NHS
The Shrewsbury and Telford Hospital
NHS Trust

QUALITY ACCOUNT

2016-2017

CONTENT

WELCOME FROM THE CHIEF EXECUTIVE

Welcome to the 2016-2017 Quality Account for Shrewsbury and Telford Hospital NHS Trust (SaTH). One of our major highlights during the year was the launch of our Organisational Strategy (more details of which are in the following pages of this document) which sets out how we will achieve our Vision to provide each and every one of our patients and their families with the safest and kindest care.

Our partnership with the Virginia Mason Institute in Seattle and the subsequent launch of our Transforming Care Institute (TCI) is central to the delivery of our Vision and, as a result, over this year we have made huge advances in improving the way we work to ensure that our patients receive the highest standards of care from staff that are supported to make changes for the better. Additionally, we have celebrated the work of our staff through our VIP (Values In Practice) Awards which is now an annual event supported by a monthly VIP award which is presented to say thank you to someone who has been recognised by their colleagues as going the extra mile.

This year has also seen unprecedented demand on our services through a very busy winter. What has been notable is the resilience and dedication of our staff to ensure that our patients receive safe and appropriate care as soon as possible. We work with patients and families to recognise what we do well and to understand how we can further improve the experience, quality, safety and outcomes that we offer our patients. All of us want to receive safe and kind care in our local hospitals and have the assurance that staff are working to provide the best care for us and our loved ones. This year's Quality Account reflects the progress we have made against the key indicators we identified this time last year and in order to deliver on-going improvements, the Quality Account sets areas where we feel that we need to progress.

We aim to be innovative not only in how we provide care but how we support and develop staff and to this end we are one of the first Trusts to pioneer the new national Associate Nurse Training Scheme, which will help us to ensure that we have our own staff caring for our patients, reducing our need to use agency staff

We are awaiting the outcome of our Care Quality Commission (CQC) report from the visit that took place in December 2016 which will really help us focus on the areas where we need to demonstrate improvement whilst showing where we provide a better service than we did when they last visited us.

I am delighted to introduce to you the Quality Account published by Shrewsbury and Telford Hospital NHS Trust 2016-2017 reflecting a positive year for the Trust in our drive to keeping our patients safe whilst identifying areas where we can continue to improve and develop services.

Simon Wright, Chief Executive

ABOUT THIS DOCUMENT

Under section eight of the Health Act (2009) All NHS Trusts are required to publish a Quality Account every year which must include prescribed information set out in the National Health Service (Quality Accounts) Regulations 2010, the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (quality Account) Amendment Regulations 2012. Additionally, every year, NSE England (the organisation that runs NHS services in England) requires that further specific pieces of information are included within the document.

Copies of this document are available from our website (www.sath.nhs.uk), by email from consultation@sath.nhs.uk or in writing from:

Chief Executives Office, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XQ.

Please contact us if you would like a copy of the Quality Account in large print or in another community language for people in Shropshire, Telford and Wrekin and Mid Wales.

A glossary is provided at the end of this document to explain the main terms and abbreviations that you will see used in the document.

We welcome your feedback on our Quality Account.

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

- Do you think that we have selected Quality Priorities that can really make a difference to people?
- Are there actions other than those we have identified for each area that we could be doing?
- How can we involve patients, their families and carers and the wider community in the improvement of our services?
- Is there any other information you would like to see in our Quality Accounts?
- Do you have any comments about the formatting of the 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

WHO ARE WE AND WHAT WE DO

The Shrewsbury and Telford Hospital NHS Trust (SaTH) is the main provider of acute hospital services for around half a million people in Shropshire, Telford and Wrekin and mid Wales.

Our main service locations are the Princess Royal Hospital (PRH) in Telford and the Royal Shrewsbury Hospital (RSH) in Shrewsbury which together provide 99% of our activity. Both hospitals provide a wide range of acute hospital services including accident and emergency, outpatients, diagnostics, inpatient medical care and critical care.

During 2012/2013 PRH became our main specialist centre for inpatient head and neck surgery with the establishment of a new Head and Neck ward and enhanced outpatient facilities. During 2013/2014 it became our main centre for inpatient women and children's services following the opening of the Shropshire Women and Children's Centre in September 2014.

During 2012/13, RSH became our main specialist centre for acute surgery with a new Surgical Assessment Unit, Surgical Short Stay Unit and Ambulatory Care facilities.

Alongside our services at PRH and RSH we also provide community and outreach services such as:

- Consultant-led outreach clinics (including the Wrekin Community Clinic at Euston House in
- Telford)
- Midwife Led Units at Ludlow, Bridgnorth and Oswestry
- Renal dialysis outreach services at Ludlow Hospital
- Community services including midwifery, audiology and therapies

We employ almost 6000 staff, and hundreds of staff and students from other organisations also work in our hospitals. We benefit from around 1,000 volunteers working at the Trust and at our main charitable partners (the Leagues of Friends of both our hospitals and the Lingen Davies Cancer Appeal).

With a turnover in the region of £350 million in 2016/2017 we saw 64,153 elective and day case spells; 55,198 non elective inpatient spells; 6,497 maternity admissions; 411,657 consultant-led outpatient appointments and 119,906 accident and emergency attendances. More information about our activity may be found in the Trust's Annual Report.

In 2015 we began an exciting partnership with the Virginia Mason Institute in Seattle as part of our journey of improvement with our aspiration being to provide the safest and kindest care in the NHS. This has continued into 2016 with the launch of the Trust's own Transforming Care Institute, which is leading the improvement work learnt in the USA.



OUR STRATEGY AND VALUES

During 2013 we worked with our staff and patients to develop a framework of Values to drive our vision for integrated, patient-centred care. These Values are:

- Proud to **Care**
- Make it **Happen**
- We Value **Respect**
- Together we **Achieve**

Our Values were shaped by our staff and patients to ensure we got them right. Our Values are not just words on a page; they represent what we are about here at SaTH. They represent the behaviours and attitudes that we expect each of our staff to display when they are at work and representing our organisation. Since they were launched, we have continued to embed them throughout the Trust.

The response of staff in the 2016 NHS Staff Survey shows that 99% of our staff know our Trust Values and, pleasingly, there has been a 9% increase in staff saying that they are seeing these Values put into practice in the workplace.

Our Organisational Strategy sets out how we will build on our achievements to deliver a transformation in our own organisation on our journey to provide the safest and kindest care in the NHS. Our values will remain our foundation as they underpin everything that we do.

The Trust is committed to becoming an integrated healthcare provider. We will work in partnership to achieve the healthiest half a million population on the planet, by helping people to age well, putting our patients first and delivering efficient, safe, kind and reliable services. We aim to be exemplary, encouraging innovation and change, supporting the development of inspirational leaders who deliver our vision and we will listen, engage and partner with patients and families at all levels to make this happen.

Organisational Strategy

OUR PARTNERS IN CARE

The majority of our patients and communities live in three local authority areas:

- Shropshire Council (unitary county authority, Conservative led administration)
- Telford and Wrekin Council (unitary borough authority, Labour led administration)
- Powys County Council (unitary county authority, Independent led administration). Our catchment area predominantly covers the former county of Montgomeryshire which comprises the northern part of Powys.

Local NHS commissioning organisations have the same boundaries as our local authorities and are:

- Shropshire Clinical Commissioning Group
- Telford and Wrekin Clinical Commissioning Group
- Powys Teaching Health Board

Specialised commissioning is undertaken through NHS England (Shropshire and Staffordshire Area Team) and Welsh Health Specialised Services Commissioning.

We work in partnership with a wide range of organisations for the delivery and planning of health services. The main statutory bodies include:

- Local Authorities (see above)
- NHS Commissioning Bodies (see above)
- Primary care services
- Other providers of health and care services for Shropshire, Telford and Wrekin and mid Wales
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (specialist orthopaedic hospital)
- Shropshire Community Health NHS Trust (community services)
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust (specialist mental health and learning disabilities)
- West Midlands Ambulance Service NHS Foundation Trust (ambulance and patient transport)
- Welsh Ambulance Services NHS Trust (ambulance and patient transport)

The main statutory bodies to represent the public interest in health services include:

- Health Overview and Scrutiny Committees for Shropshire Council and Telford and Wrekin
- Councils
- Local Healthwatch bodies for Shropshire and Telford and Wrekin
- Powys Community Health Council

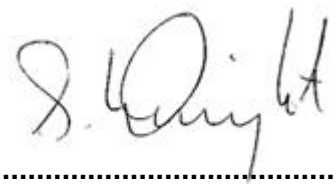



STATEMENT OF DIRECTORS RESPONSIBILITIES

Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. In preparing the Quality Account, 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
- The Quality Account has been prepared in accordance with Department of Health guidance

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



Signature .....

Date **30-Jun-2017** .....

OUR COMMITMENT TO QUALITY

Section one: Update on the Quality Priorities we set for 2016-2017:

In last year's Quality Account we outlined three strategic quality priorities. These were developed following engagement with our stakeholders, patient experience and involvement members and health and commissioning partners. For each priority we have provided a summary outlining the progress made so far.

What is important is that these priorities are not only for one year – they are usually based on existing work and will continue into the future. Therefore we have said what we are going to be doing for the year ahead even where we have fully achieved what we said we would do in 2016-2017.

Priority 1 - Implementation of Exemplar Programme

Why was this a priority for us?
We all want to provide excellent care all the time. We want to ensure that patients are central to our improvement work in ensuring that essential standards of care and best practice is shared throughout hospitals. This programme is a vital way of providing assurance to our patients and their families, our board and our colleagues across the local health economy and beyond that we are committed to the continuous improvement of our services.

What did we say we would do?
We said that we would develop a ward accreditation approach for all wards across SaTH. The Exemplar philosophy is to deliver excellence in the quality of care all day, every day for every patient at all times.

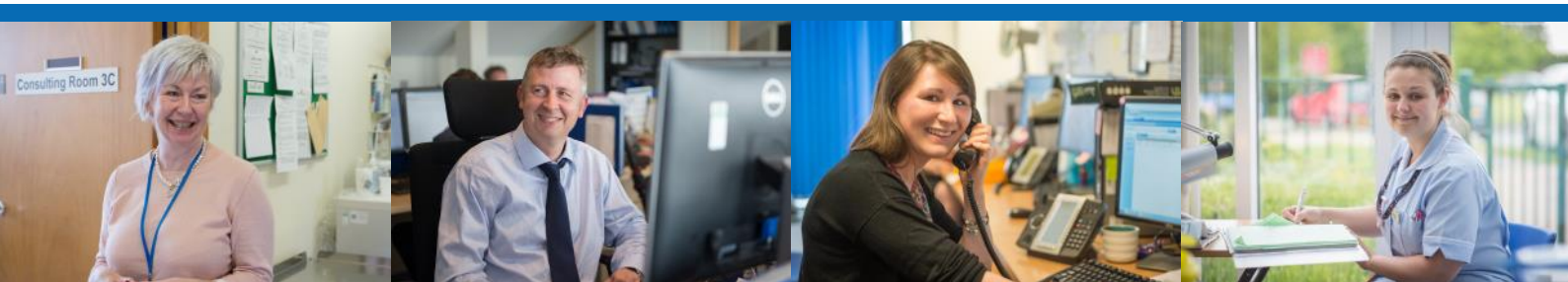
What have we done so far?
We have partially achieved this ambitious priority which will continue to be central to our quality ambitions going forward. However, in October 2016 we implemented RaTE, which is a real time experience electronic survey tool. This tool enables the majority of our wards to complete monthly quality self assessments and patient experience surveys. Maternity and Paediatric areas needed specific questions to be designed for them and so will start using RaTE in 2017.

By carrying out this kind of assessment we have been able to spend less time completing individual audits which in turn means we have more time to focus on caring for our patients.

Crucially, we will use the results from RaTE when we carry out an Exemplar assessment of a ward. These assessments will be based on the eleven core quality standards which we think are really important: leadership, environment, documentation, tissue viability, falls, nutrition and hydration, professional standards, care and compassion, communication, medicines management, infection, prevention and control.

During 2016-2017 the following key milestones have been achieved:

- Stakeholder event where over 100 staff attended
- Exemplar policy to depict process
- Handbooks for staff and assessors
- Presentations at Nursing and Midwifery Forum and Clinical Governance Executive
- Identified Early implementation sites
- Recruitment of staff and patient representatives to be part of the assessment teams
  Publicity campaign for public and staff to raise awareness and promote engagement



Next steps
One ward will be an early implementation site and will enter the programme from May 2017. This ward is fundamental to the programme and full Trust roll out across all care groups will commence in July 2017.

During 2017-2018 we will implement Exemplar in earnest and will measure how successful we have been with this in the following ways:

- The number of wards that submit to be assessed based on meeting the requirements of intelligence monitoring including RaTE self-assessment scores over a three month period, quality indicators including medicines audits, health and safety factors and results of environmental inspections and workforce metrics such as staff training and appraisal rates

- The results of the Exemplar Programme Assessments which will result in wards being awarded Silver, Gold or Diamond accreditation

- An upward trend in performance measured against quality indicators as wards prepare to meet Exemplar requirements which we monitor through our detailed quality dashboard

- We aim to have at least nine wards complete the programme in the first year (by May 2018) and will plan to increase the number per year following this initial roll out so that all wards have completed the process within three years

We will ensure that we provide details in next year's Quality Account about how we are progressing with this important programme which will contribute towards our Trust Vision.

Priority two: Developing our culture of openness

Why was this a priority for us?
We recognised that the contribution and voice of our staff helps us make a difference and improve the care and safety of our patients. Last year we said that we knew that we had to raise awareness amongst staff and instil confidence that concerns will be listened to and addressed making sure that this is a great place to work.

What did we aim to achieve?
We said that we would introduce values guardians to act as speak up champions for our staff, enabling them an alternative reporting route other than their line manager. This will ensure that the voice of our staff is heard at a senior level, providing feedback to ensure a constant opportunity for improvement through learning.

How have we done?
We have fully achieved what we said we would do during 2016-2017 but we are really committed to continuing the work to really embed our Values into the organisation. Examples of how we do this include:

Embedding our values throughout the employment life cycle will support our objective to be a values driven organisation which supports us to achieve high levels of staff engagement. Evidence demonstrates that improved employment experience enables an improved patient experience

Values based recruitment - we are seeking to ensure that our values will be reflected in the day to day care we provide. Our process helps to ensure that our people demonstrate a values set that aligns, are therefore a 'better fit' and will help us to become the safest and kindest

Our Induction programme will maintain a focus on our Trust values throughout. This will support our new people inducted into the Trust to gain a comprehensive understanding that our values touch everything we do.

Values based conversation training will embed the technique for having conversations with staff on values, behaviours and attitude

Recognising and acknowledging our peoples individual or team's behaviour, effort and accomplishments is essential in supporting delivery of our organisational goals and values. Evidence shows that when our people

see that their work is valued, their engagement and productivity will rise, and they will be more likely to be motivated to maintain or improve their good work. Recognition will not be a one-size-fits all but sits under our Values in Practice (VIP). This includes:

- Monthly Care Group VIP winner will be celebrated within the Care Groups.
- Trust wide monthly VIP winner celebrated at Trust Board
- Annual VIP awards celebration
- Our people will expect to give and receive feedback as a matter of routine

Our health and wellbeing programme, 'A Healthier You' for staff has been running since 2013. The aim of the programme was to encourage and support staff to develop and maintain a healthy lifestyle to improve their physical and emotional wellbeing in fun and enjoyable ways. The project has improved staff health, reduced sickness and improved staff satisfaction. All scores within the Health and wellbeing section of the NHS Staff survey are either average or above average when compared to the rest of the acute sector.

Our staff have the opportunity to give feedback on areas of focus within the survey and also through the Trust Health and wellbeing Champions. We are also able to utilise the data captured through our health ki-osks to understand in more detail the health behaviours of staff and this gives us the opportunity to prioritise activities for the programme.

In addition:

- Attendance and impact information is collected for the staff physiotherapy service
- Sickness data is regularly reviewed by Workforce committee as a subcommittee of the board.
- Attendance figures for activities are kept

Since April 2016 we have had the following results:

- 1144 health checks have been completed
- 500 staff members have been seen by the Staff Physiotherapy Occupational Service
- 600 staff are accessing free eye tests
- 60 teams took part in pedometer challenges and walked over a million steps
- 200 members of staff took part in the 'Harrys Potter Walk', covering 18 miles
- 110 bikes have been purchased through the Cycle2Work Salary Sacrifice scheme
- 20 bikes have been fixed through their 'Dr Bike' sessions
- Over 2000 attendances at fitness classes
- 40 staff have been supported with mindfulness training
- 88 staff participated in Workplace Challenge
- Two green gyms accessible to staff and the public
- We now have 20 health and wellbeing champions from diverse staff groups
- We are committed to developing the leaders within the organisation through recognising when a member of staff has the potential to be a leader and to provide a structured support process through our Leadership Academy

Our Organisational Strategy clearly highlights the importance of our leaders in delivering the vision and mission of the organisation

We know that leadership roles at all levels can be challenging and are often not easy. As the most senior leaders of this organisation, we agreed that we need to move towards collective leadership that fosters engagement and nurtures and develops everyone's talents. We know from all the evidence that if we get this right, our staff will be enabled to take the best possible care of our patients and provide the safest and kindest care.

Our leadership framework will help us drive toward leadership that's "fit for purpose" to help us provide the:

- Safest and Kindest care
- Success in our transformation work
- Joy and meaning in work for all our people, our leaders and all of our staff

We have a leadership framework that articulates the four leadership requirements in SaTH which spans performance management/assurance, skills development, behaviours and tone setting. In addition we have worked with our leaders to define our Vision into practice agreement which demonstrates the commitment to a consistent set of behaviour and actions required to be a leader in SaTH

We have commenced a programme of work with Aston Organisational Development to improve team effectiveness as we recognise the significant evidence base that demonstrates high levels of staff involvement/engagement are the single biggest predictor of success. **Research shows:**

- Reduced hospitalisation and costs
- Increased effectiveness and innovation
- Increased well-being of Team Members
- Inter-disciplinary teams deliver higher quality patient care and implement more innovations
- Lower patient mortality
- Reduced error rates
- Reduced turnover and sickness absence
- Increased staff engagement

Our Team based working programmes aims to ensure that every individual is located in a 'real team' which has clear objectives aligned to organisational aims and which is functioning effectively to achieve individual, team and organisational goals

We know that staff engagement is the best overall predictor of trust outcomes such as care quality, financial performance, patient mortality (in the acute sector), patient satisfaction and staff absenteeism. We will therefore measure improvement based on the results of our National Staff Survey overall engagement score and improvements in specific key findings (KF) 28-31 Errors/incidents and KF 32- patient experience. The Trust has appointed two Values Guardians to encourage a culture of openness and the 'Freedom to Speak Up'. Values Guardians act in an independent capacity to support and help drive the Trust to make it a safer place for patients and staff and a more open place to work.

They offer support and advice to those that want to raise concerns to ensure that any safety issue is addressed and feedback is given to the member of staff who raised it.

Values Guardians ensure that there are no repercussions for those that have raised the concern either immediately or in the long-term. If staff do not want their identity to be known, they can contact the Values Guardians via an Anonymous Dialogue System.

Priority three: Improving nutrition and hydration care for our patients

Why was this a priority for us?
Malnutrition and dehydration are a risk to hospitalised patients especially for those who are vulnerable such as those with dementia or the frail and elderly. As well as leading to delays in recovery, it can also be associated with increased mortality rates, hospital admissions and the development of comorbidities such as impaired cognitive function, falls, poor control of diabetes and hyperthermia.

What did we aim to achieve?
We have partially achieved this priority during 2016-2017. We said that we aimed to improve food and drink standards in both hospitals including the quality of food and drink across our hospitals so that everyone has a healthier food experience and everyone involved in its production is properly trained and valued. We have put some actions into place and will continue to do so over the coming year.

How have we done?
We have produced a Nutritional and Hydration strategy which will provide our staff with a plan for improvement over the next 12 months.

We have introduced a new Fluid Balance Chart (which is the form our staff use to monitor how much people take in and pass out) and to go with it education and training to ensure it is used correctly at all times.

We have revised the Protected Mealtime Policy which was re launched in May 2017 and we are measuring how well it is being used to ensure that patients are able to eat their meals undisturbed. A business case for a Nutritional Team is being developed which will support the care and management of patents with enteral and parental feeding.

There has been a drive to reduce sugary foods such as high sugared snacks being available across the NHS. These snacks are being replacing with more healthy options, sugary drinks are being removed from vending machines and we have introduced healthy wrap flatbread in our catering outlet at PRH.

Over the coming year we will measure how successful we have been with implementing our new strategy and initiatives such as protected mealtimes through our RaTE surveys and Exemplar ward programme. We will also prepare a case for the employment of a Specialist Nutrition Nurse to coordinate and lead the development of a nutrition service

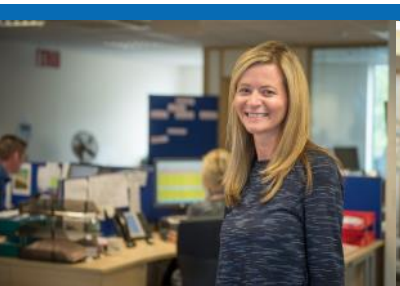
Section two: Looking forward to our Priorities for Quality Improvement for 2017-2018

The Quality Account aims to provide assurance to the people who use the services of the Trust that we provide care that is responsive, effective, well led and safe. One of the ways that we do this is to identify some priorities that we really want to concentrate on in the coming year. The priorities are identified through discussion with our Patient Experience and Involvement Panel as well as our staff and members of our partner organisations.

We have made sure that the Quality Priorities reflect our operational plan for the coming year as well as our values and strategic objectives.

Finally we have mapped our Quality Priorities against those in the NHS Outcomes Framework for 2016-2017. This framework sets out the national outcome goals that the Secretary of State uses to monitor the progress of NHS England.

One message that has been received from our patients, their families and their carers is that we need to work together with our partners in care to ensure that issues that occur across all organisations are addressed




Priority one: Making sure that people are safely discharged from our hospitals

NHS Outcomes Framework Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	
Strategic Priority: To reduce harm, deliver best clinical outcomes and improve patient experience	
Why is this a priority for us? We know that leaving hospital after a period of ill health, whilst a happy time can also be a period of anxiety for patients, their families and their carers. We need to make sure that when we discharge people from our services we do so in a way that means that they are confident they have everything they need to continue their treatment or recovery. We will make sure that we prepare people correctly before they go home – for example teaching them about new medication or ensuring that they can dress themselves or make a cup of tea safely We want to make sure that we liaise correctly with other care providers so that people's needs are met when they go home and that they do not come to any harm because we have not done so We want to make sure that people have as positive an experience as possible whilst in our care whether as an inpatient or when receiving outpatient treatment	**What will success look like?** Patients will know what their expected date of discharge is so that they and their families have time to plan for them going home We will routinely use the principles of "Red to Green" (R2G) to ensure that we do not keep people waiting to go home unnecessarily. This is a way of seeing really quickly if we are doing all the things we need to do in a timely way to make sure people do not stay in hospital longer than they have to. We will make sure that everything they need is ready for them, including medication, information and equipment which is part of the R2G work. Where necessary we will speak to other providers (such as district nurses) who may be supporting people at home to make sure that they are ready We will reduce the number of complaints that we get about discharge processes. Less people will come back into hospital because something went wrong with the discharge process Finally we aim to reduce the number of times we have to have extra beds on our wards at times of high escalation which can lead to reduced patient safety and experience. We will measure our progress through our Datix incident reporting system which we use to monitor both incidents and complaints. We will also measure our progress through feedback from our patients and their families—whether we got it right for them and if not, why not. We will measure how long people stay in with us and whether we could improve this for them by making sure we do everything we can to get them home safely at the right time. As part of this we will work closely with our colleagues in Shropshire Community Health NHS Trust and in the local authorities and CCGs.
How will we monitor our progress: We will report regularly (at least quarterly) on the measures we have described above to our Quality and Safety Committee which reports directly in to the Board.	

Priority two: Making it possible for people to tell us their stories to help us improve their care

NHS Outcomes Framework Domain 4: Ensuring people have a positive experience of care	
Strategic Priority: Embed a customer focussed approach and improve relationships through stakeholder engagement strategies	
Why is this a priority for us? We have used feedback in the form of patient stories for some time at our Trust Board meetings. We think that we can do more to capture the views of people or their families that have used our services, not only when things have gone well but where they think their feedback will show us where we can improve. Patient stories are just one way of patients, their families and carers telling us what they think of their experience of our services but it is one that we will concentrate on this year to further develop this valuable feedback method. We will continue to ask people about their experience of our services through local surveys, the Friends and Family Test and through our Complaints and PALS service.	**What will success look like?** We will have a variety of methods to capture patient stories – for example by video, in person, in writing and through feedback to our partners. We will make sure that if someone wishes to provide feedback we will work with them to do this in the best way for them We will ensure that if a patient story is presented to a group of people such as the Trust Board that we will show how we have made changes or have actions to carry out as a result of that feedback so that we can really demonstrate a difference that the feedback has made We will work with a variety of other groups such as Healthwatch or the Young Health Champions to make sure that people who sometimes do not get their voices heard are able to do so
How will we monitor our progress: We will work closely with our local partners and also our Patient Experience and Involvement Panel to progress this priority and will monitor this through the panel meetings and then to Quality and Safety Committee and the Trust Board	

Priority Three: Implementation of the Values Based Leadership and Cultural Development plan in the Women's and Children's Care Group

NHS Outcomes Framework Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm	
Strategic Priority: Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work	
Why is this a priority for us? We want to make the women and children's care group the safest, kindest and most caring that we can. In order to do this we are developing a plan to implement Values-Based leadership and further develop the culture of continuous learning that already exists. We recognise that valued and supported staff who work in an environment of continuous learning and challenge will nurture a culture of openness, caring and compassion. Our plan is to develop a values based culture across our organisation so whilst this priority is specifically about the Women's and Children's Care Group the actions will also be relevant for the other services in the Trust. The work will focus on organisational support to develop the Care Group Vision and Strategy, understand how the Trust values come to life in practice and provide the opportunity for staff to self-reflect and promote change through self-knowledge and understanding as individual leaders.	**What will success look like?** We will use staff feedback (such as the NHS staff survey, drop in sessions and through relationships with their representatives) to show where we need to improve to provide a better experience for our staff and to measure improvement. We will see a reduction in complaints and PALs enquiries particularly in relation to communication, care and compassion. We will also help and support our staff to make changes where they need to. We will evidence that the requirements of the Duty of Candour will be met in 100% of incidents that require it to be met
How will we monitor our progress: Our Workforce Committee and through them the Board receives regular reports into our culture development work.	

Section three: Quality at the Heart of the Organisation

This section of the Quality Account will show how we measure our day to day work in order to meet the requirements and standards that we aspire to and how we evaluate that the care that we provide is of the highest standard. Much of the wording of the statements in this section of the Quality Account is mandated by the NHS (Quality Accounts) Regulations.

Transforming Care Production System – Transforming Care Institute in partnership with VMI

Background:

SaTH is one of five Trusts nationally to be supported by Virginia Mason Institute (VMI), NHS England (NHSE), and the NHS Institute (NHSI), on an accelerated transformation journey. The support includes the five year programme of coaching, teaching and sensei visits to embed one improvement methodology 'Transforming Care Production System', and provide the necessary knowledge, skills and most importantly the culture to enable all our staff to generate and implement ideas to improve patient safety.

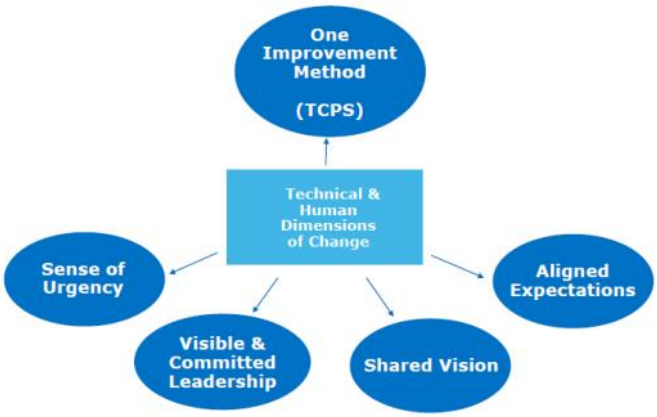


Fig 1: Requirement for Transformation: One Improvement

Value Streams

Four value streams for improvement are well established with value stream sponsor teams steering their work. These sponsor teams are led by an Executive or Member of the Guiding Team.

Value Stream #1: Discharge Pathway for Respiratory Patients

Improvements

- **13** different quality improvements made and sustained to the respiratory discharge process. Including
- **32** non value adding hours removed from respiratory discharge process (per patient)
- **1357** clinical steps removed from the respiratory discharge process (per patient)

Value Stream #2: Care of the Sepsis Patient

Improvements

- **8** quality improvements made within the sepsis pathway including use of screening tools, Sepsis trolley and reduction in late observations
- **11 ½** hours of non-value adding time removed from screening for sepsis , diagnosis of sepsis and delivery of sepsis bundle pathway (single patient pathways)
- **488** steps no longer required to collect equipment (single patient episodes)

Value Stream #3: Recruitment

Improvements

- Reduce the length of time from approval to vacancy being advertised
- Reduce the length of time from interview to confirmation letter being sent to candidate
- Reduce temporary staff usage (agency/bank)
- Reduce the number of failed recruitment appointments due to delays
- Improve the successful candidates recruitment experience

Value Stream #4 Outpatient Clinics - Ophthalmology

Improvements

- **52 day reduction** in the time from receipt of referral until first contact is made with patient
- **47% reduction** in the number of times letters are delayed due to requesting a letter after the deadline for electronic transfer to next process
- **100% reduction** in the number of Booking staff unaware of overall process for sending patient letters (Process = from referral arriving at SATH, to patient arriving in clinic)

Engagement

We are delighted to see that the engagement of our staff has taken us to nearly 2000 staff having the first building blocks of education to effectively use the methodology. We have seen some lovely examples of how these simple tools with the management and philosophy, supporting them, can achieve improvements such as: the reduction in the time taken to prepare patients for physiotherapy treatment and a 56% improvement in the number of patients who do not have the necessary personal items required for therapy treatment.

Education

Forty SATH leaders undertook 'Lean 4 Leaders' training in 2016 leading to many improvements in patient experience. One Ward manager has released eighthours a week back to direct nursing care by reducing the walking (waste of motion) required during the admission procedure on the day case ward.

Nurse Associate Training

The need to reduce our reliance on agency staff remains a high priority for us and our proactive drive on recruitment continues. This year the Trust was delighted to be invited to pilot the new national role of the Nurse Associate in partnership with Wolverhampton University; this role will expand our Nursing workforce with a new level of Registered Nurse. Eight Trainee Nurse Associates began their two year course with us in 2016 and we will recruit again for the next cohort in 2017. We will continue to recruit and train Nurses, Midwives and Healthcare professionals alongside our healthcare support staff to ensure we maintain a stable workforce and encourage staff from outside the county to join us.

Reviews of our services this year

We welcome reviews of our services as they enable us to measure how we are doing with similar services and help us to identify how we can improve against national standards. The following internal and external reviews took place between April 2016 and March 2017:

Service	Review
Endoscopy Units RSH and PRH	The endoscopy departments across the Trust completed their Joint Advisory Group (JAG) Accreditation return in September 2016. JAG Accreditation requires notification every six months of adherence to standards covering safety, quality, training, workforce and customer care. The timeliness standards were not met, resulting in JAG accreditation being withdrawn. The Endoscopy Unit was reassessed in 2017 and was successful in regaining accreditation with extremely positive comments from the assessors in relation to the safety culture within the unit.
Deloitte Audit - Policies and procedures in maternity	The scope of the audit was to evaluate the maternity complaints process. One high priority recommendation was made that the Trust should ensure that there is sufficient training available for staff, and the Care Group should have a record of which staff are RCA trained
Network review - neonatal services in relation to babies less than 27 weeks	This external review was commissioned by NHS England following concerns raised by Neonatal Clinicians at SaTH. The concerns were in relation to alleged poor outcomes of eight babies born at 27 weeks gestation or earlier transferred ex-utero from SaTH to the neonatal intensive care unit (NICU) at University Hospital of North Midlands NHS Trust (UHNM) between 1 April 2014 and 21 September 2015. This review has highlighted areas for improvement in terms of adherence to care pathways for both SaTH and UHNM.
IQIPS accreditation - Audiology	SaTH Audiology Services continues to provide a good standard of service that meets the Improving Quality in Physiological Services (IQPS) standard requirements. Evidence reviewed confirms that further service development has occurred as part of the IQIPS process. The assessment team felt that the documentation submitted as evidence confirm that SaTH Audiology Services continue to provide a good service to patients, staff and referrers. The service was commended for actioning and attempting to embed the recommended findings raised by the assessment team via previous assessments as enhancements to the service
Trauma Unit Peer Review	The Trust participated in the Trauma Unit Peer Review process and it was noted that SaTH is non-compliant with two standards: there is no cover on Saturdays for a trauma list and the Trust did not meet the standard for access to a rehabilitation specialist as it does not have access to a Consultant in Rehabilitation Medicine or any ongoing rehabilitation.
Screening Quality Assurance visit Shropshire NHS Diabetic Eye Screening Programme	The Quality Assurance visit team did not identify any immediate concerns but made some high priority findings. In addition several areas of good practice were highlighted.
Midlands and East Screening Quality Assurance Service Shropshire Bowel Cancer Screening Centre	The Trust is participated in the Quality Assurance visit and any improvements will be implemented following receipt of the report.

During 2016-2017 the Shrewsbury and Telford Hospital NHS Trust provided and/or subcontracted the full range of services for which it is registered (these are detailed in our Annual Report and via our web site).

The Trust supported a number of reviews of its services and has reviewed all of the data available for the quality of care in all our services

The income generated by the services that were reviewed represents 100% of the total income generated from the provision of NHS services by the Trust.

Registration with the Care Quality Commission (CQC)

Shrewsbury and Telford Hospital NHS Trust is registered with the CQC. The current registration status is "Registered without restrictions".

The CQC did not take out Enforcement Action against the Trust during the reporting period

The CQC carried out a planned inspection of our services in December 2016. This inspection was to review how we had progressed since the previous inspection the CQC carried out in 2014 particularly against the areas where they felt we most needed to improve.

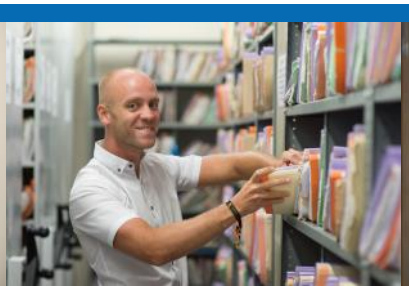
In addition to the planned inspection, three unannounced visits occurred on 01st November 2016, 30th December 2016 and 3rd January 2017. The team of 36 inspectors visited a range of wards and departments at both hospitals. They also inspected Shrewsbury, Wrekin, Ludlow, Bridgnorth and Oswestry Midwifery Led Units.

The inspection team inspected the following core services:

- Urgent and Emergency care
- Medicine
- Surgery
- Maternity and Gynaecology services
- End of life care

Early feedback indicates that the Trust has made improvements in some areas since their earlier inspection in 2014. The overall findings of the 2014 inspection are shown below but if you would like to see the specific findings of our services the report may be found on our website






Participation in Clinical Audit

Clinical Audit is a method of improving our services by measuring what we do against national standards to see if we comply with them. If we find that we do not, then we put in actions to address shortfalls and then measure again. This is what is called the audit cycle. There are two main types of audit that we participate in:

National Clinical Audit and the Patient Outcome Programme (NCAPOP)

The management of NCAPOP is subcontracted to the Healthcare Quality Improvement Partnership (HQIP) by the Department of Health. Every year HQIP publish an annual clinical audit programme which organisations review and ensure that they contribute to those audits that are relevant to their services.

During 2016-2017 there were 61 national clinical audits and 14 national confidential enquiries that covered NHS services that Shrewsbury and Telford Hospital NHS Trust provides.

During that period Shrewsbury and Telford Hospital NHS Trust participated in 51 national clinical audits and 14 national confidential enquiries in which it was eligible to participate.

The reports of 23 national clinical audits were reviewed by the provider in 2016-2017 and Shrewsbury and Telford Hospital NHS Trust intends to take the following actions to improve the quality of healthcare provided (examples):

National Cancer Patient Experience Survey 2016:

- Holistic Assessment clinics within the Head and Neck service are up and running
- We are monitoring and acting upon feedback about this service

Emergency Use of Oxygen:

- A regular slot at Junior Doctors induction to raise awareness of oxygen administration protocols has been arranged

End of Life Care Audit – Dying in Hospital:

	National Clinical Audit or Confidential Enquiry	Number Submitted	% of total required
1	6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK	0	No relevant cases identified
2	Acute coronary syndrome or Acute myocardial infarction (MINAP)	713	100%
3	Adult Asthma (BTS)	10	100%
4	BAUS Urology Audit : Cystectomy	11	100%
5	BAUS Urology Audit : Nephrectomy audit	68	61%
6	BAUS Urology Audit : Percutaneous Nephrolithotomy (PCNL)	20	100%
7	Bowel cancer (NBOCAP)	388	100% for 2014/15
8	BAUS Urology Audit : Radical Prostatectomy Audit	92	96.8%
9	Breast and Cosmetic Implant Registry (BCIR)		Currently submitting data
10	Cancer Patient Experience Survey 2016 (National)	1794	72% response rate
11	Cardiac Rhythm Management Audit (CRM)	477	100%
12	Case Mix Programme (CMP) - ICNARC	442	100%
13	Child Health Clinical Outcome Review Programme / NCEPOD - Chronic Neurodisability		Currently submitting data
14	Child Health Clinical Outcome Review Programme / NCEPOD - Young People's Mental Health		Currently submitting data
15	Consultant sign-off in the A&E Department	668	100%
16	Diabetes (Paediatric) (NPDA)	291	100%
17	Elective surgery (National Proms Programme)	828	85%
18	Emergency use of oxygen (BTS)	58	100%
19	End of Life Care Audit: Dying in Hospital	81	100%
20	Endocrine and Thyroid National Audit		
21	Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database (NHFD)		Currently submitting data
22	Head & Neck cancer (Saving Faces)	247	

23	Heart Failure (Heart Failure Audit)		
24	Inflammatory bowel disease (IBD) programme	8	
25	Major Trauma Audit (TARN)	597	100%
26	Maternal, Newborn and Infant Clinical Outcome Review Programme - National surveillance and confidential enquiries into maternal deaths		Currently submitting data
27	Maternal, Newborn and Infant Clinical Outcome Review Programme - Confidential enquiry into stillbirths, neonatal deaths and serious neonatal morbidity		Currently submitting data
28	Maternal, Newborn and Infant Clinical Outcome Review Programme - Confidential enquiry into serious maternal morbidity		Currently submitting data
29	Maternal, Newborn and Infant Clinical Outcome Review Programme - National surveillance of perinatal deaths		Currently submitting data
30	Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal Mortality Surveillance		Currently submitting data
31	Maternal, Newborn and Infant Clinical Outcome Review Programme - Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths)		Currently submitting data
32	Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal morbidity and mortality confidential enquiries (cardiac (plus cardiac morbidity) early pregnancy deaths and pre-eclampsia)		Currently submitting data
33	Maternal, Newborn and Infant Clinical Outcome Review Programme - Maternal mortality surveillance		Currently submitting data
34	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Cancer in Children, Teens and Young Adults	0	No eligible cases identified
35	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Acute Pancreatitis	8	100%
36	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Physical and mental health care of mental health patients in acute hospitals	8	80%
37	Medical and Surgical Clinical Outcome Review Programme (NCEPOD) - Non-invasive ventilation		Auditing in progress
38	Moderate & Acute Severe Asthma adult & paediatric (care in emergency departments)	200	100%
39	National A&E Survey 2016		Auditing in progress
40	National Audit of Breast Cancer in Older People (NABCOP)	388	Auditing in progress
41	National Audit of Dementia	112	100%
42	National Cardiac Arrest Audit (NCAA) – ICNARC	404	100%
43	National Children and Young People's Inpatient and Day Case Survey 2016		Auditing in progress
44	National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary Care		Auditing in progress
45	National Comparative Audit of Blood Transfusion programme - 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)		Auditing in progress
46	National Comparative Audit of Blood Transfusion programme - Audit of Patient Blood Management in Scheduled Surgery	16	100%
47	National Comparative Audit of Blood Transfusion programme - Audit of the use of blood in Lower GI bleeding (audit will not be repeated)	14	100%
48	National Comparative Audit of Blood Transfusion programme - Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	26	100%
49	National Complicated Diverticulitis Audit (CAD)		100%
50	National Diabetes Audit – Adults - National Diabetes Transition		To be confirmed

51	National Diabetes Audit – Adults - National Footcare Audit		100%
52	National Diabetes Audit – Adults - National Inpatient Audit (NaDIA)	101	100%
53	National Emergency Laparotomy audit (NELA)	280	100%
54	National Joint Registry (NJR) - Hip replacement	144	
55	National Joint Registry (NJR) - Knee replacement	91	
56	National Lung Cancer Audit (NLCA)	270	
57	National Maternity and Perinatal Audit (NMPA)	7707	100%
58	National Maternity Survey 2017		Auditing in progress
59	National Vascular Registry*	960	Submitted over the last five years for four consultants
60	Neonatal intensive and special care (NNAP)		2015 (2016 report) 1300 episodes & 1222 babies
61	Oesophago-gastric Cancer (NAOGC)	176	Apr-13 to Mar-15 (2016 report) : 176 cases
62	Paediatric asthma (British Thoracic Society)		Auditing in progress
63	Renal replacement therapy (Renal Registry)		Currently submitting data
64	Sentinel Stroke National Audit Programme (SSNAP)	929	100%
65	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	13	100%
66	Severe sepsis & septic shock - care in emergency departments	199	100%
67	Smoking Cessation BTS	310	100%

Local Audits

As well as the national audits above, we carry out many audits that our clinicians identify as being required. These are collated onto our annual Clinical Audit Programme which is structured and shows audits that we are contracted to carry out by our commissioners; audits against national guidance such as that published by the National Institute of Health and Care Excellence (NICE) and those that our clinicians identify.

The reports of 118 local clinical audits were reviewed by the provider in 2016 – 2017 and Shrewsbury and Telford NHS Trust intends to take the following actions to improve the quality of healthcare provided against all these actions:

- Sharing the learning from the audits with the relevant staff groups
- Implementing change in processes as identified within each audit
- Carry out reaudit to ensure that changes have occurred and are reflected in practice

During 2016-2017 the following local audits were carried out:

Care Group	Number of Audits
Clinical Support – Pathology and Radiology	15
Corporate – Trust wide Audits	2
Scheduled Care – Anaesthetics, Theatres and Critical Care	10
Scheduled Care – Head, Neck and Ophthalmology	7
Scheduled Care – Musculoskeletal	22
Scheduled Care – Surgery, Oncology and Haematology	31
Unscheduled Care - Medicine	9
Women's and Children's	22
TOTAL	118

Some examples of the audits that have been carried out along with the recommendations and actions as a result are shown in the table below:

Audit Title	Recommendations and Actions
CLINICAL SUPPORT - PATHOLOGY & RADIOLOGY	
Audit of Chest X-Ray (CXR) Quality 2016	To raise awareness, the results of the audit have been presented at the governance meeting Possible improvements to facilities at Whitchurch are being discussed A move to digital equipment is planned.
Wire guided localisations	Discussion points have been recorded and distributed to relevant team members A summary of the findings have been discussed at the MDT Minor changes in practice were agreed to try to reduce the number of unexpected events
CORPORATE – TRUST WIDE	
Bereavement Voices Questionnaire 2016	The results are reported to the steering group and ward managers on a regular basis. This enables the ward managers to discuss the findings and make the necessary changes in practice. End Of Life Care Training is taking place throughout 2017
Sepsis screening & treatment for Commissioning for Quality and Innovation (CQUIN) 2015	To improve screening of patients for sepsis in the A & E department, a stamp has been produced and is being used in the A&E cards

SCHEDULED - ANAESTHETICS, THEATRES & CRITICAL CARE	
Consent for blood transfusion	A transfusion care pathway has been implemented A teaching session has been incorporated into the lecture given by the blood transfusion nurse to junior doctors on consenting for blood transfusion A re-audit is planned.
Pre-operative fasting guidelines	The pre-op starvation guidelines have been updated and are now available on the intranet Ward staff were surveyed to determine their knowledge of the guidelines
SCHEDULED - HEAD, NECK AND OPHTHALMOLOGY	
Tracheoesophageal fistula valve change documentation re-audit	Regular valve clinics to be established at both sites To re-launch the use of an electronic database to record each valve change Undertake an audit of valves ordered against number of entries on database
Retro bulbar irradiation for thyroid eye disease – National Institute for Health and Care Excellence (NICE) Interventional Procedure Guidance (IPG)148	Results satisfactory, no recommendations necessary. A re-audit is planned As per NICE five year rolling programme
SCHEDULED - MSK	
National Hip Fracture Database (NHFD): How accurate are we in hip fracture classification and operative management documentation?	A hip fracture poster and National Hip Fracture Database categories poster has been distributed to the Trauma & Orthopaedic meeting room & theatre coffee room A local teaching with junior doctors and nurses responsible for National Hip Fracture Database coding has been conducted A re-audit showed huge improvement in data accuracy.
Medical record keeping in orthopaedic trauma patients; is the weight-bearing status clearly documented?	Junior doctors and physiotherapists to check clinical portal and operative report If unsure about the WB status, to liaise with the surgeon/consultant responsible for the patient. MDT meeting the best time to raise concerns Surgeon who is dictating to be specific and avoid expressions such as routine mobilisation or as pain allows. Unless there is a clear pathway that allows everyone to be on the same page A re-audit is planned
SCHEDULED - SURGERY, ONCOLOGY & HAEMATOLOGY	
Chronic myeloid leukaemia (imatinib-resistance or intolerance) – dasatinib, high-dose imatinib and nilotinib – National Institute for Health and Care Excellence (NICE) Technology Appraisal Guidance (TAG)241	All patients receive the appropriate treatment according to the guidelines A re-audit is planned as per NICE five year rolling programme
Familial Breast Cancer – National Institute for Health and Care Excellence (NICE) Clinical Guidance (CG)164	Provision of surveillance for previously affected women who continue to be at high risk will be addressed by the Breast Surgery Department Tamoxifen uptake will be audited A re-audit is planned as per NICE 5 year rolling programme
UNSCHEDULED – MEDICINE	
Casenote & Stamp Medical PRH 2015/2016	Stroke Pro-forma to have a 'plan page' similar to the medical admissions pro-forma Assign new junior FY1 doctor to include a short presentation and aide memoir for doctors joining the trust, similar to the one given out by the palliative care team Medical staffing have been sent a memo to ensure doctors receive their General Medical Council (GMC) stamps An annual re-audit has been undertaken.
IV fluid prescription	Junior doctors have been educated on the use of Dextrose saline as a maintenance fluid and improvements in fluid prescription have been evident following this
WOMEN & CHILDREN'S	
Antibiotics for early-onset neonatal infection – National Institute for Health and Care Excellence (NICE) Clinical Guidance (CG)149	Sticky labels have been introduced in the unit to document the time of decision and the time when first dose of antibiotics are given A re-audit is planned as per Trust 5-year rolling NICE audit programme.
Pregnancy (rhesus negative women) - routine anti-D (review) – National Institute for Health and Care Excellence (NICE) Technology Appraisal Guidance (TAG)156	Results satisfactory, no recommendations necessary. A re-audit is planned as per Trust 5-year rolling NICE audit programme.

PARTICIPATION IN RESEARCH

The number of patients receiving relevant health services provided or subcontracted by Shrewsbury and Telford Hospital NHS Trust in 2016-2017 that were recruited during this period to participate in research approved by a research ethics committee was 2030.

SaTH is committed to active participation in Clinical Research in order to improve the quality of care we offer our patients, and also to make a contribution to wider health improvement. In doing so our clinical staff stay abreast of the latest possible treatment regimens and active participation in research provides the evidence base for improving care and health outcomes. It crosses all clinical services and our research team provide the essential infrastructure for all specialties to have the opportunity to offer their patients appropriate participation.

We work closely with the West Midlands Clinical Research Network (CRN) to ensure a culture of Research and Innovation is embedded within the Trust.

For the year 2015 -2016 the Trust was featured in the National Institute of Health Research (NIHR) League table in 75th place for the total number of participants recruited into clinical trials and 57th place for the total number of recruiting clinical trials, which is an improvement of 33.1% and 15% respectively from the 2014-15 period.

2016 has brought several challenges in terms of meeting our patient recruitment figure, the introduction of the new Health Research Authority (HRA) approval process change which has significantly delayed the start-up of studies nationally, a funding cut from the CRN which has impacted our resources and support from pharmacy. Despite these challenges we are on target to achieve our patient figure at the end of the March 2017.

The number of actively recruiting Principal Investigators has increased from 42 to 61 with more non-Medic Principal Investigators recruiting significantly into studies, and we are recruiting into more specialties than ever before.

The Trust is proud of a number of success stories. In the cancer trial portfolio, SaTH recruited the first patient in the UK into the DARS Head and Neck cancer study; are top recruiters into the MAMMO-50 (breast cancer) study out of 102 hospitals, 2nd top recruiters into the PROMPTS (prostate cancer) study, as well as being the 8th highest recruiting Trust out of 128 hospitals nationwide to recruit into the STAMPEDE prostate cancer study. We are developing the Paediatric portfolio and were 3rd top recruiters into a study looking at acceptability of the taste or medicines to children. We are the top UK recruiters into the REVOLVE (Crohns disease) study and in the top ten hospitals for recruitment into the GLORIA AF cardiac study.

Work is on-going in improving engagement at all levels within the Trust and the public by promotional events, providing speakers at local groups, and activity reports to the Board and two lay members on the R&I Committee.

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

Commissioning for Quality and Innovation Scheme (CQUINS)

A proportion of our income in 2016-2017 was conditional on achieving quality improvement and innovation goals agreed between our commissioners through the CQUIN framework. Some CQUIN schemes are nationally agreed as they reflect national priorities and best practice and others reflect local priorities that aim to support and encourage improvement and innovation. These are the CQUINS that were agreed during 2016-2017:

Priority	Number	Scheme	Have we achieved the CQUIN?
National	1a	Introduction of staff health and wellbeing initiatives	Achieved
National	1b	Healthy food for NHS staff, visitors and patients	Achieved
National	1c	Improving the uptake of flu vaccinations for front line clinical staff	Partially achieved
National	2A1	Timely identification and treatment for sepsis in emergency departments (screening)	Partially achieved
National	2A2	Timely identification and treatment for sepsis in emergency department (treatment and three day review)	Not achieved
National	2B1	Timely identification and treatment for sepsis in acute inpatient settingsl(screening)	Partially achieved
National	2B2	Timely identification and treatment for sepsis in acute inpatients settings (treatment and three day review)	Not achieved
National	4A	Reduction in antibiotic consumption per 1000 admissions	Achieved
National	4B	Empiric review of antibiotic prescriptions	Partially achieved
Local		Outpatient ambulatory emergency same day assessment and treatment service	Achieved
Local		Promote a system of timely identification and proactive fragility within the community	Achieved
Specialist Service		Enhanced supportive care access for advanced cancer patients	Achieved
Specialist Service		Preventing term admissions to Neonatal Intensive Care	Achieved
Specialist Service		Supporting primary care to manage renal failure eGER	Achieved
Specialist Service		NHSE Haemophilia	Achieved

For further information about financial penalties and rewards in relation to CQUIN payments for 2016-2017 please refer to the Trust Board Annual Accounts and Report.

Looking forward, these are the CQUINS that have been agreed for 2017-2018 that we will report on in our next Quality Account. Many of them are carrying on from 2016-2017 and will continue into 2018-2019 to enable us to really embed improvement.

Priority	Number	Scheme
National	1a	Improvement of Health and Wellbeing of NHS staff
National	1b	Healthy food for NHS staff, visitors and patients
National	1c	Improving the uptake of flu vaccinations for front line clinical staff
National	2a	Timely identification of sepsis in emergency departments and acute inpatient settings
National	2b	Timely treatment of sepsis in emergency departments and acute inpatient settings
National	2c	Antibiotic Review
National	2d	Reduction in antibiotic consumption per 1000 admissions
National	4	Improving services for people with mental health needs who present to A&E
National	6	Offering advice and guidance – improve access for GPs to consultant advice prior to referring patients in to secondary care
National	7	NHS E Referrals – all providers to publish all of their services and make all first outpatient appointment slots available on the E referral service
Specialised Services	WC4a PICU	Paediatric Networked Care – non PICU centres
Specialised Services	GE3	Hospital Medicines Optimisation
Specialised Services	DESP 2016	Diabetic Eye Screening Programme

Our Commitment to Data Quality

Shrewsbury and Telford Hospital NHS Trust recognises the central importance of having reliable and timely information, both internally to support the delivery of care, operational and strategic management and overall governance, and externally for accountability, commissioning and strategic planning purposes.

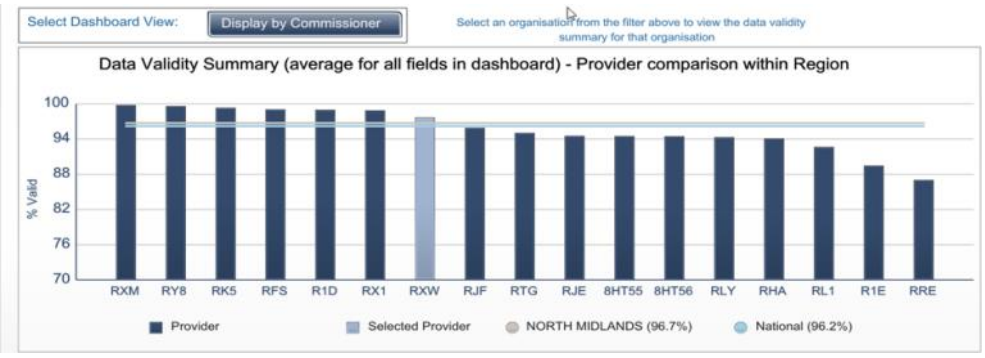
High quality and meaningful information enables people at all levels in the Trust (including external stakeholders) from frontline staff to Board level Directors to:

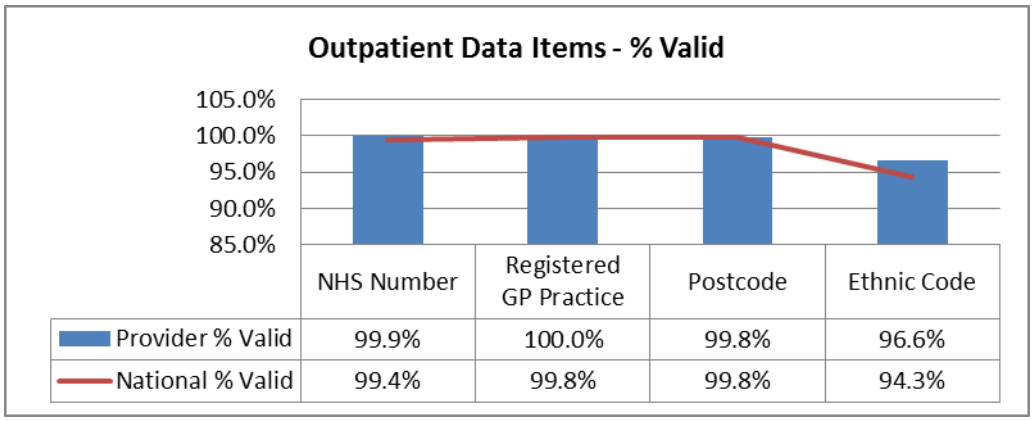
- Judge our service quality and outcomes; and to monitor progress
- Make strategic and service decisions, based on the evidence
- Investigate and analyse suspected problems and evaluate service/practice changes
- Benchmark the Trust against other Trusts and internally across services.

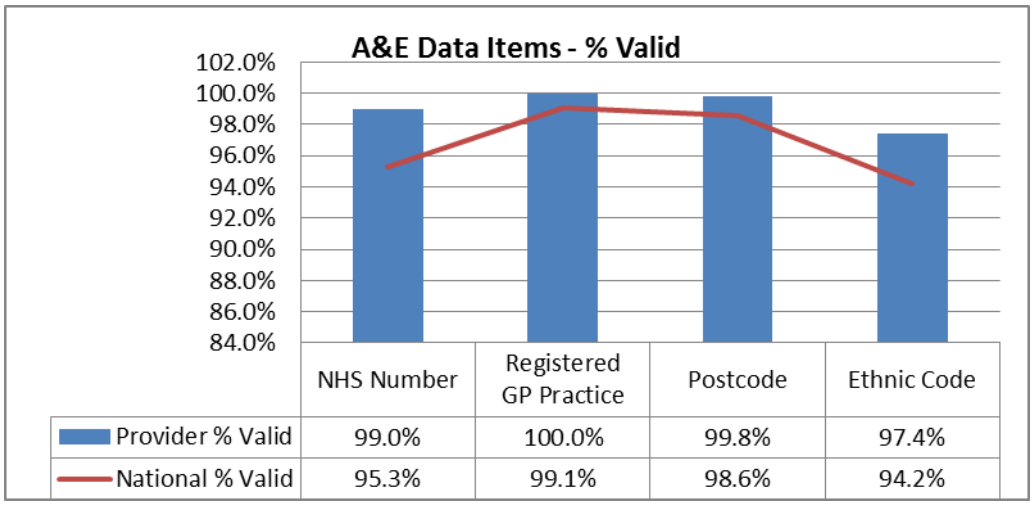
The Information Governance Toolkit Requirement Number 506 states that organisations must have documented procedures and a regular audit cycle to check the accuracy of service user data.

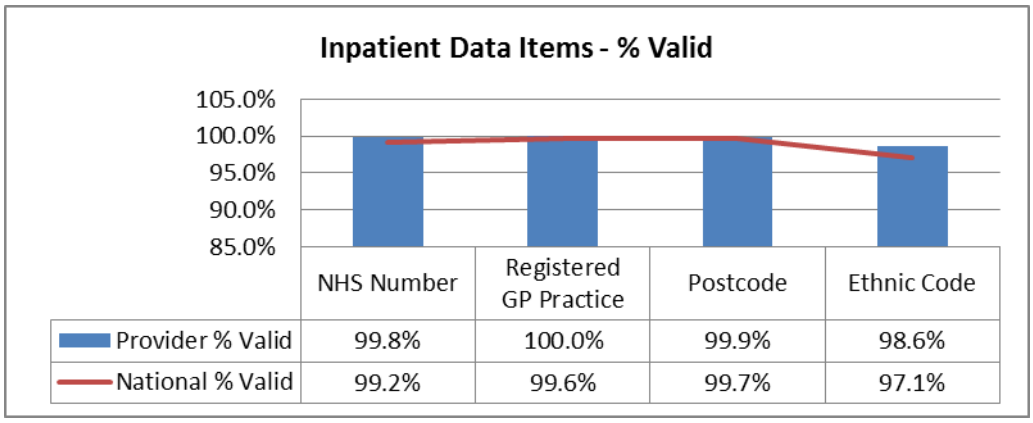
The audit should cover all key data items identified in HSCIC guidance for Acute Trusts Data Set.
In adherence with the 'Francis Report (2013) " The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved", the Data Quality Team follows good practice and has a regular audit cycle in line with the IG Toolkit Requirements. The Data Quality Team Investigate Information errors and report back to source and where necessary refer service users' for further training.

'Key' Information fields taken from Data provided for secondary use resulted in the following scores compared with National 'Validity Scores':









The Data Quality Team audit, monitor and correct ad hoc data items recorded on the Patient Administration System (PAS) to ensure Validity and Integrity for example:

Data Item: April 2016 – February 2017:	Total records completed / populated
Identification of duplicate patient registrations recorded on PAS – merged both electronically and physically	5375
Demographic Corrections - NHS Spine for validation	4470
Missing NHS Numbers against patient records – fields populated	2040
Rejected Discharge Summaries from GPs corrected and sent to valid GP	5035
Open referrals recorded on the system in error – corrected and closed	5424

Which organisational information does Information Governance cover?

Any information that the organisation holds, whether it is corporate information such as minutes of meetings, contracts, policies or whether it's personal information about staff, or patient information e.g. health records.

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

Overall Score: 75%

Initiative	Level % 2017	Grade
Information Governance Management	86%	satisfactory
Confidentiality and Data Protection Assurance	79%	satisfactory
Information Security Assurance	68%	satisfactory
Clinical Information Assurance	73%	satisfactory
Secondary Use Assurance	75%	satisfactory
Corporate Information Assurance	77%	satisfactory

Shrewsbury and Telford Hospital NHS Trust submitted records to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest version of those Statistics published prior to publication of the relevant document by the provider during 2016-2017

Shrewsbury and Telford Hospital NHS Trust submitted records to the Secondary Uses service for inclusion in the Hospital Episodes Statistics which are included in the latest published data in 2016-2017

The Trust was not subject to a Payment By Results Clinical Coding Audit during 2016-2017

Mandatory Reporting Requirements

Core Quality Account Indicators as required by NHS England.

Every year NHS England requires specific information to be included in Quality Accounts based on the NHS Outcomes Framework which sets out high level national outcomes which the NHS should be aiming to improve. The Framework provides indicators which have been picked to measure how we improve. It is important to note that whilst these indicators must be included in the Quality Accounts the most recent national data available for the reporting period is not always for the most recent financial year. Where this is the case the time period used is noted underneath the indicator description.

NHS Outcomes Framework Domain	Indicator	SaTH 2015/16	SaTH 2016/17	2016-2017			Trust Statement
				National Average	Highest Scoring Trust	Lowest Scoring Trust	
Preventing people from dying prematurely	The value and banding of the summary hospital level mortality indicator (SHMI)	96	64	70	92	46	Shrewsbury and Telford Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust reviews mortality data regularly Shrewsbury and Telford Hospitals NHS Trust has taken the actions highlighted elsewhere in this Quality Account to improve this rate and so the quality of services.
Enhancing quality of life for people with long term conditions	The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period	17.20	21.27	28.40	63.46	9.06	Shrewsbury and Telford Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust reviews all data regularly Shrewsbury and Telford Hospitals NHS Trust intends/has taken the following actions to improve this percentage and so the quality of services by continuing to place utmost importance on high quality care to palliative patients.
Helping people to recover from episodes of ill health or following injury	Patient reported outcome measures for: Groin Hernia Surgery Varicose Vein Surgery Hip Replacement Surgery Knee Replacement Surgery (Apr16 – Dec 16, published May 2017)	 0.086 0 0.439 0.28	 0.159 0.152 0.563 0.434	 0.087 0.093 0.449 0.330	 0.386 0.482 0.836 0.945	 -0.1208 -0.2675 -0.263 -0.071	Shrewsbury and Telford Hospitals NHS Trust considers that this data is as described for the following reasons: Patient Reported Outcome Measures are an important way that we measure the outcome following a procedure Shrewsbury and Telford Hospitals NHS Trust intends/has taken the following actions to improve this indicator and so the quality of services by: encouraging patients to complete the questionnaires following the procedure.

NHS Outcomes Framework Domain	Indicator	SaTH 2015/16	SaTH 2016/17	2016-2017			Trust Statement
				National Average	Highest Scoring Trust	Lowest Scoring Trust	
Helping people to recover from episodes of ill health or following injury	Percentage of patients aged: 0-14 15 or over Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of a Trust during the reporting period (Feb 17-Mar 17)	 9.90 7.66	 10.00 7.14	 8.25 5.65	 23.17 10.72	 0.45 2.77	Shrewsbury and Telford Hospitals NHS Trust considers that this data is as described for the following reasons: We measure readmission rates carefully to monitor when patients are having to come back to us following an episode of care Shrewsbury and Telford Hospitals NHS Trust intends/has taken the following actions to improve this indicator and so the quality of services by working to ensure that patients are discharged home safely and effectively
Ensuring that people have a positive experience of care	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 (Qtr 2 2016/17)	80	80	80	100	44	Shrewsbury and Telford Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust is developing processes to improve all elements of patient experience Shrewsbury and Telford Hospitals NHS Trust intends/has taken the following actions to improve this percentage and so the quality of services by continuing to work with our Patient Experience and Involvement Panel to improve patient experience of the Trust
	Friends and Family Test covering services for inpatients and patients discharged from A&E (Feb 2017)		96% 98%				Shrewsbury and Telford Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust is developing processes to improve all elements of patient experience Shrewsbury and Telford Hospitals NHS Trust intends/has taken the following actions to improve this percentage and so the quality of services by continuing to work with our Patient Experience and Involvement Panel to improve patient experience of the Trust

NHS Outcomes Framework Domain	Indicator	SaTH 2015/16	SaTH 2016/17	2016-2017			Trust Statement
				National Average	Highest Scoring Trust	Lowest Scoring Trust	
Treating and caring for people in a safe environment and protecting them from avoidable harm	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period (Jan – Dec 2016)	94.70	95.68	96.00	99.96	93.94	Shrewsbury and Telford Hospitals NHS Trust considers that this data is as described for the following reasons: The Trust reports VTE risk assessment rates on a monthly basis and provides challenge where compliance is not seen. Shrewsbury and Telford Hospitals NHS Trust intends/has taken the following actions to improve this percentage and so the quality of services by: implementing systems to ensure that patients are assessed and monthly reporting indicates any areas where this is not happening so that remedial action may be taken
	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 (Mar 2016 – Feb 2017)	0.02	6.60	12.67	67.20	0.00	Shrewsbury and Telford Hospitals NHS Trust considers that this data is as described for the following reasons: Infection Prevention and Control is a high priority for the Trust Shrewsbury and Telford Hospitals NHS Trust intends/has taken the following actions to improve this rate and so the quality of services by the actions highlighted elsewhere in this report
	The number of patient safety incidents reported within the Trust during the reporting period (Apr – Sep 2016)	3364	4398	4955	13485	1485	Shrewsbury and Telford Hospitals NHS Trust considers that this data is as described for the following reasons: We promote a culture of open and honest reporting across the Trust. Shrewsbury and Telford Hospitals NHS Trust intends/has taken the following actions to improve this data and so the quality of services by encouraging a culture of reporting and support to carry out investigations and develop action plans to ensure learning.
	The rate of patient safety incidents reported within the Trust during the reporting period per 100 admissions (Apr – Sep 2016)	28.01	35.93	40.76	71.81	21.15	
	The percentage of such patient safety incidents that resulted in severe harm or death (Apr – Sep 2016)	0.1	0.003	0.004	0.017	0.000	

MORTALITY

Understanding mortality and how we measure it

SaTH has, as part of its organisational strategy, the aim of being an organisation that is 'safest and kindest'. This involves clinically effective, safe care and provided by colleagues who do care. This is achieved, in part by monitoring and learning from mortality which can provide valuable insights into areas for areas for improvement. To support that, the governance around mortality is well developed, both in order to provide continued learning and improvements to the clinical pathways and to reduce unnecessary harm to patients.

We have seen an improvement in our performance regarding mortality over the last five years, that has been maintained over the last year. This is demonstrated over the four mortality parameters and we now are consistently lower than our peer comparators. The mortality parameters are:

- **The Hospital Standardised Mortality Ratio (HSMR).** 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)** This is similar to HSMR but compares us with a different group of hospitals
- **Crude Mortality.** This includes all deaths in our hospital.

When used together these methods provide a more balanced perspective so, at SaTH, we use all four parameters.

RAMI – SaTH v Trust Peer January 2016 – February 2017
Average Index for period SaTH 80 v Trust Peer 135

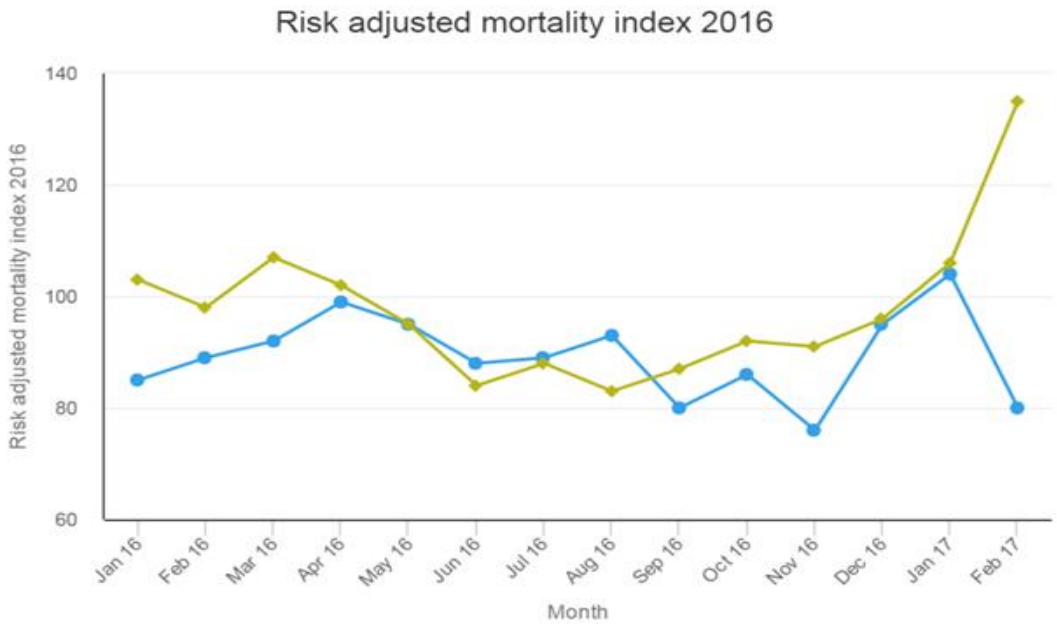


Figure 1 – Short term view

RAMI – SaTH v Trust Peer February 2011 – February 2016
(SaTH is the blue line)

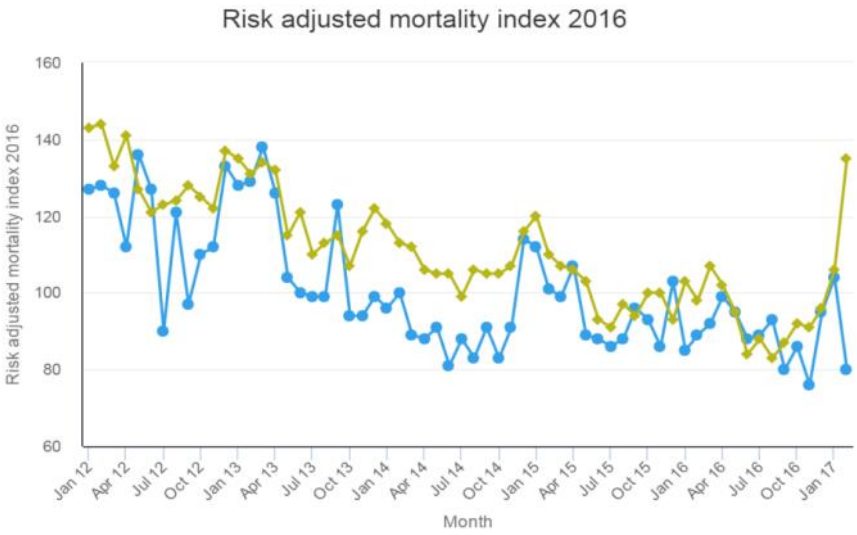


Figure 2 – Long term

Mortality Management at SaTH

We have maintained the improved mortality levels achieved by the Trust over the last five years, and continue to improve in comparison to our Peers.

We have also continued to build on and improve on the "lessons learned" practice whereby mortality reviews, where appropriate, are fed back through Clinical Governance meetings of each specialty where avoidable factors had been identified.

Our monitoring of mortality is an integral part of the Trust's work within an action schedule where we identify and review any areas where SaTH might appear as an outlier. We are reporting back to the mortality review meetings and also within the quarterly report to the Commissioners.

MANAGEMENT OF MORTALITY AT SaTH

Internal Surveillance

CHKS and HED
Quarterly Report on trends
HSMR, SHMI, RAMI
*The Trust does not subscribe to Dr Foster

NATIONAL OUTCOME AUDITS
SaTH contribues data
TARN, NHFD, ICNARC, SSNAP, RESUS COUNCIL

PATIENT SAFETY ADVISOR/ MORTALITY LEAD
Monthly horizon scanning
HSMR, SHMI, RAMI by condition
Provides support for in-depth reviews

CLINICAL MORTALITY LEADS PER SPECIALITY
Review of speciality mortality score cards.
HSMR, SHMI, RAMI and other clinical indicators

CHIEF INFORMATION OFFICER
To assure monthly sign off of NHS Digital Data by Medical Director
Review of SHMI by conditions

MEDICAL PERFORMANCE MANAGER
Reports SaTH overall
HSMR, SHMI, RAMI trend by month
Trust Mortality, SLT, CQRM

Internal Governance Structure

CARE GROUP CLINICAL GOVERNANCE STRUCTURE
Regular surveillance
Trend Analysis
Casenote review – patient level data – to identify avoidable deaths
Implementation of shared learning points
Contribute to quarterly morality reviews

TRUST MORTALITY AND MORBIDITY REVIEW MEETING (Every 2 months)
Chaired by the Medical Director
Trend analysis
Mortality casenote review
Implementation of shared learning points
Decisions on themes for next quarter
Decisions for in-depth reviews where appropriate

CLINICAL GOVERNANCE EXECUTIVE
Care Group Governance reports and actions
Summary from Trust Mortality and Morbidity Review Meeting – Mortality Review Report shared with CQRM and QSC

SENIOR LEADERSHIP TEAM MEETING
Summary metrics of overall SaTH Crude Mortality, HSMR, RAMI and SHMI
Outlier Alert information

QUALITY AND SAFETY COMMITTEE
Summary from Trust Mortality and Morbidity Review Meeting – Mortality Review Report
Individual cases in high risk report of IPR

TRUST BOARD
Regular summary reports on Mortality and Morbidity
Individual cases in high risk report of IPR

External Governance Structure

CQRM
Quarterly report
Summary metrics of overall SaTH Crude Mortality, HSMR, RAMI and SHMI

NHS ENGLAND
As requested
Summary metrics of overall SaTH Crude Mortality, HSMR, RAMI and SHMI

NHS Improvment
As requested
Summary metrics of overall SaTH Crude Mortality, HSMR, RAMI and SHMI
Reports for specific outlier reviews

ADDITIONAL EXTERNAL AGENCIES
CQC
National Hip Fracture Database
Dr Foster
Reports for specific outlier reviews

Internal Learning Structure

Care Group Medical Directors and Heads of Nursing
Implementation of action plans and shared learning via Care Group Governance Structures

Nursing and Midwifery Forum
Shared learning events

Doctors Essential Education Programme (DEEP)
Led by the Medical Director
Shared learning events

Accountable Personnel

- Medical Director
- Deputy Medical Director Quality and Standards
- Medical Performance Manager
- Patient Safety Advisor/ Corporate Mortality Lead
- Care Group Governance Leads
- Speciality Governance Leads

Where are we now?

- We have made significant progress in implementing a robust mortality review process and governance framework.
- We also continue to improve in comparison to our peers relating to our in-hospital mortality.
- We have an on-going proactive action schedule identifying areas that require further investigation for each quarter.
- We have an open and transparent approach with families who raise concerns and actively participate in external enquiries when required.
- We have an Executive (Medical Director) and a Non-Executive Director of the Board with responsibility for mortality. Both attended the Learning from Deaths conference in March 2017.

What more can we do?

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

We will continue to monitor our position for any areas that require further investigation.

We currently meet many of the recommended objectives within the National Quality Board published document 'National Guidance on Learning from Deaths' on identifying, reporting, investigating and learning from deaths in care.

The objectives for 2017/18 are to:

- maintain the improved mortality levels achieved by the Trust over the last five years, and improve further
- prepare for the introduction of the National Mortality Care Record Review Programme (NMCRR)
- participate in the national Learning Disabilities Mortality Review (LeDeR) programme when it is implemented
- participate in the collection and reporting on a quarterly basis specified information on deaths.

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.

PATIENT SAFETY

We aspire to be the safest in the NHS and so one of the ways we wanted to show our commitment was to "Sign Up to Safety" – to be part of a national initiative that aims to reduce harm in the NHS by 50% over three years (the initiative is now in its third year). All Trusts that signed up were asked to put together a Safety Improvement Plan which identifies the safety priorities for the Trust.

Our Sign Up to Safety plan is in the process of being updated for progress against the priorities that we set ourselves, some of which are reflected in this Quality Account (for example, improving the screening and identification of sepsis and the reduction of falls and pressure ulcers). Once this review has taken place we will be able to readjust our actions within the plan to ensure that at the end of the three years we will be able to show our contribution to the reduction of harm to patients.




Falls

The total number of falls in 2016-2017 has increased by 1.3% from 2015-2016 and equates to a 15% decrease in the number of reportable falls since monitoring began in 2011-2012.

Using the number of falls against recorded bed days activity which is benchmarked against the average number of falls in acute Trusts in England the Trust is well within the average of 6.6 falls per 1000 bed days.

All Falls

The average for February 2014 to January 2015 is 5.2 falls per 1000 bed days, for February 2016 to January 2017 the average has very slightly increased to 5.3 falls per 1000 bed days

The level of moderate/severe harm to patients resulting from a fall has however slightly decreased. The average for February 2014 to January 2016 is 0.15 falls resulting in moderate harm or above per 1000 bed days, and for February 2016 to January 2017 the average has slightly decreased to 0.11 falls per 1000 bed days. This is benchmarked against a national average of 0.19 falls resulting in moderate harm or above per 1000 bed days.

Pressure Ulcers

Summary 2015-2016	Avoidable	Unavoidable	Overall
Grade 4 pressure sore	0	2	2
Grade 3 pressure sore	9	11	20
Total	9	13	22

The Trusts reporting for grade 3 and 4 avoidable pressure ulcers for 2015-2016 was:

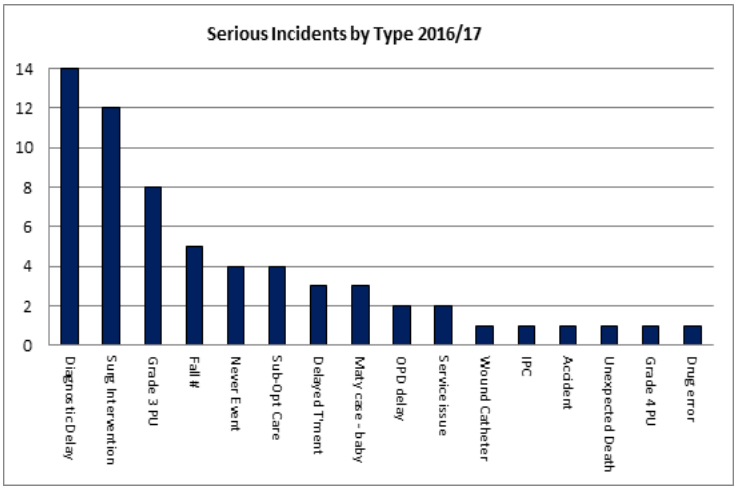
Summary 2016-2017	Avoidable	Unavoidable	Overall
Grade 4 pressure sore	1	2	3
Grade 3 pressure sore	9	11	20
Total	10	13	23

For 2016-2017:

Serious Incidents (SI)

Adjusted Serious Incidents totals for 2015-2016 were 58; this rose in 2016-2017 to 63.

The table below shows the Serious Incidents in 2016-2017 by type:



While the number of Serious Incidents relating to diagnostic delays is similar to 2015-2016, this financial year has seen a significant rise in incidents relating to 'Surgical Intervention' (there are currently 12 in the category— for 2015-2016 the end of year total for the category was three). The difference may be in part due to a reduction in the number of available categories on StEIS (the SI reporting system) but an end of year review will be conducted to assess trends and themes and a comparison with the previous years' reporting.

Never Events

NHS England (2015) defines Never Events as:

"Serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers".

The Trust reported four Never Events in 2016-2017.

One related to the removal of the wrong tooth and the other three events related to retained foreign objects following an invasive or surgical procedure. All four were reported in accordance with our incident reporting processes and through the agreed processes to our commissioners (Shropshire Clinical Commissioning Group and Telford and Wrekin Clinical Commissioning Group) and NHS Improvement, our regulators.

This series of Never Events presents the Trust with the opportunity to implement our vision of being the safest in the NHS through learning and implementing change. Staff are proactive in reporting such events and are committed to learning from them to ensure that our patients remain safe. The events triggered in depth reviews of the areas and changes to practice to enhance safety procedures. Support for Human Factors training has been a significant outcome of the reviews into these cases.

Duty of Candour

Since November 2014 all health and social care organisations registered with the CQC have had to demonstrate how open and honest they are in telling people when things have gone wrong. This process is called the "Duty of Candour" and as a measure of its importance it is the sole element of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Duty of Candour has been implemented across the Trust. In support of this a policy has been written to help those undertaking the Duty of Candour to quickly identify what they need to do.

The initial roll out of the regulatory requirements focussed on Serious Incidents to ensure that we have strong systems in place. These are in place and performing well.

We are also making sure that clinicians implement the Duty of Candour for those incidents resulting in what is described as moderate harm. We want to make sure that the communication with patients, their families or carers is of the highest standards whether it is verbal or written. During 2017 we will be reviewing all incident reports on datix to ensure that where needed it is recorded that the requirements of the Duty of Candour Regulation have been met.

Safety Alerts

Through the analysis of reports of serious incidents and new safety information from elsewhere NHS England develops advice for the NHS that can help to ensure the safety of patients, visitors and staff. As information becomes available, NHS England then issues alerts on potential (and known) risks to patient safety. At SaTH these are coordinated and monitored by the Patient Safety Manager who disseminates the alerts to the appropriate clinical teams who ensure that we are already compliant or that there is an action plan to ensure we become so. This process is monitored every time our Clinical Governance Executive meets to make sure it remains at a high level of visibility. The table below shows the alerts that we have received during 2016-2017 and our progress against them. We fully complied with the compliance deadlines for those that have




Alert Identifier	Alert Title	Date received/ Circulated	Closure target date	Closure date	Open/ Closed
NHS/PSA/ RE/2016/003	Patient safety incident reporting and responding to Patient Safety Alerts	22/04/2016	03/06/2016	03/06/2016	closed
NHS/PSA/ W/2016/004	Risk of death and severe harm from failure to recognise acute coronary syndromes in Kawasaki disease patients	Issued 13/5/2016 circulated 17/05/2016	22/06/2016	07/06/2016	closed
NHS/PSA/ Re/2016/005	Resources to support safer care of the deteriorating patient (adults and children)	issued 12/07/16 circulated 14/07/16	31/01/2017	31/01/2017	closed
NHS/PSA/ RE/2016/006	Nasogastric tube misplacement: continuing risk of death and severe harm	issued 22/07/16 circulated 22/07/16	21/04/2017	18/04/2017	closed
NHS/PSA/ RE/2016/007	Resources to support the care of patients with acute kidney injury	circulated 17/08/16	17/02/2017	16/02/2017	closed
NHS/PSA/ D/2016/008	Restricted use of open systems for injectable medication	Issued 07/09/2016 Circulated 15/09/2016	07/06/2017		open
NHS/PSA/ D/2016/009	Reducing the risk of oxygen tubing being connected to air flowmeters	Issued 04/10/2016 Circulated 4/10/2016	04/07/2017		open
NHS/PSA/ W/2016/010	Risk of death and severe harm from error with injectable phenytoin	Issued 09/11/2016 Circulated14/11/2 016	21/12/2016	20/12/2016	closed
NHS/PSA/ W/2016/011	Risk of severe harm and death due to withdrawing insulin from pen devices	Issued 16/11/2016 Circulated 17/11/2016	11/01/2017	11/01/2017	closed
NHS/PSA/ Re/2017/001	NHS/PSA/Re/2017/001 - Resources to support safer care for full-term babies	Issued 23/02/2017 Circulated 28/02/ 2017	23/08/2017		open
NHS/PSA/ RE/2017/002	Resources to support the safety of girls and women who are being treated with valproate	Issued 06/04/2017 Circulated 06/04/ 2017	06/10/2017		open

NHS Safety Thermometer

This year we have continued to submit data as part of the NHS Safety Thermometer data set – a "snapshot" of all patients in the NHS on one day per month, measuring whether they have a pressure ulcer, have fallen in the previous 72 hours, have a catheter with an associated infection or a venous thromboembolism (blood clot) as these are the four most common harms that are measured in the NHS. This year (2016-2017) our average percentage of patients recorded as being free from any of these harms was 94.17% and our average percentage of patients that we recorded as not having developed any of these harms in our care was 97.94%.

Patient Led Assessments of the Care Environment (PLACE)

Patient Led Assessments of the Care Environment (PLACE) Assessments took place between May and June 2016. These assessments were supported by members of our local Healthwatch and our Patient Experience and Involvement Panel.

	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity & Well Being	Condition, Appearance and Maintenance	Dementia	Disability
SaTH Average	99.4	90.50	81.71	93.61	68.99	91.41	58.14	74.10
National Average	98.06	88.24	87.01	88.96	84.16	93.37	75.28	78.84

The results were published in September and the scores for Shrewsbury and Telford Hospital are compared to the national average below:
Following the inspections we have put together an action plan to address the issues that were raised during the assessment. We will measure how successful this has been by repeating the PLACE inspections in 2017-2018.

Equality and Diversity

We aim to ensure that our services are delivered in a fair way to all users. This means that patients do not suffer detriment, disadvantage or unequal treatment because of age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race including nationality and ethnicity, religion or belief, sex or sexual orientation.

By diversity we mean that we value the different contributions that all staff, patients, families and carers can bring.

To make sure that we are complying with national standards and doing the right thing for our patients and staff we measure how we are getting on through:

The Workforce Race Equality Scheme (WRES) against which we measured ourselves in the summer of 2016 (the reporting template may be found on our website)

The Equality Delivery System Two (EDS2) against which we are carrying out an assessment at present. When complete this will be published on our website

Against both we have action plans that we will use to measure our progress against the standards within the documents and ensure that we are continually improving and developing our services to be responsive and equitable to all

Infection Prevention and Control

The Trust reports all cases of C Difficile (CDI) diagnosed in the hospital laboratory to Public Health England. However only cases where the sample was taken more than 72 hours after admission are considered attributable to the trust. Our target for C Difficile in 2016-2017 was to have not more than 25 Trust apportioned cases in patients over the age of two years. The number of C Difficile cases at the end of year is 21 so we have achieved our target and the numbers reported have dropped from 31 last year.

Each identified CDI case is assessed with the relevant clinical teams to see if there was a lapse of care. If the outcome was that there was not a lapse of care it would be put through to a CCG review panel for consideration.

Eleven cases were apportioned to SaTH in first six months of the year (samples taken post 72 hours). This dropped to ten cases in the second six months. For the first 17 cases of the year the CCG review panel found that 12 were associated with a lapse in care, so this will be taken into account when determining financial penalties.

CDI lapse in care common themes included delay in sending samples, lack of compliance with antibiotic policy (overuse of Meropenem and Tazocin) and delay in providing isolation facilities for the patient.

At year end we have had one case of MRSA Bacteraemia (bacteria in the blood). It is now over 250 days since our last recorded case in the Trust. Although we have not achieved our target of zero cases this continues our current very low level of MRSA bacteraemia.

Vancomycin resistant enterococcus (VRE) (post 48 hours) - we have had 59 cases (compared to 117 last year). There had been a continuous rising trend over the last few years. Fortunately most patients have been colonised rather than showing active infection.

MRSA new cases (not bacteraemia) – 18 cases so far compare to 30 cases last year—we are reducing the ways that people can pick up the bacteria in the first place. We do this by screening all admissions apart from those in very low risk groups and if MRSA is detected we can then make sure we can offer a clearance regime with topical creams and sometimes milder antibiotics.

Hand Hygiene Compliance Audits - we have been 95% or above for the last 12 months

MRSA Emergency screening - we have been just under 95% on average for the last 12 months. The Unscheduled Care Group has been extremely proactive over the last quarter to increase their compliance.

MRSA Elective screening, we have been over 95% on average for the last 12 months.

Section four: A Listening Organisation

How we use feedback to develop our culture

2016 Survey of Adult In Patients carried out by the CQC.
The results of the survey improved in almost 50% of the areas covered by the survey.

The results follow positive results in the 2015 survey, which saw a 75% improvement on the 2014 survey, including 19 statistically "significant" improvements.

The Trust saw improvements in 30 of the 61 comparable questions answered by patients in the latest survey. Of the 18 areas which saw a fall in patient satisfaction, only two were considered statistically "significant". The other areas of the questionnaire saw no change, or did not have a comparison in 2015.

Patients were asked questions based on their experience in different departments of the Trust, as well as about their experience with Doctors and Nurses and their care and treatment.

In the overall results, 98% of patients said they felt well looked after by hospital staff, and the same proportion said they were treated with respect and dignity.

The survey also revealed that 96% of patients had confidence and trust in the doctors treating them and 98% had confidence and trust in the nursing staff.

SaTH performed statistically significantly better than in the previous 2015 results in three areas: Patients being bothered by noise at night from hospital staff; the cleanliness of hospital rooms and wards; and the cleanliness of the toilets and bathrooms which patients used.

SaTH performed worse than the average in one area in which patients did not feel they received enough support from staff to help with their recovery or to manage their condition after leaving hospital.

This diagram shows that in both 2015 and 2016 we have been consistently "About the Same" as other Trusts in England, for each of the eleven sections.

Friends and Family Test (FFT)

The Friends and Family Test allows all NHS patients the opportunity to give feedback on their care as often as they wish to, and provides Trusts with a good measure of where best to target improvements. It is also a good way for Trusts to inform the public about how well they are doing, and how patients feel about their care with us. During 2016-2017 SaTH brought all of the collection and processing of this data in-house, using Young Apprentices appointed for one year to gain the necessary skills to move into a permanent job role in the NHS. This has had a very positive impact on both Trust response rates and the number of patients who are likely to recommend our services.

The new system is allowing more efforts to be focused on increasing our response rate, to ensure that the data we receive is representative of the views of a wide range of our patients. It has also allowed us to identify problems more quickly and respond to these.

In November 2015, the Trust overall response rate was 15%, with an A&E response rate particularly challenged at just 12.6%. Since appointment of the Apprentices, the most recently published overall Trust response rate for November 2016 now stands at 23.4%, with the A&E response rate having more than doubled, standing at 34%.

Over the last year, growth has been such that SaTH's results now compare favourably to other Trusts. In the most recent figures published by NHS England (for September 2016), SaTH had the third highest response rate for A&E in the country at 34%.

In the most recent national data for October 2016, SaTH was ranked joint second nationally, alongside 11 other Trusts for percentage of Inpatient Promoters (Patients "very likely" or "likely" to recommend), with only one other Trust in the country achieving a higher score. For maternity, SaTH alongside a number of other Trusts achieved the highest score in the country, at 100%.

		Inpatient	A/E	Maternity	Outpatients
2014/15	% of promoters	92.0%	91.2%	86.1%	NA
	Response rate	27.6%	6.7%	15.7%	NA
2015/16	% of promoters	96.40%	90.40%	98.80%	95.50%
	Response rate	22.10%	19.10%	26.60% (birth only)	NA
2016/17	% of promoters	98.1%	94.6%	98.80%	95.9%
	Response rate	18.2%	23.1%	14.8% (birth only)	NA

Complaints and Patient Advisory and Liaison Service (PALS)

During 2016-2017, the Trust has focused on learning from complaints from patients and their families. Action plans are allocated to each complaint as required and complaint responses and actions are reviewed at relevant meetings to inform wider learning.

The process for triaging complaints and PALS has changed to ensure that all complaints are captured formally and the number of complaints in 2016-2017 was 422, which represents a 32% (105) increase compared to 2015-2016 (317).

The PALS team support patients and their families with on the spot resolution and in 2016/17 assisted 1908 patients/families with concerns. This represents a 19% (456) decrease compared to 2015-2017 (2364), which is in keeping with the change in process for triaging concerns raised by patients and their families.

From January 2017, the PALS office location moved on to the main corridor in the ward block, to make it more visible so that patients and their families are able to access the service more easily. In addition, the team is working with wards and departments to raise awareness of their role and the support that they can offer patients and their families.

Some examples of learning and changes in practice that have arisen from complaints are set out below:

- Where two patients with a similar name are on the same ward, they will be nursed in different parts of the ward where possible and an alert will be placed on the ward whiteboard to ensure staff are aware of the potential for error
- Ensure joint working between SATH and RJAH (Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust) booking teams regarding follow-up clinics and sharing of information on prior bookings
- Additional information leaflets printed to be given to patients prior to the procedure
- A standard operating policy is to be developed relating to the process for transferring patients to other hospitals to ensure that where a wait for a bed exceeds an agreed timescale, the hospital then starts the process of contacting other centres to ensure that the patient is transferred as quickly as possible
- The Tissue Viability Lead Nurse has arranged additional training for nursing staff, using an anonymised complaint as a case study.
- Neonatal feeding guideline is being updated to provide more clarity and triage cards and checklists are being developed to support midwife conversations about breastfeeding support and assessment of neonatal health.
- All cleaning on public corridors is now done using battery operated machines to avoid having trailing cables.
- The Dementia Nurse Specialist is working closely with ward staff to deliver training on caring for agitated patients.
- Review of consent procedure for Gastroscopy patients
- Neurology secretaries are keeping a log of all outstanding test results and submit these to available consultants in the absence of the requesting clinician
- Closer working between the End of Life (EOL) Care Team and ward staff to ensure EOL care plan is followed.
- Comprehensive information regarding community services including contact details is given to patients on discharge.
- Phlebotomy records are now retained for twelve months to ensure that they are there to be checked when the blood sample is not reported on.
- Receiving wards now contact patient's relatives when ward transfers take place to ensure that the families are aware.
- Appointment of a new stroke consultant to respond to the increase in demand for stroke and Transient Ischaemic Attack (TIA) follow up to meet national guidelines.
- Partnership in Care documentation prepared for the patient hand held records in maternity care to ensure that past history is taken into account during labour.

n a number of complaints, individual members of staff have been given the opportunity to reflect on the experience of the complainant and the impact of their actions and/or words, and have been able to review their practice.

Going forwards, the Trust intends to continue to monitor actions arising from complaints and to audit these to ensure that all learning is properly embedded into practice. In addition, the Trust is reviewing ways of capturing concerns that are resolved locally by ward and department staff to ensure that any learning and changes in practice from this can be shared more widely.

The Trust is also looking at encouraging more resolution of concerns at a local level to ensure that issues are not escalated to a formal complaint unnecessarily. Systems will be put in place to ensure that all these concerns are also captured so that any trends and learning can be identified.

Cancer Patient Experience Survey

The Trust is committed to participating in, and acting upon, the results of the National Cancer Patient Experience survey. The results of the 2015-2016 survey were very reassuring and demonstrated that the actions taken to improve access to Clinical Nurse Specialists two years previous had made a positive impact. The Trust scored in keeping with the National average in all but 4 areas. In one of these areas as a Trust we were above the National average, however in 3 we fell below. Work has begun to address these areas of concern and also to improve in areas where we currently score well in order for us to excel further so that we are recognised at above National average when the survey is next conducted.

The Trust also ensures that more timely feedback from users of our cancer services is sought in order for any remedial actions to be implemented and for positive improvements to be rolled out across other areas. Additional local surveys are carried out specific to targeted areas e.g. the Hamar Help and Support Centre, the response from which has been exceptionally positive.

West Midlands Quality Review Service (WMQRS)

The WMQRS exists to support NHS organisations in the West Midlands in improving the quality of health services by undertaking reviews of the quality of clinical services. In May 2015 the WMQRS conducted a local health economy quality review of the way that the transfer patients from the acute hospital setting into intermediate and community services.

The WMQRS told the Trust that we improve the way we supply patients with medications (TTO) on discharge from hospital.

The Trust used a rapid improvement model to review and improve the way that TTO are dispensed and delivered to patients on the ward.

The WMQRS told the trust that we needed to provide patients with more information about the treatment they had received in hospital, what their plan was for on-going care and treatment and what to do if they encountered a problem when they arrived home.

The Trust now gives very patient who is discharged from our care a copy of the same letter that we send to their GP. This contains a comprehensive account of their treatment and on-going care. We audit this process to ensure that the Trust is consistently making sure that this happens.

The WMQRS to the Trust that we needed to work with other local health care partners to ensure that the quality of information we provided when we transferred a patient from our care, ensured that the transfer was timely, safe and effective.

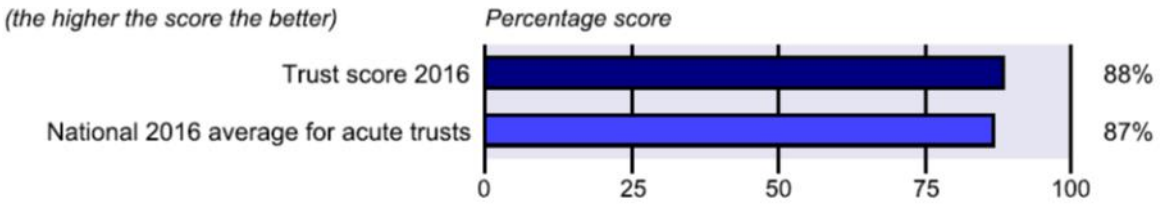
The Trust has held workshops with our community partners to identify and share best practice to help achieve safe and effective transfer of care for patients. We regularly audit the patient's experiences of discharge to ensure we are delivering a good quality transfer of care and identify any areas for improvement.

NHS Staff Survey

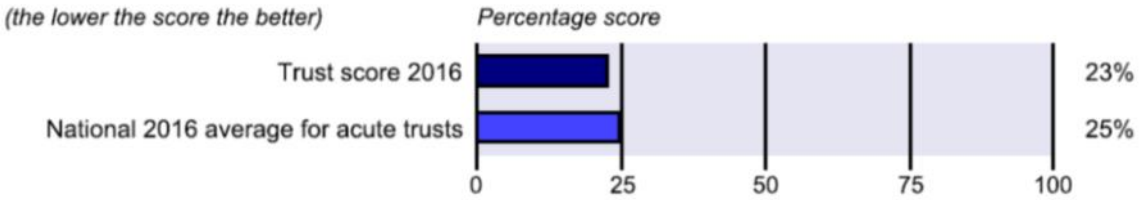
One of the ways that we measure whether we have an open culture in our Trust is through the annual NHS Staff Survey. Last year we said that our score for staff confidence and security in reporting concerns was slightly below the average for Trusts like SaTH across the NHS.
We wanted to make sure that this improved and that our staff felt safe to report concerns that they might have about patient safety in our services so that these may be investigated and addressed.

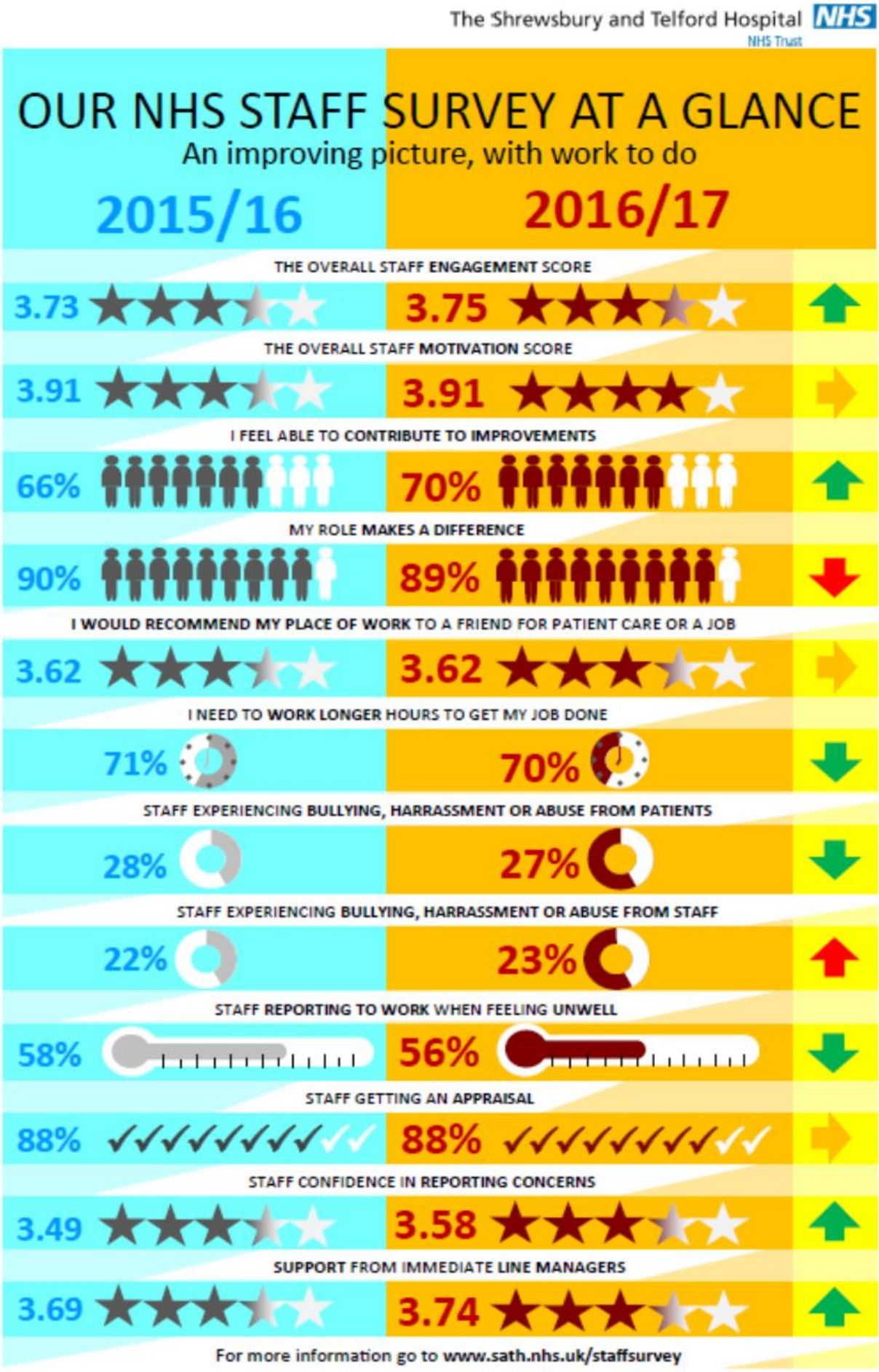
Whilst we have seen an improvement in our score from 2015, it is still below the national average so we know that we still need to prioritise this over the coming year.

We have put the key results from the staff survey into the diagram below. In addition we are specifically required to report on the following two indicators:



KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12




The Shrewsbury and Telford Hospital NHS
NHS Trust
OUR NHS STAFF SURVEY AT A GLANCE
An improving picture, with work to do
2015/16
2016/17
THE OVERALL STAFF ENGAGEMENT SCORE
3.73
3.75
THE OVERALL STAFF MOTIVATION SCORE
3.91
3.91
I FEEL ABLE TO CONTRIBUTE TO IMPROVEMENTS
66%
70%
MY ROLE MAKES A DIFFERENCE
90%
89%
I WOULD RECOMMEND MY PLACE OF WORK TO A FRIEND FOR PATIENT CARE OR A JOB
3.62
3.62
I NEED TO WORK LONGER HOURS TO GET MY JOB DONE
71%
70%
STAFF EXPERIENCING BULLYING, HARRASSMENT OR ABUSE FROM PATIENTS
28%
27%
STAFF EXPERIENCING BULLYING, HARRASSMENT OR ABUSE FROM STAFF
22%
23%
STAFF REPORTING TO WORK WHEN FEELING UNWELL
58%
56%
STAFF GETTING AN APPRAISAL
88%
88%
STAFF CONFIDENCE IN REPORTING CONCERNS
3.49
3.58
SUPPORT FROM IMMEDIATE LINE MANAGERS
3.69
3.74
For more information go to www.sath.nhs.uk/staffsurvey

How do we keep everyone informed of the latest news and developments?

We have several ways of keeping colleagues at our two main sites and our other satellite sites up to date with all the news and developments that happen at such a busy and vibrant Trust.

The methods of reaching our staff include our weekly/biweekly newsletter Chatterbox, a weekly message from a member of the Trust Board with specific topical information, One Minute Briefs for flash messages that are used for alerting staff to new initiatives, patient safety messages or other updates and our very helpful and informative staff intranet which all staff use to access the information and technology they need in their day to day work.

We engage with members of the public and staff through our twitter feed (@sath) and advertise job opportunities not only through NHS Jobs but also via Facebook and Twitter (@SaTHjobs).

Additionally specific clinical areas have worked with patients to help them access the information that they need through their journey with us. For example, an innovative App has been developed to help patients understand and monitor the side effects of chemotherapy treatment and the long-term follow-up of prostate cancer.

The App which was funded by the Lingen Davies Cancer Fund, was launched at the Royal Shrewsbury Hospital in December 2016. The App focuses on enabling patient-centred care through information and technology, it is packed with important information about chemotherapy and advice about when to contact the helpline to ensure patients are seen at the earliest opportunity. It is hoped the technological advance will result in fewer chemotherapy patients being admitted to hospital as an emergency."

The exciting digital health solution is being produced as a result of extensive consultation between patients and clinicians about how the Trust can improve the way in which people with cancer can access services.

The team developing the App will showcase its innovative Cancer App at a prestigious national health conference in July 2017.

Section five: Statements from our partners

Statement from Shropshire Council:

Shropshire Council's Health and Adult Care Scrutiny Committee is unable to provide comments on the 2016/17 Quality Account due to the fact that the national timetable for Scrutiny Committees to comment on Quality Accounts coincides with the pre-election period of Shropshire Council's elections and the appointment of the new Scrutiny Committee at Annual Council.

Statement from Shropshire Clinical Commissioning Group for Shrewsbury and Telford Hospitals NHS Trust (SaTH) Quality Account for 2016/17.

NHS Shropshire Clinical Commissioning Group

Shropshire CCG acts as the co-ordinating Commissioner working closely with Telford & Wrekin CCG for Shrewsbury and Telford Hospitals NHS Trust (SaTH). We welcome the opportunity to review and provide a statement for the Trust's Quality Account for 2016/17. This Quality Account has been reviewed in accordance with the National Health Service (Quality Accounts) Amendment Regulations 2011 and the National Health Service (quality Account) Amendment Regulations 2012.

Both CCGs remain committed to ensuring with partner organisations, that the services it commissions provide the highest of standards in respect to clinical quality, safety and patient experience.

It has been a challenging year for the Trust as referenced in their Quality Account, which includes the difficulties experienced due to a high demand for healthcare over a protracted winter period with some patients waiting to be seen longer that expected to access hospital services. It is recognised by Commissioners that the Trust and its staff demonstrate both resilience and dedication to ensure a continued focus to ensure it delivers safe and effective services. This is demonstrated in the Quality Account with the successes the Trust has achieved through the partnership work with Virginia Mason Institute in Seattle and the Transforming Care Institute to deliver their vision.

The key successes of the 4 value work streams of the Transforming Care Institute of 2016/17 are clearly reflected in the Quality Account and commissioners welcome the opportunity to see your table of reviews of services for 2017/18 including endoscopy, maternity and a network review of Neonatal services and look forwarding to seeing progress on these during the coming year.

We congratulate the Trust in consistently maintaining improvements in 2 main areas;

- Mortality performance over the past 5 years and continuing to build on the lessons learnt from the reviews of deaths.
- Participation in research with an increase in the total number recruited to clinical trials.

We recognise the work undertaken by the Trust to improve the quality of patient care and patient experience through the 2016/17 CQUIN schemes. We would have expected that the impact of these schemes were given in greater detail in the quality account. Equally we acknowledge the work undertake by the Trust for the "Sign up to Safety" initiative, we would have expected a reference to the safety improvement plan the Trust has developed to support this ongoing work.

The Trust Reported 4 Never Events in 2016/17 which triggered in depth reviews and improvements in practice by the Trust. As part of the assurance process commissioners visited the hospitals operating theatre departments and were pleased with the measures which have been put in place to improve patient safety and experience in these areas. We would however have expected more emphasises on learning the lessons from the Never Events, how these will be monitored across the Trust.

The Trust reported a similar number of serious incidents as reported in 2015/16 and 12 were related to diagnostic delays. We would have expected that the learning from these were included in the narrative of the Quality Account. Whereas, examples of the learnings from the complaints the Trust had reported were clearly captured in the report.

The CCG whilst recognising the work being undertaken by the Trust to improve the safety and experience of mothers and babies continue to have significant concerns and await the outcome of the Secretary of State Review of Avoidable Baby Deaths. This in turn has led to enhanced scrutiny of those services including the CCG Commissioned MLU review and increased surveillance of maternity services through a jointly agreed enhanced maternity services CQRM from June 2017.

The Trust has highlighted a number of fragile services and it is important that the Trust continues to systematically manage and report on patient safety within those services and proactively monitor patient experience.

We would ask the Trust to revisit the Infection Prevention Control (IPC) section in the report given its narrative content is unclear and limited particularly in relation to actions the Trust needs to address to make IPC improvements.

We acknowledge the Trust's work to strengthen the adult safeguarding process, this would have been greater assisted to mention the ways that safeguarding has been strengthen and what the impact has been. It would have been particularly interesting to see analysis of safeguarding concerns for both adults and children services and the outcomes.

On a positive note, the Trust should be congratulated on their results from the 2016 staff satisfaction survey and 99% of the staff knew the Trusts values. We look forward to the Trust's continued progress during 2017/18.

We note the achievement of the Trusts key priorities for 2016/17 including the Exemplar Programme and the impact of the implementation with the new RaTE assessment system which has reduced the amount of time completing individual audits resulting in more time to focus on caring for patients, the Trust's culture of openness and improvements in nutrition and hydration. Commissioners look forward to seeing further progress and with continued improvements in these areas during 2017/18.

We are pleased to see the Trust's priorities for 2017/18 include; delivery of the Red to Green (R2G) principles, enhance a more customer focused approach and the leadership and culture of the organisation.

We wait to receive the Trust's Care Quality Commission (CQC) planned inspection report of December 2016 to review how the Trust has progressed since the previous inspection the CQC carried out in 2014 particularly against the areas where they felt the Trust most needed to improve.

The CCGs remain committed to working closely during 2017/18 with the Trust's clinicians and managers, monitoring service delivery and performance through monthly Clinical Quality Review meetings and addressing any issues with regards to the quality and safety of patient care.

<u>Accuracy of Information contained with the Quality Account 2016/17</u>
The CCG has taken the opportunity to check the accuracy of relevant data presented in the draft version of the document received and has raised several queries, which the Trust has confirmed will be revised in the final version of the Quality Account.

Section six: External Audit Limited Assurance Report

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

We are required to perform an independent assurance engagement in respect of Shrewsbury & Telford Hospital NHS Trust's Quality Account for the year ended 31 March 2017 ("the Quality Account") and certain performance indicators contained therein as part of our work. 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 2017 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infections
- Friends and Family Test patient score element

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 2014-15 published on the NHS Choices website in March 2015 ("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 2016 to June 2017;
- papers relating to quality reported to the Board over the period April 2016 to June 2017;
- 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;
- the latest national patient survey dated May 2017;
- the latest national staff survey dated 2016 ;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2017;and
- the annual governance statement dated 30thMay 2017;

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 Shrewsbury & Telford Hospital NHS Trust.

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 Shrewsbury & Telford Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the 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;
- 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 Shrewsbury & Telford Hospital NHS Trust.

Basis for qualified conclusion

We were unable to test the accuracy, validity and reliability of the data for the reported Friends and Family Test indicator as the Trust does not retain the supporting records. The indicator reporting the Friends and Family Patient element score therefore did not meet the accuracy, validity and reliability dimensions of data quality set out in the testing requirements.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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.

Ernst & Young

No 1 Colmore Square Manchester

30 June 2017

The maintenance and integrity of the Shrewsbury & Telford Hospital NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the Quality Accounts since they were initially presented on the web site.

Legislation in the United Kingdom governing the preparation and dissemination of the Quality Accounts may differ from legislation in other jurisdictions

Section seven: Glossary of Terms and acknowledgements

Care Quality Commission (CQC)	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
Clinical Audit	Clinical Audit is a way to find out if healthcare is being provided in line with standards and allows care providers and patients know where a service is doing well and where there could be improvement. The aim is to make those improvements to improve outcomes for patients.
Clinical Research	Clinical research is a branch of healthcare science that determines the safety and effectiveness of medications, devices, diagnostic products and treatment regimens intended for human use. These may be used for prevention, treatment, diagnosis or for relieving symptoms of a disease. Clinical research is different from clinical practice. In clinical practice established treatments are used, while in clinical research evidence is collected to establish a treatment.
Clostridium Difficile (C Diff)	Clostridium Difficile, also known as C. Difficile or C. Diff, is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics but can spread easily to others. C. Difficile infections are unpleasant and can sometimes cause serious bowel problems, but they can usually be treated with another course of antibiotics
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
Commissioning for Quality and Innovation (CQUIN)	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
Equality and Delivery System Two (EDS2)	EDS2 s a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.
Exemplar Ward Programme	The Exemplar Programme represents our vision and aspirations for our Trusts. The core standards build upon our previous achievements and ambitions for Nursing and Midwifery to be the best in the NHS. The patient experience will be at the centre of Exemplar.
Health Research Authority (HRA)	The HRA protects and promotes the interests of patients and the public in health and social care research.
Health and Social Care Information Centre (HSCIC)	HSCIC (now called NHS Digital) provides national information, data and IT systems for health and care services.
Healthcare Quality Improvement Partnership (HQIP)	HQIP is an independent organisation lead by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices. It was established in April 2008 to promote quality in healthcare and in particular to increase the impact that clinical audit has on healthcare quality improvement.

Learning Disability Mortality Review (LeDeR)	LeDeR was set up as a result of one of the key recommendations of the Confidential Inquiry into premature deaths of people with a Learning Disability (CIPOLD). It aims to make improvements in the quality of health and social care for people with learning disability and to reduce premature deaths in this population.
Learning from Deaths	Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and their families, and identify where they could do more. A CQC review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England opens in a new window found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.
Methicillin-resistant Staphylococcus Aureus (MRSA)	MRSA is a bacterium responsible for several difficult-to-treat infections.
National Clinical Audit and Patient Outcomes Programme (NCEPOP)	This programme consists of more than 30 national audits related to some of the most commonly occurring conditions. These collect and analyse data supplied by local clinicians to provide a national picture of care standards for that specific condition. On al local level, the audits provide trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help participants identify necessary improvement for patients.
National Institute for Health and Care Excellence (NICE)	NICE provides national guidance and advice to improve health and social care.
National Institute for Health Research (NIHR)	NIHR is funded by the Department of Health to improve the health and wealth of the nation through research.
National Mortality Case Record Review (NMCRR)	NMCRR aims to improve understanding and learning about problems and processes in healthcare associated with mortality and also to share best practice.
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS Outcomes Framework	The NHS Outcomes Framework sets out the indicators that will be used to hold NHS England to account for improvements in health outcomes
Nurse Associate Role	The Nursing Associate role is a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. Following huge interest some 2,000 people are now in training with providers across England. (https://hee.nhs.uk/our-work/developing-our-workforce/nursing/nursing-associate-new-support-role-nursing)
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
Red to Green (R2G)	The R2G approach is a visual management system to assist in the identification of wasted time in a patient's journey. It can be used in wards in both acute and community settings as part of the Safer Care Bundle (https://improvement.nhs.uk/resources/safer-patient-flow-bundle/)
Workforce Race Equality Scheme	Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

QUALITY ACCOUNT 2016/2017