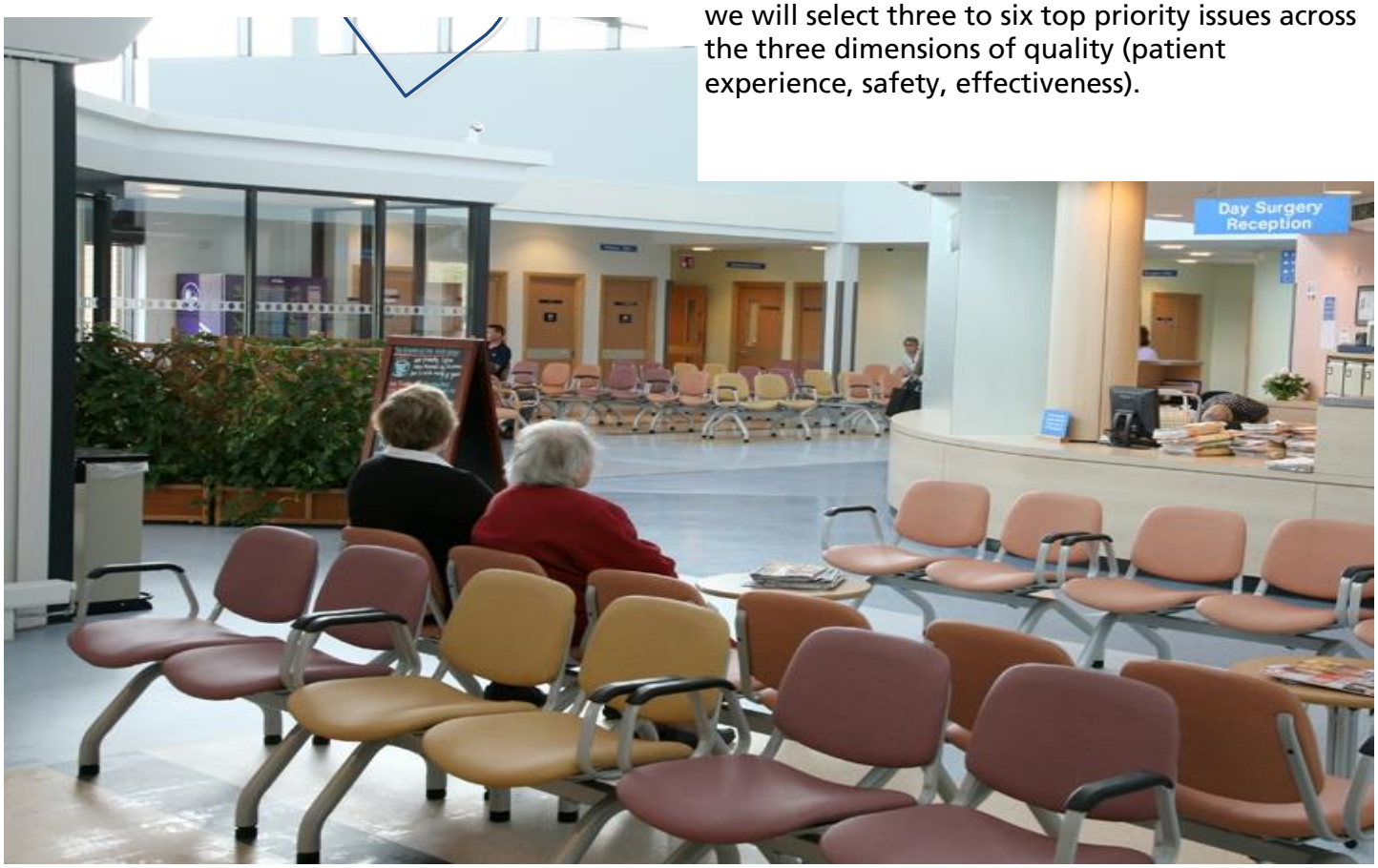
By fax to 01743 261489 – please put "Quality Account" as the subject of your fax

By post to Quality Account, c/o Director of Nursing and Quality, 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 can we further 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 2015/16 – 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 (KPIs) reported and monitored by The Shrewsbury and Telford Hospital NHS Trust are based on national and local priorities.

	Description of Target	2011/12	2012/13	2013/14	2013/14 Target
Patient Safety Measures					
1	MRSA Bacteraemia (bloodstream) infections	2	1	1	0
2	Clostridium difficile infections	41	45	31	27
3	Clostridium difficile infections per 100,000 bed days*	-	11.9	12.1	-
7	Hand Hygiene	98%	99%	98%	95%
8	Percentage of admitted patients risk assessed for Venous Thromboembolism (VTE)*	92%	90%	94%	90%
10	Safe Surgery checklist compliance	99%	100%	100%	100%
11	Rate of patient safety incidents per 100 admissions*	6.66	6.85	6.83	-
13	Number of patient safety incidents reported*	7748	8095	7172	-
14	Number of patient safety incidents resulting in severe harm/death	74	49	21	-
15	Percentage of patient safety incidents resulting in severe harm or death as a percentage of the number of patient safety incidents*	0.5%	1.2%	0.3%	-
16	Avoiding preventable pressure ulcers (grade 3 & 4)	20	42	27	-
Clinical Outcome Measures					
17	Standard Hospital Mortality Indicator (SHMI) + (lower is better)*	-	105.3	99.7	-
	Percentage of palliative care deaths which is coded appropriately (at either diagnosis or specialty level)*	17%	17%	18%	-
19	2 week wait for cancer referrals	98%	96%	95%	93%
20	18 week GP referral to first treatment - Admitted	95%	78%	76%	90%
21	18 week GP referral to first treatment - Non Admitted	87%	95%	95%	95%
22	Patient Reported Outcome Measure - groin hernia surgery*	-	99%	84%	-
23	Patient Reported Outcome Measure - varicose vein surgery*	-	99%	81%	-
24	Patient Reported Outcome Measure - hip replacement surgery*	-	97%	38%	-
25	Patient Reported Outcome Measure - knee replacement surgery*	-	96%	32%	-
26	Percentage or patients aged 0 - 14 readmitted within 28 days of discharge*	9%	10%	10%	-
27	Percentage or patients aged 15+ readmitted within 28 days of discharge*	5%	5%	6%	-
Patient Experience Measures					
28	A&E 4 hour wait	95%	91%	93%	95%
29	Responsiveness to inpatients personal needs (maintain or improve)* - Score out of 100		64.3	62.1	-
30	Staff survey - Percentage of staff who would recommend the Trust to friends or family needing care*	-	46%	47%	-

* Benchmarking data available in table on following page

A number of key performance indicators (KPIs) are selected for comparison against other NHS trusts across the country.
KPIs reported and monitored by The Shrewsbury and Telford Hospital NHS Trust are listed below with a comparison to national averages and other Trusts to provide benchmarking information.

	National Average	Highest Trust	Lowest Trust	Reporting Period
The data made available to the trust by the Information Centre with regard to—				
(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and	1	1.19	0.63	Oct'12 - Sep'13
(b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	21.28	44.9	0	Oct'12 - Sep'13
The data made available to the trust by the Information Centre with regard to the trust's patient reported outcome measures scores for—				
(i) groin hernia surgery,	0.086	0.158	0.013	Apr'13 - Dec'13
(ii) varicose vein surgery,	0.101	0.158	0.02	Apr'13 - Dec'13
(iii) hip replacement surgery, and	0.439	0.527	0.301	Apr'13 - Dec'13
(iv) knee replacement surgery,	0.33	0.416	0.193	Apr'13 - Dec'13
The data made available to the trust by the Information Centre with regard to the percentage of patients aged—				
(i) 0 to 14; and	4.19	14.94	0	2011/12
(ii) 15 or over,	6.16	41.65	0	2011/12
readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.				
The data made available to the trust by the Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.	68.1	84.4	57.4	2012/13
The data made available to the trust by the Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	65	93.92	38.03	2013
The data made available to the trust by the Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	96%	100%	77%	February 2014
The data made available to the trust by the Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	17.3	0	30.8	2012/13
The data made available to the trust by the Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.				
Number of patient safety incidents	4.39	7.75	1.96	Apr'13 - Sept'13
Rate of patient safety incidents per 100 admissions	7.07	11.06	3.85	Apr'13 - Sept'13
Percentage of patient safety incidents that resulted in severe harm or death	0.6	2.6	0.1	Apr'13 - Sept'13

In some cases, the Trust's results fall below the national average. Where this occurs, the performance of that metric is monitored and where necessary included in pieces of focussed work. For example, we have fallen below the national average for risk assessment of venous thromboembolism and responsiveness to inpatient need. Both of these measures are now identified as priorities in this year's Quality Account.

2.2 Statements of Assurance

Progress and assurance against achievement of this year's quality priorities will be reported to the Quality and Safety Committee which is a formal subcommittee of the Trust Board. Further assurance against progress is achieved in reporting to the Commissioning Quality Review meeting and will also be reported in the 2014/15 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 in relation to patient experience surveys and audits throughout the year. The Quality and Safety Committee will also receive monthly progress on patient experience metrics and will hold us to account for delivery of the priorities relating to patient experience. Our performance will also be reported to our commissioners through the Commissioning Quality Review meeting on a monthly basis.

Patient Safety

All elements of patient safety including our priorities will be monitored by specific task groups that will support the implementation of the work that needs to be done to make improvements. These and a range of safety metrics are presented and discussed by clinicians within care groups and senior nurses at the Nursing and Midwifery Forum where peer and corporate challenge is given with actions for improvement agreed. The Quality and Safety Committee will receive information regarding 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 an executive safety visit 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

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. Further reporting relating to workforce metrics (such as sickness absence, training and appraisals) and 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 2013/14 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 2013/14 or via our web site).

The Trust supported a number of reviews of its services during 2013 and 2014. These were undertaken by external organisations and included:

- *The Care Quality Commission*
- *Annual Cancer Peer review*
- *CCG review of Ophthalmology*
- *Ofsted/CQC review of children's safeguarding services in Shropshire, Telford & Wrekin.*
- *Adult Safeguarding Peer review—Telford & Wrekin*

The Trust undertook via internal auditors a review it's falls prevention programme. We also reviewed and supported individual wards on a quality improvement framework, reviewed patient flow processes and supported the CCG Ophthalmology review by sharing trust investigation findings. The Trust has reviewed all of the information available in relation to the services provided.

The income generated by those NHS services that were reviewed in 2013/14 represents 100 per cent of the total income generated from the total provision of NHS services by the Shrewsbury and Telford Hospital NHS Trust for 2013/14

2.3 Reviews of Services

The following internal and external reviews tool place during 2013—2014

Trust Wide Inspections CQC	The Trust was reviewed by the CQC during unannounced inspections on 25th April 2013 at Princess Royal Hospital and 23rd October 2013 at Royal Shrewsbury Hospital. Reasons for the visits were part of the CQC routine schedule of planned reviews. Both visits resulted in improvement notifications being submitted to the Trust by the CQC where concerns were raised against specific outcomes. Significant progress has been made against those actions required and the CQC have received implementation plans for assurance against progress.
Trust Wide PLACE Assessments	From April 2013 the Trust introduced PLACE assessments; a new system for assessing the quality of the patient environment using patient representatives to support the inspection. PLACE replaces the old Patient Environment Action Team (PEAT) inspections and will be undertaken formally every year.
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	The MHRA inspected both aseptic units in Q1 of 2013/14; which resulted in the Trust achieving licensed status at RSH and maintaining the license status at PRH. There has also been a quality audit of pharmacy training standards undertaken by Health Education West Midlands who reported favourably on standards of training.
Maternity	Maternity services were reviewed both internally and externally during 2013/14 and received positive reports from the following reviews: • Shropshire CCG services review • CNST Maternity standards review achieved Level 3 • 3 yearly inpatient survey provided 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.
Paediatrics	The Royal College of Paediatric Child Health undertook a review of the proposed service model in preparation of service re-configuration. The review tested potential models for future service delivery.
Paediatric Oncology	A Peer Review was undertaken in August 2012. The validated self assessment will take place in Summer 2014 (24.06.14)
Paediatric Diabetic:	A Peer Review was undertaken during the last financial year.
Paediatric Cystic Fibrosis	A Peer Review was undertaken in March 2013 No urgent actions required Move to 6 monthly CF Centre team reviews from previous 12 monthly interval En-suite accommodation will be delivered by 29.09.14 when new children's ward opens Mid-IVs clinical review process to be formalised, with proforma generated and spirometry equipment purchased for home spirometry monitoring
Gynaecology Oncology	A Peer Review was undertaken during the last financial year. The validated self assessment will take place in Summer 2014 (25.06.14)
Fertility	A HFEA full review took place in May 2013
Emergency Services	Health Education West Midlands—visit did not raise any significant concerns however due to the amount of reconfiguration at SATH it has been agreed that annual visits will be required. Follow up visit arranged for the 9th July 2014 for both sites
Pathology Service	Reconfiguration of laboratory services, resulting in transfer of Gynae-Cytology service from SaTH to University Hospital of North Staffordshire, consolidation of Serology, Molecular and Microbiology at RSH, consolidation of non-Gynae Cytology and Histology services at RSH Improvement of specimen reception area at RSH Release of laboratory space at PRH for the development of Women & Children's services

Phlebotomy Service	Transfer of service into new accommodation at Elizabeth House. Communication with GP practices regarding opening times and arrangements for fasting patients Recruitment and commencement of training of new phlebotomists to facilitate implementation of a 7 day service for in-patients at both PRH and RSH
Environmental Health Food Safety Inspection	Environmental Health Food Safety Inspections were carried out for both hospital sites by Shropshire Council and Telford & Wrekin Council. We achieved 5/5 Food Hygiene Rating for both Princess Royal Hospital and Royal Shrewsbury Hospital.
Food Service Audits and Protected Mealtime Audits	Unannounced Food Service and Protected mealtime audits were carried out on wards at both hospital sites . Standards were assessed using an audit tool which incorporates standards for food service, quality, presentation and protected mealtimes. Members from PEIP were included in the audit team
Quality & Safety Committee	Continue to support and receive assurance from quality and safety committee members observations of clinical areas.
WHO Safe Surgery Checklist	The Trust undertakes a review of all records in both hospital sites in response to the Who Surgical Safety Checklist. Theatres within SaTH undertake a monthly review of how compliant theatre staff are in completing the Who Safer Surgery Checklist. The Trust consistently achieves 99— 100% compliance with this audit.
Shropshire, Telford & Wrekin Ofsted Inspection for Safeguarding Children	The Trust took part in the annual peer review of both Shropshire, Telford & Wrekin local authorities in relation to safeguarding children during 2013. Positive feedback from the peer review team included the Trust's collaboration and involvement with safeguarding children with both authorities.

2.4 Participation in Clinical Audit

Participation in clinical audit is an important element of the Trust's approach to quality improvement that seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and implementing change. Aspects of the structure, processes, and outcomes of care are selected and 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 the Trust and across the NHS as a whole.

Clinical Audits

Section 2

During 1st April 2013 to 31st March 2014, **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 **53 / 58 [91%]** of the national clinical audits and **5 / 5 [100%]** national confidential enquiries of the national clinical audits and 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 2013 to 31st March 2014 [**63**] are listed at
www.sath.nhs.uk/Library/Documents/Clinical_Audit/qa201314_table1.pdf

Section 2.3

The national clinical audits and national confidential enquiries that the Shrewsbury and Telford Hospital NHS Trust participated in between 1st April 2013 and 31st March 2014 are listed at:
www.sath.nhs.uk/Library/Documents/Clinical_Audit/qa201314_table2.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 2013 and 31st March 2014 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:
www.sath.nhs.uk/Library/Documents/Clinical_Audit/qa201314_table3.pdf

Section 2.5

The reports of [**23**] national audits were reviewed by the provider during 1st April 2013 and 31st March 2014.

Section 2.6

The Shrewsbury and Telford Hospital NHS Trust intends to take the actions listed to improve the quality of healthcare provided:
www.sath.nhs.uk/Library/Documents/Clinical_Audit/qa201314_table4.pdf

Section 2.7

The reports of [**117**] local clinical audits were reviewed by the provider during 1st April 2013 and 31st March 2014

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:
www.sath.nhs.uk/Library/Documents/Clinical_Audit/qa201314_table5.pdf

2.5 Participation in Clinical Research

The Trust is committed to active participation in clinical research in order to improve the quality of care we offer and also to make a contribution to wider health improvement. In doing so our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

How have we achieved?

We work closely with the West Midlands North Comprehensive Local Research Network (CLRN) and the Topic Specific Networks to promote a strong research culture. We will continue to do so with the larger West Midlands Local Research Network coming into place from 1st April 2014.

Research activity has grown and this year we entered the National Institute for Health Research (NHIR) list of 100 top recruiting hospitals and we are proud to have one Chief Investigator for an international clinical trial. 7 studies have been opened in the new areas of neurology, critical care, ophthalmology, audiology and haematology and the number of recruiting commercial studies has increased from 7 in 2012/13 to 11 in 2013/14. The number of actively recruiting Principle Investigators has increased from 32 to 36.

The Trust approval process for new studies continues to be completed within 30 days and the proportion of studies recruiting the first patient within 30 days of receiving approval has increased to 69%. Work is on-going in improving engagement at all levels within the Trust and the public by promotional events, providing speakers at local groups, activity reports to the Board, 2 lay members on the R&D Committee and inclusion of a Research Award within the Trust's annual awards scheme.

The Trust also acts as a Continuing Care site for local children recruited into cancer studies at Birmingham Children's Hospital and delivers all the treatment and follow up care required. Radiology and pathology services are also provided for patients taking part in clinical research in our local mental health trust and primary care. Maintain or increase participation in commercial trials.

The number of patients receiving NHS services provided or sub-contracted by The Shrewsbury and Telford Hospital NHS Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 1586

Specialty	Total no of studies 2012/13	Recruitment 2012/13	Total no of studies 2013/14	Recruitment 2013/14
Cancer	24	301	25	399
Cardiovascular	3	137	9	600
Gastro-Intestinal	16	443	15	292
Stroke	2	32	3	4
Respiratory	1	1	1	1
Reproductive Health	3	30	5	36
Medicines for Children (inc non drug studies)	5	63	7	98
Renal		23	5	38
Dementia		189	1	38
Dermatology	1	6	1	1
Neurology			2	8
Critical care			1	6
Ophthalmology			1	22
Audiology			1	13
Haematology			1	3
Other	4	42	1	1
Local			81	26
Totals	60	1273		1586

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

2.6 Data Quality

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

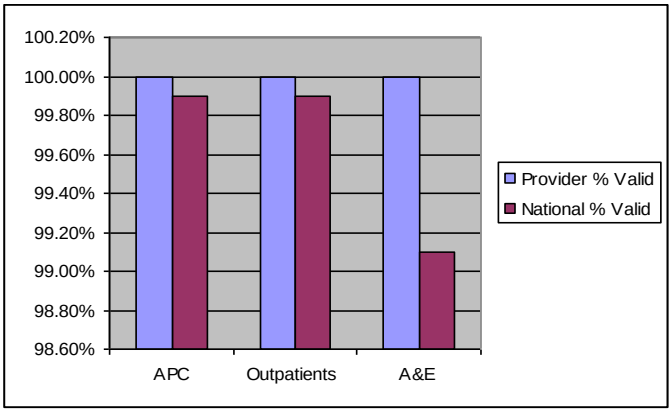
During the reporting period April 2013 to January 2014, the Trust submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics.

The percentage of records in the published data (based on April to Jan 13/14 SUS data at the month 10 inclusion date):

which included the patient's valid **General Medical Practice Code** was

- 100% for Admitted Patient Care
- 100% for Outpatients Care
- 100% for Accident and Emergency Care

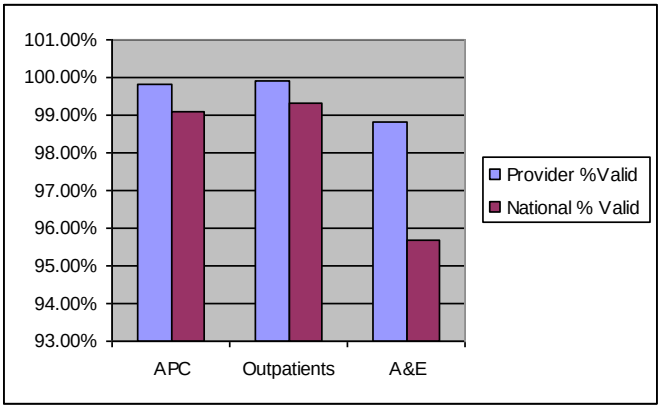
Valid General Medical Practice Code



Which included the patient's valid **NHS number** was:

- 99.8% for Admitted Patient Care
- 99.9% for Outpatients Care
- 98.8% for Accident and Emergency Care

Valid NHS number



The Francis Inquiry recommendation number 269; cited that the only practical way of ensuring reasonable data accuracy is vigilant auditing at local level of the data put into the system. The Trust have put into place a Data Quality Audit plan, which will measure each months data collection requirements and the validity of the data captured. The findings of these audits will be taken to the Trust Data Quality Group, where recommendations and remedial actions will be discussed and forwarded to the appropriate areas. The Audits will also identify areas with:

- Lack of standards and guidance
- Poor training and awareness of the impact of poor quality data

This will be supported by recommendations for further training in these areas, this will be regularly monitored and reviewed with the Data Quality Group.

Data Quality: Clinical Coding

The Shrewsbury and Telford Hospital NHS Trust has not been subject to Payment by Results clinical coding audit during the reporting period April 2013 to March 2014 by the Audit Commission.

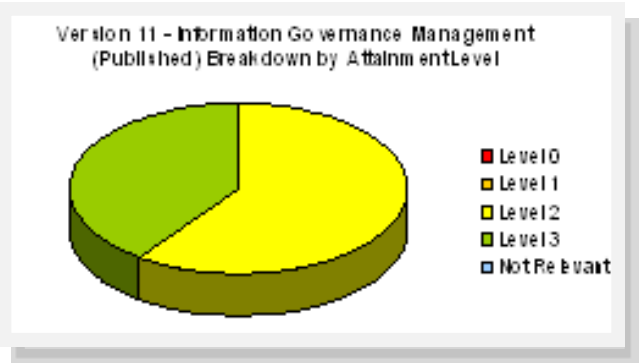
2.7 Information Governance

There have been a number of key developments in the world of healthcare information governance since the last quality account. March 2013 saw the 'To share or not to share?' Information Governance Review (also referred to as Caldicott2). The overarching aim of this review was to ensure that there was an appropriate balance between the protection of patient or user's information, and the use and sharing of such information to improve care. This review was written within a few weeks of the publication of the Francis report on Mid Staffordshire NHS Foundation Trust, and this too recommended the need for a cultural change in the NHS. It stated that a re-balancing of sharing and protecting information is urgently needed in the patients' and service users' interests.

Initiative	Level achieved 2014	Grade
Information Governance Management	80%	Satisfactory
Confidentiality and Data Protection Assurance	91%	Satisfactory
Information Security Assurance	77%	Satisfactory
Clinical Information Assurance	80%	Satisfactory
Secondary Use Assurance	70%	Satisfactory
Corporate Information Assurance	66%	Satisfactory
March 31st 2014 -Overall score	78%	**Satisfactory**

The review also stressed that there is clearly an ongoing need for education and training in this area for staff, and also for patients and service users. Given the imperative to meet the needs of an ageing population, particularly at the boundary between health and social care, it is crucial that systems for principal sharing of information are well understood. As the Health and Social Care Act 2012 takes effect public health, within its new managerial structure, must also be involved.

With invoice validation continuing to make the headlines among the NHS information governance community NHS England are focusing on this area of work. The Secretary of State for Health has approved the NHS England application for support under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 (Section 251 Support). This allows CCGs and CSUs to process some personal confidential data required for invoice validation purposes. This is subject to a set of conditions and is a temporary measure only.



The current IG Toolkit assessment has been submitted for March 31st 2014. The Trust has achieved a 'satisfactory' result as all the categories have at least a level 2 compliance score.

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

A proportion of Shrewsbury and Telford Hospital NHS Trust income in 2013/14 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.

No	CQUIN Goal	
1	Friends and Family Test. Improve response rates in order to improve the experience of patients	Met
2	Friends and Family Test. Phased expansion to include Maternity and A&E services	Met
3	Friends and Family Test. Improvement of score within staff survey	Met
4	Dementia. Ensuring that at least 90% of patients aged over 75 and who are admitted, are assessed and referred on to	Met
5	Dementia. Ensuring sufficient clinical leadership and appropriate training	Met
6	Dementia. Ensuring carers of people with dementia feel adequately supported	Met
7	VTE. Proportion of adult inpatients that have a VTE risk assessment on admission to hospital.	Met
8	VTE. Number of root cause analysis on confirmed cases of pulmonary embolism deep vein thrombosis	Met
9	Medicines Management. Improvement from 2012/13 CQUIN on information in discharge summaries	Partially
10	Medicines Management. Antibiotic prescribing checked as clinically appropriate in line with microbiology formulary	Met
11	Patient Flow. Implement improved discharge checklist	Partially
12	Patient Flow. Develop and use patient and family information packs for simple and complex discharge	Partially
13	Patient Flow. Discharge training for registered nurses	Partially
14	Organisational Culture. Introduction of values-based recruitment for new staff in designated staff groups, and ensur-	Met
15	Falls Reduction. Further reduction in falls resulting in serious harm	Not met
16	Falls Reduction. Delivery of corporate falls action plan on serious harm falls reduction	Met
17	Falls Reduction. Implementation of falls team and partnership across local health economy	Met
18	Maternity. Implementation of 2nd year Baby Friendly	Met

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	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 2014/15 2.5% of our contract values with Clinical Commissioning Groups in England will be based on achievement of 8 national CQUIN goals and 6 locally agreed CQUIN goals. The current draft schemes are summarised in table below

No	CQUIN Goal - National Requirement
1	Friends and Family Test. Implementation of Staff Friends and Family Test
2	Friends and Family Test. Implementation in Outpatient Department and Day Surgery Units
3	Friends and Family Test. Increasing response rates in inpatient wards and A&E
4	Friends and Family Test. Decrease or maintain zero negative response rate
5	NHS Safety Thermometer. Further reduction in the prevalence of category 2-4 pressure ulcers
6	Dementia. Find, Assess, Investigate, Refer. (FAIR)
7	Dementia. Clinical Leadership
8	Dementia. Supporting Carers of people with dementia
	CQUIN Goal—Locally Agreed
1	Patient Experience. Maternity and Cancer Services
2	Patient Experience. Friends and Family Test
3	Maternity. Achieving level 3 Baby Friendly
4	NHS Safety Thermometer. Medicines Management
5	Discharge. Improving communications with patients and relatives
6	7 Day Services

There are goals relating to Specialised Services, summarised in draft in the table below.

No	CQUIN Goal
1	Friends and Family. Phased expansion
3	NHS Safety Thermometer. Moved from local to a national requirement.
4	Dementia.
5	Clinical Quality Dashboards across specified clinical specialities
6	Breast Milk in Preterm Infants
7	Shared Haemodialysis Care
8	Parenteral Nutrition

2.9 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 with conditions. The Care Quality Commission has not taken any enforcement action against The Shrewsbury and Telford Hospital NHS Trust during 2013-2014 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 2013-14.

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 CQC uses 6 standards of quality and safety to regulate health and adult social care in provider organisations with each standard having a number of associated outcomes (28) that are expected.

The Trust was reviewed by the CQC during unannounced inspections on 25th April 2013 (PRH) and 23rd October 2013 (RSH). The reasons for the visits were part of the CQC routine schedule of reviews. Both visits resulted in improvement notifications being submitted to the Trust by the CQC where concerns were raised against 3 standards relating to 5 outcomes. Significant progress has been made against those actions required and the CQC have received implementation plans for assurance against progress.

PRH - Improvement was required in Outcome 1 relating to privacy, dignity and listening to patients views. Improvement was required in Outcome 4 relating to people and their experience of care, treatment and support that met their needs.

RSH - Improvement was required in Outcome 2, relating to consent to care and treatment, Outcome 17 in relation to improving complaints processes and Outcome 21 in relation to patient records and care planning.

Outcome	CQC Judgement	
	RSH	PRH
1: Respecting and involving people who use services	Compliant	Not fully met
2: Consent to care and treatment	Not fully met	Compliant
4: Care and welfare of people who use services	Compliant	Not fully met
17: Complaints	Not fully met	Compliant
21: Records	Not fully met	Compliant

Annex 1

Statements from local Healthwatch, Health and Adult Social Care Scrutiny Committees and Clinical Commissioning Groups

Healthwatch Telford and Wrekin

Healthwatch Telford and Wrekin was established to replace LINk in 2013 with a new board and staff team working closely with Telford Council, Healthwatch England, Healthwatch Shropshire and others. Roles include: information and advice, signposting, patient and community engagement, enter and view, intelligence, trends & evidence, representation and influencing. Healthwatch exercise certain statutory powers.

The Shropshire & Telford Hospital NHS Trust draft Quality Accounts were presented to the Healthwatch Telford and Wrekin board on the 28 April 2014 by Jo Banks and Nick Holding from the NHS Trust. HWT&W is developing its knowledge of services and seeking the views and concerns of service users on health and social care. HWT&W is an independent body and voice but is seeking to work constructively with providers and will seek a regular dialogue and effective communication with The Shrewsbury & Telford Hospitals NHS Trust. We are grateful for the meetings and engagement with both hospitals that has already been established and we look for this to continue and develop.

We welcome the Executive Statement and that the QA priorities have been influenced and identified with patients, staff and partners by listening to views and comparison with other NHS Trusts. We note they provide a "snapshot" of the broad range of hospital activities. We support your view that we must all respond to the changing needs of the health of our community. We welcome attention to the critical issue of improved nursing levels on wards and attention to the patient experience and the patient journey. We also welcome efforts to improve communication with patients and relatives, including a focus on the process of discharge from hospital and going home. We welcome that particular attention is being given to patients with cancer and their carers, and also to those with dementia. We are pleased to be involved in the assessment of the new Women's and Children's unit (opening later in 2014) and to help ensure that any issues are covered in both hospitals in the transition.

Healthwatch Shropshire

Healthwatch Shropshire is pleased to be invited to consider and comment on the Trust's Quality Account 2013-14.

We recognise that the Trust was graded as satisfactory in the Information Governance Toolkit for 2013-14 and that the overall score of 78% is not the lowest among local NHS Trusts. However, there has not been any improvement on last year's score and there are other local NHS Trusts with higher scores.

It is positive to note that both the number of formal complaints and concerns raised with PALS has decreased.

The reconfiguration of Women's and Children's Services will be a significant change with the potential to impact considerably on patient experience, so it is disappointing that this section of the Account was not available for consideration.

It is also disappointing that details regarding the outcomes of internal and external service reviews as well as data on participant in clinical audit and research were not available. However, it is encouraging to note the Trust's stated commitment to participation in research, which we hope will be reflected in the figures when they are available, in particular of patients recruited which is an important area for patient involvement.

While Midwife Led Units are intended to provide a homely atmosphere, it is crucial that the necessary procedures and training is in place to support the safety of these units. Following on from the requirements identified in these areas from the Shropshire Clinical Commissioning Group's Maternity Services Review in 2013, Healthwatch Shropshire is keen to see that the Trust takes all the necessary steps to address the recommendations and areas for development contained in the review.

It is disappointing to note that the Trust's CQC registration is now with conditions and that there were various outcomes in which the Trust was non-compliant.

We look forward to continuing to develop the strong working relationship with the Trust and using our patient experience data to contribute to the ongoing improvement in patient care.

Shropshire Council Health and Adult Social Care Scrutiny Committee

The representatives from Shropshire Council's, Health and Adult Social Care Scrutiny Committee gave praise to the appointment of a falls practitioner that had started in January. They also praised the Trust's work completed on pressure ulcers and hoped that this would continue into the future and especially their work in promoting awareness within the community and other health organisations. There was agreement that safe and effective discharge was an important aspect of the Trust's work. Strong relationships and effective communication with community partners was a key component to the discharge process and they were pleased to see a move to do this in the patients' home. It was suggested that some simple telephone contact numbers could be given when the patient was discharged. The work that had been undertaken on the employment experience was welcomed.

Credit was given to the extremely good cleanliness standards and they were hopeful that the food ratings would improve, which were lower than the national average. They were pleased to see a fall in the number of formal complaints and noted the changes in process that had taken place. The difficulty of parking and access at both hospital sites was raised, which undoubtedly had an impact on the overall experience for visitors. It was recognised that there was a challenge with the management of patient notes. It was recommended that the Trust should consider some of the electronic options such as personal electronic cards and in the meantime look to improve the general information management process of paper records.

Praise was given to the Trust's participation in clinical research, which in turn helped to attract good staff to the area. There was agreement that the Quality Accounts would be considered again in six months time to review progress against the highlighted priorities

Telford & Wrekin Health and Adult Care Scrutiny Committee

The Telford and Wrekin Membership of the Joint Health Scrutiny Committee is a sub-committee of the Health and Adult Care Scrutiny Committee. The main focus of the work of the Joint Health Overview and Scrutiny Committee during 2013/14 has been the need to reconfigure health services to reduce the demand on the acute hospital and the role of the community hospitals in achieving this. During the summer of 2013 the Committee raised concerns about the sustainability of some services across the two hospital sites in the county.

The Committee has welcomed the approach of the local health economy which has resulted in the Future Fit Programme. The Shrewsbury and Telford Hospital NHS Trust has engaged particularly well with the Committee and has responded constructively to both being held to account for the services currently provided and the process to plan services for the future. The Committee has sought assurance that the plans being developed through Future Fit are aligned to other strategic programmes for example the Better Care Fund.

The Committee has been assured that the outcomes for stroke patients has improved following the temporary centralisation of stroke services at the Princess Royal and had received an update on the transfer of women's and children's services.

An ongoing concern for the Committee has been to ensure that patients with mental health issues who are receiving care at in an acute setting for a physical illness receive appropriate care and therefore welcome that this has been identified as a priority for 2014/15. The Committee has recommended that better partnership working between the Royal Shrewsbury Hospital NHS Trust and the South Staffordshire and Shropshire NHS Trust would improve outcomes for these patients and their families. The Chair of the Committee has been informed of the Mental Health Crisis Care Concordat which will inform the Committee's scrutiny of this issue.

When considering the Trusts Travel and transport plan the Committee has also recommended that this includes transport to the acute mental health facility at the Redwood Centre.

The Chair of the Scrutiny Committee recognised that the target set to reduce the number of falls should be challenging but achievable.

Shropshire Clinical Commissioning Group

Shropshire CCG is pleased to have the opportunity to comment on this Quality Account.
In partnership with Telford and Wrekin CCG and other organisations, we continually monitor the quality of the services delivered by the Trust. This is done by utilising a range of methods, including announced and unannounced quality and safety visits and the review and triangulation of data from a number of sources.
We believe that this Quality Account is a balanced and accurate record of the organisations key quality challenges and improvements during 2013/14. The CCG is pleased to note in the priorities for 2014/15 the continued commitment of the Trust to 'Strive to reduce harm to patients and continue to learn from examples of where the

care provided could have been better' and also so to improve the patient journey and experience.
The CCG looks forward to receiving progress reports during the coming year and to continued partnership working with the Trust

Accuracy of Information contained with the Quality Account 2013/14
The CCG has taken the opportunity to check the accuracy of data presented in the draft document in relation to locally commissioned services and believes it to be a factual account.

Montgomeryshire Community Health Council

As you will be aware Jo Banks, Acting Deputy Director of Nursing and Nick Holding, Quality Improvement Programme Manager attended Montgomery Community Health Council's meeting on 14th May. Their presence was very helpful to the Council's discussion.
Your colleagues explained the approach being taken by the Shrewsbury and Telford Hospital NHS Trust to develop a separate quality account reporting mechanism in respect of the NHS Wales standards applying to patients whose services are commissioned from you by Powys Teaching Health Board. Montgomeryshire CHC welcomes this approach as part of the Council's function to monitor and scrutinise on behalf of the population it represents.
Consequently, in respect of the NHS Trust's Quality Account for 2013/14, Montgomery CHC will not offer any comment. However as indicated in paragraph above, the CHC is looking forward to the revised format for 2014/15 and will provide comment upon the draft in 2015.

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.
As with previous year's 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.

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

- We have updated the glossary to reflect additional abbreviations used within the Quality Account and removed unnecessary ones.
- We have included more detail relating to the CQC Essential Standards, and amended some terminology based on suggestions and advice.
- We have provided further clarification on the Key Performance Indicators

The Trust will endeavour to act upon all stakeholder feedback in order to attain year on year improvements to the Quality Account.

We have produced a summary version of the Quality Account, which is available on request

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 2014 ("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 2014 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for veneous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

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 2013/14 issued by the Audit Commission on 17 February 2014 ("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 2013 to June 2014;
- papers relating to the Quality Account reported to the Board over the period April 2013 to June 2014;
- feedback from the Commissioners;
- feedback from Local Healthwatch;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey;
- the latest national staff survey dated;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2014;
- the annual governance statement dated 5/6/2014;
- Care Quality Commission quality and risk profiles/intelligent monitoring dated 2013//2014;

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 our appointment under the Audit Commission Act 1998 and in accordance with the Commission's 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 2014:

- 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, Statutory Auditor

One Snowhill,

Snow Hill Queensway

Birmingham, B4 6GH

26 June 2014

Glossary

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. Clinical Commissioning Groups (CCG) in England and Local Health Boards (LHBs) in Wales are the key organisations responsible for commissioning healthcare services for their area. Shropshire CCG, Telford and Wrekin CCG 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
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 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
IS0 9000	The ISO 9000 family of standards is related to quality management systems and designed to help organisations 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
MDT	Multi Disciplinary Team—A group of health care professionals who provide different services for patients in a co-ordinated way

MRSA	Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several difficult-to-treat infections.
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
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.
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.
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
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

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- Acting Deputy Director of Nursing & Quality
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- Business Manager—Estates and Facilities
- Patient Safety Team Manager
- Chief Information Officer
- Complex Discharge Manager
- Deputy Head of Midwifery
- Lead Nurse, Women and Children Care Group
- Clinical Governance Manager
- Clinical Coding Manager
- R&D/Clinical Trials Manager
- Data Quality Manager
- Information Governance Manager
- Hygiene and Compliance Officer
- Communications Team
- Lead Midwife for Community Services
- Quality Improvement Programme Manager
- Members and contributors from the following groups
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    - Telford and Wrekin Clinical Commissioning Group
    - HealthWatch Telford & Wrekin
    - HealthWatch Shropshire
    - Shropshire and Telford & Wrekin, Health and Adult Social Care Scrutiny Committees
    - Montgomery Community Health Council (CHC)
    - Powys Teaching Health Board

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
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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