The Shrewsbury and Telford Hospital NHS
NHS Trust

The Quality Account

2011/12

Contents

Information about this Quality Account

Copies are available from www.sath.nhs.uk, by email (consultation@sath.nhs.uk) or in writing from:
Chief Executive's Office, The Shrewsbury and Telford Hospital NHS Trust, Princess Royal Hospital, Grainger Drive, Apley Castle, Telford TF1 6TF
Chief Executive's Office, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XQ

Our Quality Account is also available on request in large print. Please contact us at the address above or by email at consultation@sath.nhs.uk to request a large print version of the Quality Account.

Please also contact us if you would like to request a copy of our Quality Account in another community language for people in Shropshire, Telford & Wrekin and mid Wales.
A glossary is provided at the end of this document to explain the main terms and abbreviations used in our Quality Account.

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1 Introduction to our Quality Account 2011/12

Section 1 of a Trust's Quality Account provides a statement on quality from the Chief Executive.

"This Quality Account is the most important document we publish each year. In this year's document we outline the improvements and progress we have made with an emphasis on 2011/12. We also outline where improvements have not gone far enough. We know we have more to do and the further improvements that we want to make are outlined in our Account.

In 2011/12 we established a clear commitment to improving patient safety and I commissioned a "Leading Improvements in Patient safety" (LIPS) program within the Trust with the support of the "National Institute for improvement and Innovation". Over 100 clinical staff attended this program in June 2011. Following this programme the team developed clear ideas about the improvements that they wanted to make. These improvements are described within the Quality account. The Trust Board has committed to continue the investment in supporting the LIPS program and as this Quality account goes to print, the 2nd cohort of the LIPS program is commencing with 40 clinical staff from the Clinical Centres all eager to make further improvements for patients in our hospitals. There will be further programs planned for later in 2012/13, spreading the number of safety improvements being made and enabling the sharing of the principles and methods of safety improvements with their clinical colleagues.

In setting out our guiding principle, **Putting Patients First,** I am very aware that the care we provide for every patient who comes through our hospitals either for a planned procedure or as an emergency, always has a large impact on that patient and their family. Our clinical and support teams in the Trust take that responsibility very seriously. We know too that whilst we are very proud of the care provided in the majority of cases, there are times when we do not always provide the level of care expected or required. I am as Chief Executive ultimately accountable for that care provision.

As outlined in my introduction to last years Quality Account, we introduced during 2011/12 a clinician led organization and that structure began operating in the final six months of last year. These clinical leaders are committed to taking this organization forward and providing the best care for each and every patient. They now lead their clinical teams in each centre and regularly review the safety and effectiveness of the care delivered in the Centre. They are also committed to making the improvements that are still needed to the standards of care and the organization of the patient journey through our services.

We cannot make all the improvements required by ourselves and we have worked with our GP colleagues and Commissioning partners to help develop improvement in the wider health economy with initiatives during the winter period to support care provision at each stage of the patient's journey. We know for example that with the right resources at the right point in the patient's journey, we can improve the assessment and support needed by elder frail patients and have been able to increase the number of patients who have been discharged safely within 72hrs. The Trust is continuing to work with GP and other stakeholders to improve patient flow (how patients receive the care they need and are supported as they move beyond the hospital). We are committed to reducing waiting times in our emergency services (A&E and our Acute Medical assessment Units) and we will in the year ahead completely overhaul our entire scheduling and booking system to help make attending as an outpatient or planned admission much easier for patients.

We accept that we must also become more productive and efficient so we make better use of our resources, including being financially resilient. This is a challenging time for the NHS generally and to support staff engagement and to develop collective solutions, we held a number of listening events during the year, where we listened to staff frustrations and also their ideas for action and implementation. From these events and briefings, our staff helped to identify improvements that can be made that are making us more efficient and effective. We have already acted on many of their ideas and will continue to do so.

Following the major public consultation on service reconfiguration, we have received full support for our Outline Business Case and at the point of publication are awaiting approval of the Full Business Case to enable us to make the service improvements outlined in that public consultation. We have over the year worked with patient groups and clinicians so our plans reflect what we need to do to bring about these major improvements to the quality, safety and sustainability of key services. We will continue to work with patients, GP and Commissioners to ensure that the detailed project management leads to a successful transfer of all services in 2014.

In the last year (2011/12), we developed a range of methods for reviewing our performance on quality standards. We introduced comfort rounds to support particularly the elder / vulnerable patients which ensure that patients are reviewed and supported in their care needs. This has resulted in positive feedback from patients and carers and from our regulator the Care Quality Commission. These initiatives reduced the number of falls within the Trust and contributed to reduced number of pressure ulcers. These improvements and other fundamental aspects of care are reviewed by senior nurses and clinicians through a "ward to board" process that reviews a set of patient care indicators, ultimately reporting this to the Board. During 2011/12 a patient experience and involvement panel (PEIP) was formed, which brings together statutory patient representatives (Telford and Wrekin LINKs, Shropshire LINKs and Montgomeryshire Community Health Council) as well as other local patient groups, patients and carers. PEIP has been instrumental in forming a work programme which will support our improvement goals. PEIP will support us in reviewing care delivery and receiving real time patient feedback. I thank them for their valuable time and contribution to these improvements.

The Trust is committed to improvements across the three dimensions of quality:

- Safety;
- Patient experience;
- Clinical effectiveness.

The Trust Board undertook a major consultation with staff, stakeholders, and patients about what their priorities are for improvements for the next 5 years. A Quality Improvement Strategy was developed as a result of this work and was approved by the Trust Board in March 2012. This will provide a basis for ensuring ongoing improvement and will be reported through each year's Quality Account.

Whilst maintaining quality services in a tough financial climate is challenging, the Trust is committed to improvements across the three dimensions of quality, safety, experience and clinical effectiveness.. This will provide a basis for on-going improvements and will be reported through each years Quality Account.

Most of you will know that I move onto a new challenge in June 2012 as Chief Executive in Cardiff, but I will continue to live in Shropshire and will take an active interest in the continuous improvements that I know the Trust will make over the next few years. I would like to offer to the staff of the Trust my thanks and good wishes for the future and reassure the public that the Trust is now in a positive position to make the experience of all its patients a paramount priority and the clinical leaders within the organization will ensure that this continues."

Mandatory statements	**Declaration** The Secretary of State has directed that the Chief Executive should be the Accountable Officer for the Trust. The responsibilities of Accountable Officers include accountability for clinical governance and hence the quality and safety of care delivered by the Trust. To the best of my knowledge and belief the Trust has properly discharged its responsibilities for the quality and safety of care, and the information presented in this Quality Account is accurate.

What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of the services we provide. They set out: where the Trust is doing well; where improvements in quality can be made; priorities for improvement in the coming year; and, how service users, staff and others with an interest in the Trust have been involved in determining the priorities for the coming year. They aim to enhance accountability to the public for the quality of NHS services.

This is our third statutory Quality Account. It builds on our experience from the last two years and has been influenced by the development of our Quality Improvement Strategy, which underpins this year's account and will continue to do this for all Quality Accounts over the next five years. The Quality Improvement Strategy is a 5 year plan which demonstrates how we intend to improve the quality of care that the Trust provides and also sets out our specific objectives for the next 5 years. In order to ensure that the strategy was robust and reflective of our patients needs we held workshop sessions for a variety of staff groups from nursing and Allied Health Professional staff to board members. We also held a large workshop for patient involvement and representative groups. In relation to this year's Quality Account we have also engaged patient and community representatives through our Patient Experience and Involvement Panel, invited comment from our Primary Care Trusts, Local Health Board, Local Involvement Networks, Community Health Council and Health Overview and Scrutiny Committees.

The 2011/12 Quality Account focuses on areas of quality improvement where we need to continue to work hard to improve the care we provide and also to look at new areas of quality improvement that have been identified through clinical audit or by our staff or patient representatives. These quality priorities which are underpinned by the Quality Improvement Strategy and CQUIN framework will ensure that we have the capacity and opportunity to make real improvements for our patients and their families across the three domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience. By building on our improvements from last year's priorities we can continue to improve the things that patients tell us are really important such as the information we give to people, the services we provide to Frail Elderly patients, pressure ulcer and falls reduction and good diabetic care.

Quality Improvement will continue to be a high priority for the Shrewsbury and Telford Hospital NHS Trust despite the increasing financial challenge that all NHS organisations are currently facing. The priorities set out in this Quality Account are core to our mission of "Putting Patients First" and we must and will work in partnership with other partners and stakeholders to achieve these within the financial constraints of the current economic climate.

2 Priorities for Improvement in 2012/13 and Statements of Assurance

Section 2 of a Trust's Quality Account focuses on (a) priorities for improvement in the year ahead and (b) statements of assurance relating to the quality of the Trust's services.

2.1 Priorities for Improvement in 2012/13

This section should identify clear priorities to improve quality in specific areas for the year ahead. A minimum of three priorities should be detailed which fall across the three recognised domains of quality; Patient Safety, Patient Experience and Clinical Effectiveness. This section should also explain how the Trust as a whole approaches and supports quality and the structures that underpin this.

2.1.1 How we developed our Quality Priorities for 2012/13

The Trust has continued to develop the structure for monitoring, reporting and developing the quality agenda by ensuring that a wide variety of quality indicators are measured and acted upon. The Quality and Safety Committee that was formed during 11/12 is now well embedded at the heart of this structure and receives the range of information and makes recommendations accordingly. Further groups that feed into this committee include the High Risk Scrutiny Committee, the Quality Performance Committee and the Shrewsbury and Telford Infection Prevention and Control Committee

In developing our Quality Priorities for 2012/13 we have consulted with our external stakeholders such as LINk's and the CHC plus Shropshire Commissioning PCT and also internally with our Staff and Patient groups. These consultations have resulted in some new priorities and the extension of existing ones where we have not improved enough and also where we need to achieve different things as we move ahead. A key influence in the development of our priorities for the coming year was the development of a robust Quality Improvement Strategy. This 5 year plan sets out what we intend to achieve year on year in the form of clear objectives and the framework we will use to do this. The strategy and objectives were developed following extensive consultation and discussion workshops across a wide variety of stakeholders from patient groups to front line medical, nursing and allied health professional staff to board members. The strategy will naturally inform our annual quality accounts over the next 5 years and will be viewed as a living document that is updated annually based on the changing needs of our patients.

If you would like more information about the Quality Improvement Strategy and the priorities within it, then please contact us using the address detailed on page 3 of this account.

Patient Safety

Preventing Avoidable Pressure Ulcers
Further Reduction of Falls
Safer Blood Transfusion

Patient Experience

Using Patient Involvement to Improve Patient Experience
Improving the Experience of Frail Elderly Patients

Clinical Effectiveness

Providing Effective Diabetes Care to Our Patients
Improving the Patient Journey

	Preventing avoidable pressure ulcers	Achieving year on year reduction in falls
Status	**Existing**	**Existing**
Why is this a priority?	Last year we aimed to eliminate grade 4 pressure ulcers and halve the number of grade 3 pressure ulcers developed within the Trust. We have not achieved this within the last year so must focus on doing this in 2012/13. The Trust is fully committed to achieving this priority as we recognise that this is also important to patients and that we must and will provide safe and effective pressure area care to all patients at risk.	During 2012/13 we aimed to reduce the total number of falls by 10% and the number of falls resulting in serious harm by 50%. We did not achieve this, however did reduce the number of patients that fell by 8.5% which exceeded the target set by the CQUIN framework of 5%. The number of falls reported that resulted in serious injury increased by 11.5% during 2011/12. Whilst the Trust recognises that we must reduce this incidence the increased culture of reporting within the Trust over the last year must be noted as good practice.
Where are we now?	We did achieved an 11% reduction in grade 4 pressure ulcers and a 37% reduction in grade 3 pressure ulcers during 2011/12. We have achieved a 64% compliance with risk assessing patients admitted and delivered staff competency training to registered nurses working on our wards. Nursing Documentation has been extensively reviewed and a new assessment document and evidence based care plans will be rolled out during July 2012	Falls in our hospitals have reduced overall by 8.5% and falls that have resulted in serious harm have increased by 11.5%. Several initiatives are being trialled across the Trust in relation to falls reduction. Comfort rounds have been implemented across all inpatient wards to ensure we minimise the reasons for falls occurring.
What are our plans for 2012/13?	Further competency based training for our staff to improve knowledge and understanding of the risks of pressure damage and pressure ulcer prevention and annual updates for relevant registered nurses Demonstrate through our Ward to Board review and audit process that risk assessments and interventions are being carried out within appropriate timeframes. Use the Safety Thermometer and Pressure Ulcer reporting system to demonstrate improvements The above improvements will be reported through to the Quality and Safety Committee on a monthly basis to ensure they are tracked and acted upon if not met. **We will achieve:** **Zero grade 4 ulcers by December 2012** **Zero grade 3 ulcers by March 2013** **Reporting a baseline of the number of grade 2 ulcers and completing a Root Cause Analysis on 100% of these** **Ensuring 100% of our patients receive an assessment of their skin integrity within 2 hours of admission**	The falls task group has been reformed with clear objectives for the coming year. Annual falls prevention training will be implemented for relevant registered nurses across the Trust Comfort rounds will be audited monthly and reported through to the Quality and Safety Committee via the monthly quality report **We will achieve:** **Further 10% reduction in overall falls** **25% reduction in falls resulting in harm** **Ensure 100% of our patients receive a comfort round according to their need (1-2 hourly)**

Patient Safety

Safer Blood Transfusion

Status	New

Why is this a priority?	We know from conducting audits and monitoring our performance that there are three areas relating to blood transfusion that we need to do better; 1) Waste less blood products 2) Reduce the number of sample errors we make 3) Ensure we perform observations at the right time, every time We must ensure that we focus on these 3 areas to deliver the improvements that are right to ensure good, safe care.
Where are we now?	Over the last year we haven taken steps to ensure that we understand the accurate position of care currently being delivered to give us a baseline upon which to set improvements. The Blood Transfusion Team has conducted and coordinated audits and communicated the results of these across the Trust to the Clinical Centres. Blood transfusion training has improved by over 25% during the year 2011/12, however we must improve from our current position of 71.3% to 90% by the end of 2012/13
What are our plans for 2012/13?	We will increase the amount of training delivered to staff in relation to the collection of samples and continue to audit this and report to Centre governance meetings so that action can be taken. We will commence annual mandatory training on safe blood transfusion for all relevant registered nurses. We will change the way in which blood is obtained to ensure that wastage is reduced by 25% We will audit patients who receive transfused blood products to ensure that the administration policy has been followed. **We will achieve:** • **25% reduction in wasted blood products** • **50% reduction in sample errors** • **50% Improvement in observations** • **90% appropriate staff trained**

Clinical Effectiveness

	Ensuring effective diabetes care	Improving the patient journey
Status	**New**	**New**
Why is this a priority?	Diabetes is a condition that affects a significant proportion of patients either directly or indirectly through carers and relatives. 1 in 5 patients admitted to our hospitals have diabetes. Following the implementation of the "Think Glucose" campaign across the Trust during 2011, several areas for increased awareness and improvement have been highlighted for focus across all 3 domains of quality during 2012/13 with the overall aim being to reduce incidents relating to the prescribing and administration of Insulin and to improve outcomes and experiences for patients with Diabetes.	We recognise that the patients journey has many steps and stages and that we need to ensure that these run as continuously as possible. We need to ensure that when patients are admitted to one of our hospitals that we give them the right information about their stay including how long this is likely to be and also ensuring that we know what support the patient might need when they go home. For outpatients we need to ensure that we communicate the right information at the right time whether that's before their appointment or after they have arrived.
Where are we now?	The "Think Glucose" campaign was introduced in 2011 raised awareness of diabetes and identified lead nurses across our wards and departments to champion excellence in diabetes care. Learning modules, study days and education sessions were made available to a wide range of staff. During 2011/12 there were 39 incidents reported within the Trust relating to the prescribing and administration of insulin and other diabetes medication.	Inpatient services—We have recently formed a Patient Information Panel to review the written patient information that the Trust provides. The new PSAG (Patient Status at a Glance) project will ensure that the Estimated Date of Discharge is clearly discussed, documented and communicated both to the patient and to teams of staff to ensure understanding. Outpatient Services—We know that we currently sometimes give patients conflicting information that may not be timely and accurate, both prior to and during their outpatient attendance. We have reviewed our outpatient survey results and developed an action plan to address issues raised.
What are our plans for 2012/13?	**We will achieve:** **We will see a reduction in the number of prescribing and administration errors recorded on Datix, the Trust's incident reporting system. This will be achieved by the following;** **80% of appropriate staff will complete the learning modules as outlined by the NPSA** **Single Point Lessons will be developed and made available to staff which act as a quick reference guide and will cover a variety of subjects such as; complications of diabetes, prescribing insulin, managing emergency situations.** **An awareness campaign led by the Endocrine Consultants and Diabetes Nurse Specialists which is supported by the board which focuses on specific diabetes related subjects and incorporating and awareness day and road show for a variety of staff** **A survey of diabetic patients to capture their experience of care delivered by the Trust** **An audit of identified inpatient areas against Key Performance Indicators**	**We will achieve:** **We will review our written patient documentation and ensure that accurate information is available for patients on admission about what they can expect during their hospital stay.** **We will ensure that 90% of our adult inpatients have an Estimated Date of Discharge that is discussed with them and communicated throughout the healthcare team.** **We will ensure that 80% of outpatients receive timely and accurate notice of their appointment and that once they have arrived for their appointment are kept updated about what they can expect to experience. We will update our Ward to Board Patient experience survey to ensure that we capture this information directly from patients.** **We will improve signage across our outpatient areas including installing real time waiting time displays**

Status	New	Existing
	Using Patient Involvement to improve Patient Experience	Improving the experience of Frail Elderly patients
Why is this a priority?	We currently receive feedback from patients in a variety of ways which we can then use to make improvements in the way we deliver our services. Moving forward we need to involve patient representatives more in reviewing and measuring the quality of care that we provide and in informing our approach to developing services within the Trust	Frail elderly patients have specific needs that require the right level of support and expertise from our staff. We know that this patient group are much more likely to develop complications such as pressure ulcers and also more likely to fall whilst in hospital.
Where are we now?	A Patient Experience and Involvement Panel was set up in 2011 by the Chief Nurse which consists of representatives from local community groups such as LINk and the CHC. The group also has previous and current patients plus volunteer workers as members. The patient group have attended a training programme and have agreed to a work programme using different methods of observing a listening to patient experiences, and will report to the Chief Nurse and her team on improvements required	The Trust Frailty Team has been working hard over the last year to set up systems and processes to support frail elderly patients throughout their hospital stay and after discharge by working with stakeholders across the whole health economy to agree a programme of care and frailty scoring system.
What are our plans for 2012/13?	**We will achieve:** **The Patient Experience and Involvement Panel will deliver a comprehensive work plan of monitoring, reviews and visits including; Observations of care, patients stories, patient diaries, Ward to Board patient experience metrics** **We will use the net promoter question to ask 10% of our patients that are discharged each week whether they would recommend the Trust to their family and friends.** **We will expand the use of the Ward to Board patient experience survey to include outpatient and speciality areas such as the renal dialysis units and Accident and Emergency departments.** **We will develop clear action plans to address issues identified in both inpatient and outpatient national surveys**	**We will achieve:** **We will ensure that 90% of all patients admitted as an emergency or for unplanned care will receive a frailty assessment on admission.** **90% of frail elderly patients admitted via our Acute Medical Units will receive support from a member of the Frailty Team** **70% of unplanned admitted patients over the age of 75 will receive Dementia screening and, if necessary on-going risk assessment and referral for diagnosis**

2.1.2 How will we increase capacity and capability for quality improvement?

A wide range of activities are taking place to increase capacity and capability for quality improvement in the Trust. Table 2.1.2a sets out some of the developments currently underway.

Table 2.1.2a

Theme	Improving capacity and capability for quality improvement
Patient Experience	During 2011 the trust established the Patient Experience and Involvement Panel and agreed a work plan for the coming year. This plan underpins the quality priorities set out in the quality improvement strategy and ensures independent challenge, scrutiny and assurance. The panel will be engaged in many aspects and work streams across the Trust such as; Patient stories, observations of care, Patient Environment Action Team inspections and the Equality and Diversity Committee
Monitoring, measuring and acting upon quality performance	In September 2011 the Trust introduced the Ward to Board programme which focuses on measuring nursing care and patient experience across our adult inpatient areas. During 2012 we will be further refining and expanding what we measure to include outpatient, Accident and Emergency, Renal Dialysis, Endoscopy, Children's Services, Maternity Services, Critical care, Theatres and Radiology areas.
Clinical Governance Structures and reporting on quality	Now that the Quality Improvement Strategy has been developed and is in place the Trust has commenced working towards the development of standardised quality monitoring reports for clinical areas, centres and the Quality and Safety Committee. Clinical Centres and the Quality and Safety Committee will be consulted in conjunction with national and local requirements in the selection of Key Performance Indicators that will be measured and reported at all levels to ensure consistency and comparability.
Patient Safety Walkabouts	An extensive timetable of walkabouts to all areas of the Trust whether patient facing, such as outpatient clinics and wards, or areas such as medical records is underway. Each walkabout team consists of an Executive Director, a Non Executive Director and a member of the Corporate Nursing Team. This enables the board to have assurance that quality initiatives and priorities are implemented and that problems can be identified and resolved.
Leading Improvements in Quality and Safety	Following on from the successful implementation of this approach last year a further cohort of clinical staff will be attending a further Leading Improvements in Patient Safety programme during 2012/13. Last year's event empowered clinical staff to have the capacity and capability to proactively lead change

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

Patient Experience

Within each priority for the coming year, clear goals are identified and the progress towards and achievement of these will be monitored in a number of ways. These priorities were discussed at a Patient Experience and Involvement Panel meeting and the panel will continue to review the progress towards them throughout the year both directly through participating in their work plan and indirectly through receiving and reviewing quarterly progress reports. These will also be discussed within Clinical Centres at Clinical Governance meetings and will be included in the monthly quality report that is scrutinised and challenged by the Quality and Safety Committee. The Ward to Board Patient Experience survey will also give us real time information about the patient experience that will be reviewed within clinical centres and by the Quality and Safety Committee

Safety

Through implementing standardised and consistent quality reports across the Trust we will be able to monitor patient safety improvements both within clinical departments, centres and at board level against the priorities in this account for the coming year. Because Key performance Indicators will be agreed across the clinical centres the Quality and Safety committee will be able to compare data and ensure that any areas falling behind receive sufficient support to enable the improvements to be achieved. The Safety Thermometer will give us real time patient safety data that can be acted upon quickly if needed.

Clinical effectiveness and outcomes

Clinical Audit programmes will be developed to ensure improvements are on-going in relation to quality improvements and priorities where appropriate.

Further work will be done in relation to measuring clinical outcomes this year which will be reviewed by the Quality and Safety Committee. Measurement of the progress towards achievement of the priorities will be through clinical audit, training provision and attendance, use of the Datix incident reporting system and completion of action plans.
During consultation with clinical centres to develop agreed key performance indicators national guidance such as NICE Guidelines will be consulted and included where appropriate

Progress and achievement of this year's quality priorities will be reported to the Quality and Safety Committee which is a formal subcommittee of the board, externally to commissioners where related to the CQUIN framework and in the 2012/13 quality account

2.2 Statements of Assurance

This section of our Quality Account confirms our commitment to review quality across all the services we deliver. This review takes into account the three dimensions of quality: patient experience, safety and effectiveness.

2.2.1 Review of Services

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

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

Mandatory statements

During 2011/12 the Shrewsbury and Telford Hospital NHS Trust provided and/or subcontracted the full range of services for which it is registered NHS Services (these are detailed in the Trust's Annual Report 2011/12 or via our web site).

The Trust supported a number of reviews of its services during 2011 and 2012. These were undertaken by external organisations and included:

- *The Care Quality Commission*
- *Annual Cancer Peer review*
- *West Midlands Quality Review Service: Review of services for the care of vulnerable adults in acute hospitals*
- *Review of Medical Assessment Unit services at the Royal Shrewsbury Hospital*

The Trust did not formally review any of its own services but supported the reviews and developed action plans to implement recommendations to improve the quality of care to our patients. The Trust has reviewed all of the information available in relation to the services provided.

The income generated by those NHS services that were reviewed in 2011/12 represents 100 per cent of the total income generated from the total provision of NHS services by the Shrewsbury and Telford Hospital NHS Trust for 2011/12.

We review the quality of our services in a variety of ways. Examples from 2011/12 are set out in Table 2.2.1a.

Table 2.2.1a

Trust Wide NHSLA Inspections		The Trust was successfully assessed at Level 1 of the NHSLA Risk Management Standards in December 2011.
Trust Wide Inspections CQC	**5 Minor Concerns** **1 Moderate Concern**	An unannounced inspection forming part of the CQC annual inspections programme was carried out in November 2011. The inspection found that the Royal Shrewsbury Hospital had a minor concern relating to one outcome and that the Princess Royal Hospital had one moderate concern and 4 minor concerns. A detailed action plan was developed and shared with the CQC which will be complete by September 2012
Trust Wide Environmental Health Review		5 star food hygiene rating awarded to both sites
Trust Wide NPSA PEAT Assessment		Formal annual assessment undertaken across both sites with an outcome of "excellent" rating
Reconfiguration of Services		During 2011/12 we continued to develop our plans with clinicians, staff, patients and the public to reconfigure some of our hospital services. This will see: • The majority of patients will going to the same hospital as they do now • Outpatients, diagnostics and day cases taking place at both our hospitals • Adult surgery consolidated on the RSH site (excluding breast, gynaecology and orthopaedics • Head and Neck inpatient services relocated to PRH • Consultant-led maternity services, neonatology, gynaecology and inpatient paediatrics (including paediatric oncology and haematology) consolidated within a new Women and Children's Unit at PRH
Medical Engineering Services		The auditor reviewed the organisation's position against ISO 9001:2008 and on-going ISO 13485:2008 Medical Devices Materials. Continued certification to both standards was recommended and the Trust achieved a high level of performance across all areas assessed. This is the Thirteenth consecutive annual external audit without non-compliance.
Trust Wide Pharmacy		SATH Pharmacy was subject to three external reviews and audits during 2011. The audits demonstrated the unit was fully compliant.
Maternity		The regional cluster undertook an assurance visit to the maternity services in January 2012, in order to review governance arrangements, meet clinical staff and patients. The visiting team included a cluster lead nurse, Obstetrician, Primary Care Trust quality lead and the West Midlands Local Supervising Authority Maternity Officer (WM LSAMO). Feedback following the review was extremely positive. Maternity services successfully achieved level 2 in the CNST assessment conducted in February 2012
Midwifery		Midwifery services are reviewed annually by the West Midlands Local Supervising authority Maternity Officer (WM LSAMO) to ensure that the arrangements for and the execution of Supervision of Midwives are satisfactory. The Trust consistently receives positive feedback from this review and has a very proactive team of supervisors.
Laboratory Services		Clinical Pathology Accreditation (CPA) visits took place during the year. The Trust laboratories received full accreditation.
Mortuary		The Human Tissue Authority (HTA) assessed standards in the Mortuary. The Trust was found to meet the HTA standards

Table 2.2.1a (cont.)

Apley Ward		All internal audits are up to date, and quality measurements and objects remain in force and effective. The external ISO auditor reviewed the ward's position against ISO 9001/2008 – Provision of nursing care and support services to private patients including Out Patients Department, with outcome of compliance recorded. Apley ward has participated in this external audit for the past eleven years.
Care of vulnerable adults		West Midlands Quality Review Service review of Mental Health Services, Health Services for People with Learning Disability, Dementia Services and Care of Vulnerable Adults in Acute Hospitals was conducted during 2011 which identified several areas for improvement. An action plan has been developed to address these and will be monitored by the Trust Safeguarding Committee
2011/12 Annual Cancer Peer Review		Fourteen of our Cancer Multi-Disciplinary Teams were reviewed by Self -Assessment and Internal Validation during 2011/2012. Two immediate risks were raised, one has been resolved and one downgraded on review. There were four serious concerns raised, relating to the availability of histology services and consultant workload and radiological investigation. Examples of excellent and good practice were identified for each team in a number of areas; the continued development of one stop and fast track clinics ,excellent patient information, good leadership, audit and reporting of clinical outcomes, developing acute oncology services and improved waiting times. Three of our teams have undergone external review and the final reports are awaited. The Cancer Value Stream Leads within the trust meet with all the teams to discuss the Peer Review Reports and what action may be taken to address concerns and disseminate excellent practice within the trust.
Medical Assessment Unit		An external review was commissioned on the Medical Assessment Unit at the Royal Shrewsbury Hospital which was undertaken in response to the findings of a 'Review of Urgent Care Report' from the West Midlands Quality Review Service (2011) . The completed review recommended improvements around Quality, Safety and Patient Experience in areas such as; the patient journey, flow, support services, facilities and medical and nursing staffing/skill mix arrangements. Approved action plans have been developed to address the issues identified.
HSMR (Hospital Standardised Mortality Ratio)		Over the last year we have completed a number of separate reviews of patient deaths in order to ensure we understand areas of improvement. As a result of this many changes have been made including the provision of a much more Consultant delivered service, especially out of hours as well as improvements that enable the right care to be delivered at the right place by the right person. By the end of March 2012 we will have completed a pilot for a process that enables us to review 100% of our in hospital deaths in a systematic way. The aim is to have rolled this mortality review process out across the hospital by the end of April 2012.
Environmental Health Inspection Food Services		Environmental Health Inspections were carried out for both sites. We achieved a score of '4' for our Food Hygiene rating.
Internal Assurance reviews		Ward to board surveys of patient experience and nursing care commenced in September 2012 as a monthly review of each adult inpatient ward. Internal ward reviews continued throughout the year with external stakeholders from commissioners and patient groups involved. Patient Safety walkabout programme with Non executive and executive directors.
Quality & Safety Committee		Safety walkabouts – to observe care and discuss issues with staff Patient Stories – to reflect positive and negative experiences Monthly quality report – to enable the committee to review performance and triangulate trends and themes
Hygiene and Compliance Audits		Annual review of cleanliness compliance assessed against the National Standards of Cleanliness Internal Peat audits are carried out monthly

2.2.2 Participation in Clinical Audit

This section of our Quality Account provides information about our participation in clinical audit. Clinical audit is "a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery." Participation in national clinical audits, national confidential enquiries and local clinical audits provide an important opportunity to stimulate quality improvement within individual organisations and across the NHS as a whole.

Mandatory statements

Clinical Audits

During 1st April 2011 to 31st March 2012, 74 national clinical audits and 4 National Confidential Enquiries covered NHS services that the Shrewsbury and Telford Hospital NHS Trust provides.

Section 2.2.2a

During that period the Shrewsbury and Telford Hospital NHS Trust participated in 58/74 [78%] of the national clinical audits and 4/4 [100%] national confidential enquiries of the National Clinical Audits and National Confidential Enquiries which it was eligible to participate in.

Section 2.2.2b

The national clinical audits and national confidential enquiries that the Shrewsbury and Telford Hospital NHS Trust was eligible to participate in during 1st April 2011 to 31st March 2012 [78] can be accessed at:
http://www.sath.nhs.uk/services/audit/default.aspx

Section 2.2.2c

The national clinical audits and national confidential enquiries that the Shrewsbury and Telford Hospital NHS Trust participated in between April 2011 and 31st March 2012 can be accessed at
http://www.sath.nhs.uk/services/audit/default.aspx

Section 2.2.2d

The national clinical audits and national confidential enquiries that the Shrewsbury and Telford Hospital NHS Trust participated in, and for which data collection was completed during 1st April 2011 and 31st March 2012, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry can be accessed at:
http://www.sath.nhs.uk/services/audit/default.aspx

Section 2.2.2e

The reports of 9 national audits were reviewed by the provider during 1st April 2011 and 31stMarch 2012.

Section 2.2.2f

The following are examples of actions that The Shrewsbury and Telford Hospital NHS Trust intends to take to improve the quality of healthcare provided, as a result of participation in National audits.

- Results of the national Paediatric Fever audit showed that the Trust is following NICE (National Institute for Clinical Excellence) antibiotic guidelines. An information sheet for parents has been developed, and education in this area is being incorporated into the Nurse's and Doctor's teaching programme to ensure patients receive all appropriate investigations.
- Participation in the national audit of continence care has led to the development of trust wide documentation to aid management of continence in older patients, and the Trust is planning to appoint a specialist nurse to lead this service.
- Review of Trust results for the National Dementia audit has led to a number of actions, including a programme of skills competency framework
- Development for nurses, introduction of specialist documentation and care plans, and introduction of a validated assessment tool to identify patients with dementia on admission
- The National comparative audit of blood transfusion has led to implementation of various actions to improve patient safety, including updating the policy, intensive staff training and closer observation of patients. There are also plans to invest in a system that will only allow trained staff access to the fridges where blood is stored.

A complete table of all actions that The Shrewsbury and Telford Hospital NHS Trust intends to take to improve the quality of healthcare provided, as a result of participation in National audits can be accessed at:
http://www.sath.nhs.uk/services/audit/default.aspx

Mandatory statements

- Staff training has been carried out to assist staff in appropriate identification and support of vulnerable adults admitted to hospital
- Patients being treated on any ward in the Trust who are suspected of having a stroke are referred to the Stroke team and transferred to the Stroke Unit
- Assessment of patients for Venous thrombo-embolism risk factors is now carried out electronically for all appropriate patients
- Audit of treatment of elderly patients admitted with a fractured neck of femur has led to increased cover by specialist doctors and the appointment of a specialist nurse. Work is underway to further develop osteoporosis and falls prevention in these patients and to further reduce the waiting time for surgery.
- Monitoring of observations to identify deteriorating patients has been improved
- Patient satisfaction surveys in Ophthalmology have led to a notice being placed in the waiting areas to update patients on expected waiting times, and a review of the appointments process is underway

A full list of the actions that The Shrewsbury and Telford Hospital NHS Trust intends to take to improve the quality of healthcare provided can be accessed at:
http://www.sath.nhs.uk/services/audit/default.aspx

During the past year the Clinical Audit Department has run clinical audit workshops for a large number of Trust Staff across all disciplines. These workshops give an overview of the clinical audit process, and prepare staff to carry out their own audits.

The Clinical Audit Forward Plan for 2012-13 has been developed, incorporating both local and national priorities for clinical audit.
During 2012-13 the department plans to involve patient
representatives in the audit projects, to ensure the patient's perspective is considered in all aspects of the process.

Section 2.2.2g
The reports of 61 local clinical audits were reviewed by the provider during 1st April 2011 and 31st March 2012

Section 2.2.2h
The following are examples of actions that have arisen following local audits during the reporting period.

- Staff training has been carried out to assist staff in appropriate identification and support of vulnerable adults admitted to hospital
- Patients being treated on any ward in the Trust who are suspected of having a stroke are referred to the Stroke team and transferred to the Stroke Unit
- Assessment of patients for Venous thrombo-embolism risk factors is now carried out electronically for all appropriate patients
- Audit of treatment of elderly patients admitted with a fractured neck of femur has led to increased cover by specialist doctors and the appointment of a specialist nurse. Work is underway to further develop osteoporosis and falls prevention in these patients and to further reduce the waiting time for surgery.
- Monitoring of observations to identify deteriorating patients has been improved
- Patient satisfaction surveys in Ophthalmology have led to a notice being placed in the waiting areas to update patients on expected waiting times, and a review of the appointments process is underway

A full list of the actions that The Shrewsbury and Telford Hospital NHS Trust intends to take to improve the quality of healthcare provided can be accessed at:

http://www.sath.nhs.uk/services/audit/default.aspx

During the past year the Clinical Audit Department has run clinical audit workshops for a large number of Trust Staff across all disciplines. These workshops give an overview of the clinical audit process, and prepare staff to carry out their own audits.

The Clinical Audit Forward Plan for 2012-13 has been developed, incorporating both local and national priorities for clinical audit.
During 2012-13 the department plans to involve patient representatives in the audit projects, to ensure the patient's perspective is considered in all aspects of the process.

2.2.3 Participation in Clinical Research

This section of our Quality Account describes our participation in clinical research. Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people it serves. Participation in clinical research has benefits for individual organisations and their patients, as well as for the NHS as a whole.

Mandatory statements	The number of patients receiving NHS services provided or sub-contracted by SATH in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 1270

Research is a core part of the NHS, enabling the NHS to improve the current and future health of the people we serve.

How have we done?

The Shrewsbury and Telford Hospital NHS Trust works closely with the West Midlands North CLRN and the Topic Specific Networks to promote a robust research culture. We continue to increase recruitment into studies in a wide variety of specialties.

The number of patients receiving NHS services provided or sub-contracted by The Shrewsbury and Telford Hospital NHS Trust in 2011-2012] that were recruited during that period to participate in research approved by a research ethics committee was 1270.

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

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

Specialty	Total no of studies 2010/11	Recruitment 2010/11	Total no of studies 2011/12	Recruitment 2011/12
Cancer	35	501	33	624
Cardiovascular	4	30	2	47
Gastro-Intestinal	6	112	14	467
Stroke	3	33	3	62
Respiratory	4	23	3	19
Reproductive Health	4	258	3	10
Medicines for Children	5	13	5	16
Renal	2	8	4	16
Surgical	0	0	2	7
Dementia	0	0	1	62
Dermatology	0	0	1	4
Other	4	132	1	49
Totals	**67**	**1109**	**71**	**1384**

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

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

Examples of immediate improvement to practice resulting from involvement in research:

- Introduction of Intensity Modulated Radiotherapy for non trial patients founded on the quality assurance work for radiotherapy trials
- Patient information cards for contra-indicated medications for trial medication extended to none trial patients.
- Facilitated introduction of national guidelines to standard practice when put in place for trial patients.
- Improved referral pathways driven by need to meet tight time frames for trial entry

In the last three years, a number of publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

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

What we will do in the coming year

- Increase the number of national portfolio trials open at The Shrewsbury and Telford Hospital NHS Trust to allow 1600 patients to participate in high quality research.
- Increase The Shrewsbury and Telford Hospital NHS Trust's participation in commercial studies to provide access for patients to new drugs and medical devices.
- Embed the parallel process identified through Lean Working exercises to facilitate the first patient into a trial within 30 days of becoming open to recruitment.

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

This section of our Quality Account describes how the Commissioning for Quality and Innovation (CQUIN) payment framework is used locally. The CQUIN payment framework aims to support a shift within the NHS to ensure that quality is the organising principle for all NHS services. It provides a means by which the payments made to providers of NHS services depends on the achievements of locally agreed quality and innovation goals. For NHS acute trusts, 1.5% of the contract value was dependent on CQUIN targets in 2011/12. This increases to 2.5% in 2012/13.

A proportion of Shrewsbury and Telford Hospital NHS Trust income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between Shrewsbury and Telford Hospital NHS Trust and any person or body they entered into contract, agreement of arrangement within England for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available electronically at http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html. During 2011/12 1.5% of our contract values

No	CQUIN Goal	Achievement
1	VTE. Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE). 90% of admitted patients to have a VTE assessment every month.	Partially met
2	Patient Experience. Improve responsiveness to personal needs of patients. Maintain or improve upon 2010/11 survey results (67.3).	Not met
3	Reduction in falls of patients admitted to hospital. Reducing falls in hospital will reduce unnecessary length of stay and further health deterioration. To achieve this it is expected that trusts will have a falls risk assessment process in place with appropriate care plans. 5% reduction on 10/11 outturn.	Met
4	Tissue Viability-Pressure Ulcers. Admitted patients assessed within 2 hours patients at risk to have preventative/treatment actions documented. Reporting of grade 3 or 4 ulcers, reporting deterioration of grade 2+ ulcers.	Partially met
5	End of Life-Liverpool Care Pathway. Number of admitted patients (identified as at end of life) who had followed the Supportive Care pathway or Liverpool End of Life Care Pathway. 10% increase on 10/11 outturn.	Met
6	Medicines Management. Development of a pharmaceutical care plan for at risk patients. To achieve 50%	Met
7	Maternity. Agreed development related to safer childbirth staffing ratios obstetrician and midwives. To achieve and maintain 100% by Q3	Met
8	Improved Patient Discharge Ready to Go No Delays and EDD for all Inpatients. Effective discharge planning resulting in safe discharge, a reduction in length of stay and excess bed days. To improve on a baseline audit and reduce AvLoS	Partially met
9	Nutrition. Nutritional screening, assessment and delivery of an agreed individual action plan to maintain or improve an 'at risk' inpatients nutritional intake. To improve on Q3 baseline 63%	Partially met

with PCTs in England were based on achievement of 9 CQUIN goals. These are summarised below

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

No	CQUIN Goal	Achievement
1	VTE. Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE). 90% of admitted patients to have a VTE assessment every month	Partially met
2	Patient Experience. Improve responsiveness to personal needs of patients. Maintain or improve upon 2010/11 survey results (67.3)	Not met
3	Access to renal home therapies. 18% of renal patients to be on home therapies	Met
4	Access to Organs for Transplant. To increase the availability of solid organs for transplant within the UK; improving the quality of life for patients with end stage solid organ failure whilst achieving the economic benefits associated with transplantation compared with alternative treatments.	Met
5	Avoiding preventable blindness in neonates. This CQUIN will establish a baseline for screening babies at risk of severe Retinopathy of Prematurity (ROP) and then move towards achieving a 95% screening rate for this high risk group.	Met
6	Improving neonatal care pathways. This CQUIN is to audit of the management of West Midlands babies requiring neonatal services agreed Newborn Network care pathways	Partially Met

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

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

No	CQUIN Goal
1	VTE. Reduce avoidable death, disability and chronic ill health from Venous--thromboembolism (VTE).
2	Patient Experience. Improve responsiveness to personal needs of patients
3	Safety Thermometer. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter.
4	Improve Dementia Diagnosis. Improve awareness and diagnosis of dementia, using risk assessment, in a acute hospital setting
5	Medicines Management. Improving discharge information to GP's - drug regime changes/renal function/ allergies/TTO supplies.
6	Nutrition. Continuation in part from 2011/12.
7	Tissue Viability (pressure sores). Continuation in part from 2011/12.
8	Net Promoter Question. Real time feedback to support the Patient Revolution work as embedded in the SHA Ambitions.
9	Maternity. To achieve Baby Friendly accreditation for SaTH Maternity Service at level 2 by April 2012.
10	Making Every Contact Count. Number of NHS staff completing locally agreed training in delivering brief advice as required to implement the Making Every Contact Count ambition.
11	VTE - prophylaxis.

There are goals relating to renal dialysis and neonatal care for our contract with Specialised Services, summarised in the table below.
Further details are available on http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html.

No	CQUIN Goal
1	VTE. Reduce avoidable death, disability and chronic ill health from Venous--thromboembolism (VTE).
2	Patient Experience. Improve responsiveness to personal needs of patients
3	Safety Thermometer. Improve collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter.
4	Improve Dementia Diagnosis. Improve awareness and diagnosis of dementia, using risk assessment, in a acute hospital setting
5	Implementation of clinical dashboards for specialised services
6	Increasing use of home renal dialysis
7	(Neonatal) Increase effectiveness of hypothermia treatment
8	(Neonatal) Discharge planning/family experience and confidence

2.2.5 Registration with the Care Quality Commission

This section of our Quality Account describes our registration with the Care Quality Commission (CQC), as well as any reviews they have undertaken of our services (either periodic reviews or special reviews). From 1 April 2010 all providers of NHS services are required to register with the Care Quality Commission. Registration provides us with a "licence to operate" to provide NHS services. To be registered, NHS Trusts must show that they are meeting essential standards of quality and safety. Compliance with these standards is monitored on an on-going basis by the Care Quality Commission.

Mandatory statements

The Shrewsbury and Telford Hospital NHS Trust is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken any enforcement action against Shrewsbury and Telford Hospital NHS Trust during 2011-2012 and the Trust is not subject to periodic review by the Care Quality Commission

The Shrewsbury and Telford Hospital NHS Trust has not taken part in any special reviews or investigations by the CQC under section 48 of the Health and Social Care Act 2008 during 2011-12

CQC Responsive Review

The Trust was reviewed by the CQC during an unannounced inspection during November 2011 which formed part of the CQC's annual programme of inspections. Both Hospital sites were reviewed during this inspection with outcomes reported in the table below. The Trust recognised that the care provided in the areas reviewed at that time was not as good as it should have been and developed a detailed and robust action plan which was shared with the CQC and closely monitored by the Quality and Safety Committee. A total of 5 outcomes across both hospitals received a minor concern and 1 received a major concern. The further 6 outcomes were reported at fully compliant.

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

Outcome	Area of concern	Action taken
1	Some delays seen in responding to patient needs Patients needs and wishes not always documented	Comfort rounds implemented once or twice hourly dependent on patient need which record patients needs and action taken
4	Patients needs not always met in a timely manner Assessments and care plans not always personalised or comprehensive	Comfort rounds implemented as above which are audited Full trust wide nursing documentation review commissioned resulting in new comprehensive evidence based patient nursing care records
5	Patients don't always receive the support needed at mealtimes	Protected mealtimes introduced to ensure that staff are always available to support patients
7	Poor communication between teams may lead to safeguarding concerns	External safeguarding investigation now closed by the local authority with allegations partially substantiated. However, significant improvements to care were recognised and commended
13	Poor deployment of staff was reported	Bay based working to increase visibility and accessibility to staff for patients was introduced in the area visited by the CQC

2.2.6. Data Quality

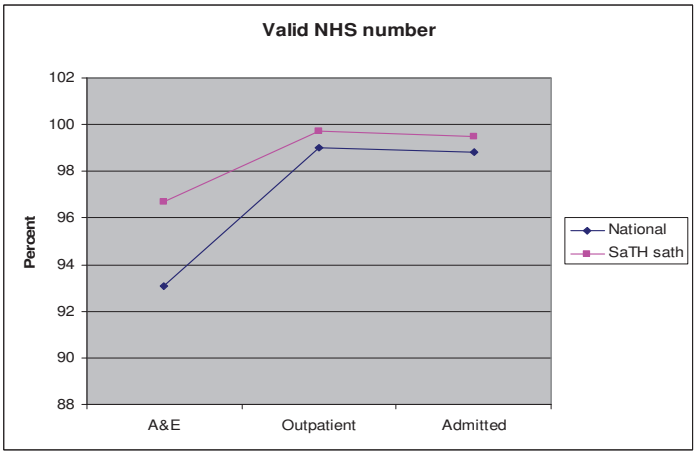
This section of our Quality Account provides information about data quality. Good quality information underpins the delivery of effective patient care and is essential if improvements in quality of care are to be made.

Mandatory statements

During the reporting period April 2011 to March 2012, the Trust submitted records to the Secondary Uses service for inclusion in the Hospital Episode Statistics.

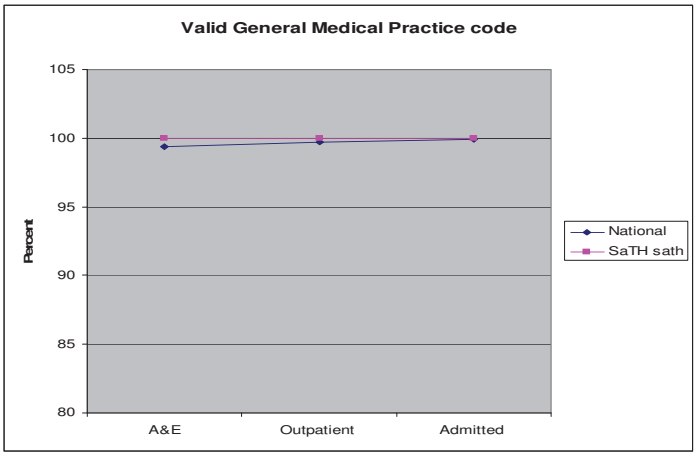
The percentage of records in the published data (based on April-Jan 11/12) SUS data at the month 10 inclusion date) which included the patient's valid NHS number was:

- 99.5% for Admitted patient care
- 99.7% for Outpatient care
- 96.7% for Accident and Emergency care



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

- 100% for Admitted patient care
- 100% for Outpatient care
- 100% for Accident and Emergency



Improvements in Data Quality

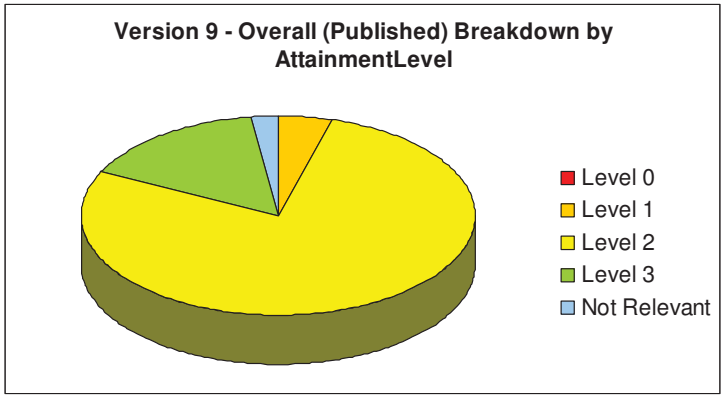
To enable us to comply with these standards and ensure that we make an improvement in our data quality, the Trust has recently established a Trust Data Quality Group. We have established a number of key performance indicators, which are monitored and reviewed by the Data Quality Group, chaired by the Finance Director. There is also a robust system of audit in place in compliance with IG Standard 506, where information is checked between the physical case-notes and the electronic information we keep. This is supported by the Data Quality Audit Procedure and Review of Accuracy of Recorded Information.

The Data Quality Group have also put in a place an Organisation-wide Data Quality Plan & Guidance, which underpins the Trust Data Quality Policy.

2.2.7 Data Quality: Clinical Coding

Mandatory statements	The Shrewsbury and Telford Hospitals was subject to the Payment by Results clinical coding audit during the reporting period April 2011 to March 2012 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were: Primary Diagnosis incorrect 15.5% Secondary Diagnosis incorrect 9.7% Primary Procedure incorrect 9.2% Secondary Procedure incorrect 6.0%

2.2.8 Information Governance Assessment



The IG Toolkit (IGTT) is a self-assessment tool that sets the requirements and standards that NHS organisations need to
achieve to ensure it fulfils its obligations to ensure that information about patients and staff is handled legally, securely,
efficiently and effectively. The purpose of the assessment is to enable organisations to measure their compliance against the
law and central guidance and to provide assurance to its stakeholders. This in-turn increases public confidence that 'the NHS'
and its partners can be trusted with personal data.
The IGTT has recently undergone significant revision which has changed the scoring system and is now divided into two broad categories 'satisfactory' and 'non satisfactory'.
There are six initiatives and 45 requirements, all of which require level 2 to achieve compliance. Although we had an overall score of 70 per cent this year, we did not achieve level two in requirements:

- 324 Pseudonymisation
- 508 Clinical involvement in validation.

We therefore received a 'not satisfactory' score. The Trust will continue to work hard towards improving those areas that were not compliant.

Requirement 324 Pseudonymisation

This is dependent on other requirements being met, providing they are met (and updated on the IG Toolkit before the deadline allowing us time to update the relevant section) then level 2 can be achieved.

Standard 508 Clinical Involvement in Validation

At level 2, it requires us to have clinicians involved in data validation on a regular basis. At present this is not happening, therefore we remain at level 1.

We set up a Clinical Coding Governance Committee in March 2012 which is chaired by the Medical Director and has clinical representatives from each centre as members. One of the remits of this committee is to monitor coding quality by centre. This will be achieved by providing information to centres on a regular basis to include KPIs which will require centres to validate and own their data. The main focus of the committee is to improve recording in source documentation by clinical staff to improve clinical coding. The committee will decide on a strategy to educate and train clinical staff together with a plan for its rollout. Next year we plan to achieve level 2.

3 3.1 Review of Quality Performance in 2011/12

Section 3 of a Trust's Quality Account sets out a review of quality performance during the previous year. It also includes statements from local Primary Care Trusts, Local Involvement Networks and Health Overview and Scrutiny Committees in relation to the quality of services provided in the Trust.

What were our Quality Priorities for 2011/12 and how are we doing?

3.1.1 Performance against our Quality Priorities

In last year's Quality Account we outlined twelve quality priorities for 2010/11. For each priority we have provided a report outlining the work undertaken within the Trust to underpin the improvements required (section 3.2).

Quality Priority 2011/12	Current Status of Priority	Comment
Leading Improvements in Patient Safety		We are making excellent progress towards achieving our target of a 20% reduction in mortality by march 2013 and may achieve this ahead of schedule.
Preventing avoidable pressure ulcers		Although we failed to eliminate grade 4 pressure ulcers (11% reduction achieved) during 2011/12 we did achieve a 37% reduction in the number of grade 3 pressure ulcers. A robust action plan will be implemented throughout 2012/13 to achieve the required improvement. The Trust did achieve its CQUIN target for the reduction of grade 3 pressure ulcers
Reducing Inpatient Falls		Despite a decrease in inpatient falls of 8.5% which exceeded our CQUIN target of 5% we did not achieve the 10% reduction we set in the 2010/11 quality account.. We have re-launched our falls task group who are monitoring falls and implementing measures to continue this reduction to ensure we meet this target. With regard to falls resulting in serious injury we have seen an increase of 11.5% of reported falls in the last year. Whilst the Trust set out to achieve a 50% reduction in falls resulting in serious harm we must also recognise the increased emphasis on reporting falls during 2011/12 which may have contributed to this increase. We will reduce this by March 2013.
Preventing Venous Thromboembolism		We achieved 90% compliance with completing VTE risk assessments for the first time in December 2011and have sustained this improvement for the remainder of the year.
Improving Dignity in Care		We have reported zero breaches of the same sex accommodation requirements to our commissioners. Since commencing our ward to board monitoring in September 2011 we have consistently received a high score for respect and dignity from our patients.
Improving the experience of older frail patients whilst acutely ill		We have developed a frailty model and team working collaboratively with partner organisations that provides a comprehensive service across the frail elderly patient group. We will see the full benefit of this work throughout 2012/13
Improving the care delivered to patients with Dementia or reduced capacity		Significant work has been conducted into the development of a dementia pathway with additional time and resources focused on improving the quality and availability of our training and education for staff.
Improving the Nutritional Status of Patients		Following the implementation of protected meal times a number of audits have already been conducted to monitor compliance along with a full audit programme being planned for the next year.
Improving Patient Access & Waiting Times		A significant improvement in access and performance against 18 week referral to treatment targets has been achieved.
Reducing Delayed Discharges		We have reduced the number of delayed discharges by 50% however will be continuing to work to achieve further reductions during 2012/13

3.1.2 Monitoring Quality

Alongside the detailed priorities in section 3.2, we also monitor quality in a wide range of other ways. Some of our main measures are regularly discussed at the Trust Board and at formal sub Committee's. Some of these quality measures are reported in this Quality Account, so that you can understand some of the work being undertaken and the improvements made. These are set out in section 3.3.

Key Performance Indicators reported and monitored by the Shrewsbury and Telford Hospital NHS Trust based on national and local priorities. The table below reports performance against these against the previous year and overall target where applicable.

No.	Description of Target	10/11	Target 11/12	11/12
Patient Safety Measures				
1	MRSA Bacteraemia (bloodstream) infections *	2	2	1
2	Clostridium *difficile* infections *	68	54	41
3	Surgical Site Infections +++	2.6%	n/a	0.75%
4	MRSA Screening Emergency Admissions +	92%	95%	96%
5	MRSA Screening Elective Admissions +	n/a	95%	91%
6	Hand Hygiene	96%	95%	98%
7	Percentage of admitted patients risk assessed for Venous Thromboembolism (VTE)	40%	90%	91.48%
8	Reducing inpatient falls	n/a	10%	8.5%
9	Safe Surgery checklist compliance	n/a	100%	99%
10	Rate of patient safety incidents per 100 admissions ++	4.1	n/a	6.2
11	Avoiding preventable pressure ulcers (grade 3 & 4)	36	32	20
Clinical Outcome Measures				
12	Hospital Standardised Mortality Ratio (HSMR)	115	105	99 (to Feb 12)
13	2 week wait for cancer referrals	92.35%	93%	97.86%
14	18 week GP referral to first treatment - Admitted	86.67%	90%	94.48%
15	18 week GP referral to first treatment - Non Admitted	68.59%	95%	87.31%
Patient Experience Measures				
16	A&E 4 hour wait		95%	94.52%
17	Responsiveness to inpatients personal needs (maintain or improve) - CQUIN Score out of 100	66.9	n/a	64.3
18	Staff survey - Rating score of staff who would recommend the Trust to friends or family needing care (1-5 scale)++++	3.35	n/a	3.33

* Trust attributable infection cases only
+ Based on admission criteria
++ The Trust this year has made a significant effort to promote the reporting of incidents
+++ Defined basket of procedures
++++ 1 being low, 5 being high

3.2 Update on Quality Priorities in 2011/12

3.2.1 LIPS: Improving Patient Safety at the heart of everything we do

Our ambition is always to Put Patients First. If we are putting patients first then we always provide the right care for our patients. But, all of us know that sometimes the Trust does not get it right.

We reached a major milestone in our journey to make our hospitals a safer place for patients in June 2011, with over 100 clinicians and other hospital staff attending an intensive LIPS course.

Leading Improvement in Patient Safety (LIPS) is about being open about the challenges we face, and getting better at improving patient safety. It aims to give staff across the Trust the passion, confidence, skills and support to eliminate harm to patients.

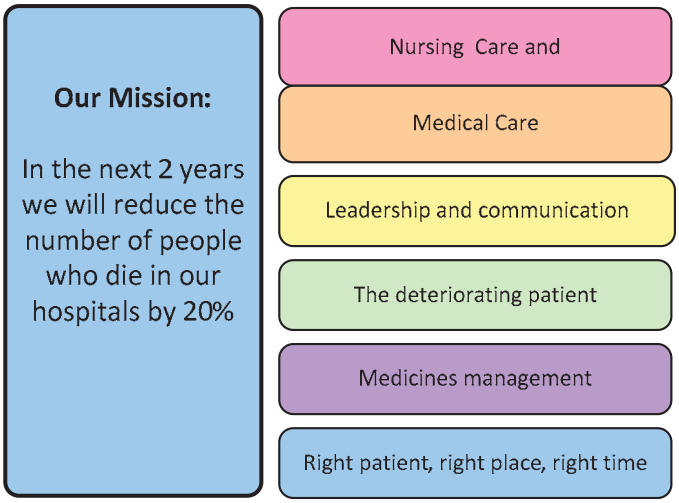
Overall, LIPS as been helping us in the last year to:

- Identify our main priorities for improving patient safety
- Identify the factors that contribute to harm events, so that we can eliminate them
- Develop tools and techniques to make improvements that we can sustain
- Focus on areas that will have the greatest impact and that make sense for staff
- Measure the progress that we are making, so that we can demonstrate and share successes

The week-long event followed our LIPS taster event on 16 March. That event generated a lot of different ideas for improving patient safety. These ideas have been brought together into a high level Patient Safety Plan for the Trust that we are continuing to refine and develop.

The overall mission for the Trust's Patient Safety Plan is to reduce the number of people who die in our hospitals by 20% over the next two years. It focuses on six key themes, or "primary drivers", which are summarised in the diagram on the right.

- an Executive Lead (the Medical Director, Chief Nurse, Chief Operating Officer or Chief Executive)
- two to three "secondary drivers" where we will focus our initial improvement efforts



At the LIPS course, participants worked together in multi-disciplinary groups, each focusing on one of these "secondary drivers". The groups used the tools and skills developed during the course to develop an outline plan for improvement. With support and challenge from a named clinical lead, the groups are now beginning to bring these plans back to the Trust.

Examples of this work are already being shared across the Trust. For example the "deteriorating patient" primary driver groups are beginning to collect data on emergency calls and cardiac arrest calls to help them measure improvements made as a result of their work.

Participants are also bringing the LIPS tools and techniques to other aspects of their work, to help make sustainable improvements.

For each of these "primary drivers" we have identified:

Some key issues that we have developed through the LIPS programme

Preventing Falls: A PDSA cycle (see below) has been taking place on half of the bays on Ward 4 to determine whether the introduction of 'comfort rounds' reduces patient falls. Ward 4 was chosen as this ward recorded the highest number of falls of any ward, between Jan'07 and May'11.

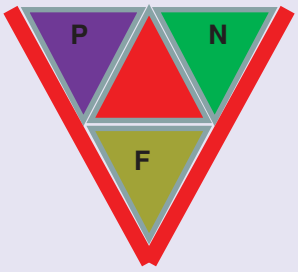
Plan - Undertake hourly comfort rounds in 2 bays asking 4 questions:

1. ***Do you need to go to the toilet?***
2. ***Are you in pain?***
3. ***Do you need a drink?***
4. ***Is there anything else I can do for you?***

Do - Study for 25 consecutive days

Study - Analyse data, comparison with 'control' bays

Act - If successful, roll out to other areas within trust



The Nutritional group focused on the red tray system and protected meal times but combined efforts with the falls group and pressure ulcer prevention to create a symbol of awareness for nurses, where patients were at high risk from Nutrition, falls and pressure ulcers.

Early indications were that the intervention may be reducing the number of falls and also reducing the need for dedicated one-to-one observation of patients. Kim Bromley, Ward Manager commented that since the introduction of hourly comfort rounds, 'the call bells have stopped ringing'. On the basis of this success the Chief Nurse, Matrons and Ward managers agreed to roll this out across the Trust and this has been successfully embedded into practice with positive evaluation from patients and relatives.

Pressure Ulcer Prevention Group: Our first Plan, Do, Study, Act (PDSA) cycle was to review 25 sets of patients notes retrospectively. Using a structure check list we analysed how well staff had documented the SKIN Bundle. SKIN stands for:

S = Surface the patient is nursed on

K = Keeping the patient moving

I = Incontinent assessment

N = Nutritional score assessment

We also checked the recording of the Waterlow skin risk assessment tool along with the height and weight recorded on the nutritional score which enables the BMI to be calculated for a complete nutritional assessment of the patient. Our results showed that there were inconsistencies in all areas of the documentation. We have followed progress carefully and across the Trust have focused on gaining timely and effective documentation which has resulted in a reduction of pressure ulcers at grade 3&4. As reported in the Quality account, we still need to make further improvements. The LIPS model for improvement begins with three questions (see right). Based on the answers to these three questions, everyone can take responsibility for developing plans for improvement. This involves four steps, known as a PDSA:

- **Plan**—identifying the problem and the most likely causes, and identifying potential solutions and how you will measure whether they have been effective
- **Do**—putting your solution into practice and collecting the data that will help you decide whether it has been effective
- **Study**—looking carefully at your data and drawing conclusions
- **Act**—recommending what should be done next on the basis of your conclusions, and putting this into practice.

The LIPS programme will continue and build on the successes of 2011/12 by holding two further cohorts of the LIPS programme enabling clinicians and staff across the Trust to build on the positive safety culture across the Trust.
By building on staff confidence to challenge practice and implement positive change, we are hopeful that we can achieve the overall high level aim of the Safety programme and reduce our mortality by 20% by June 2013.
Our current position by the end of March 2012 is that crude mortality rate had reduced by 11.3%, which means that we are well on the way to achieving the overall aim established at the beginning of the LIPS programme.
The next programme will be held in May 2012 with the Trust continuing to work with the Institute for innovation and Improvement and the Trusts LIPS faculty to support staff with the safety projects that they wish to make.

3.2.2 Preventing Avoidable Pressure Ulcers

The issue and how we made this a priority

Improving both the efficiency and effectiveness of pressure ulcers management has been the goal of the Tissue Viability team, this year the CQUIN targets and the NHS drive for "no avoidable pressure ulcers" have been an additional driving force.

Aim

During 2011/12 we aimed to eliminate grade 4 pressure ulcers and reduce grade 3 pressure ulcers by 50%

Trust Initiatives

A group of staff were tasked to develop actions to develop actions to implement the desired changes. A range of activities were developed to support the initiative:

- A workbook has been developed, that all staff working on adult inpatient wards are required to complete in order to update and improve their knowledge in pressure ulcer prevention and management.
- Root cause analysis was implemented and led by the Chief Nurse for all grade 3 and 4 pressure ulcers that occurred within the Trust. These were supported by the Tissue Viability Team.
- An additional Tissue Viability Nurse specialist was appointed.
- A full review of the nursing documentation within the Trust commenced in December 2011 will result in completely revised assessment documents and care plans being embedded by September 2012.
- Two hourly comfort rounds with repositioning schedule are an accepted part of the nursing care and are supported and monitored by an audit programme
- Documentation in relation to tissue viability and pressure ulcer management is recorded and evaluated on a monthly basis by ward managers/matrons.

Education and Training

Education has been provided both full day study session and link nurse sessions. A total of 92 staff accessed the full day study sessions, and 241 staff accessed the short 1 hour session. Education has also included a Tissue Viability conference

available to all nurses in the county. This provides an opportunity to promote collaborative care with local community Trusts. The tissue viability team have carried out assessments and/or treatment on 1764 patients during the period many of these had pressure ulcers.

Tissue Viability Nurse Specialists have routinely assessed all grade 3 and 4 pressure ulcers within 72 hours of admission advising on management and on many occasions have carried out debridement procedures.

What has improved and what is the evidence?

	Grade 3	Grade 4	Total
2010/11	26	9	33
2011/12	14	8	22

- Pressure ulcers can only be prevented if interventions are implemented rapidly after admission. Risk assessment is the starting point for all pressure ulcer care. Recent audits have confirmed these improvements.
- The Trust database shows that the acquired pressure ulcers for the year 2011/2012 stands at 20 whereas 2010/2011 it stood at 36 which is greater than 10% reduction.
- The Huntleigh audit confirmed the improvement. The prevalence of pressure ulcers within the Trust was 7.53%, 71% of these were superficial (grade 1 and 2). Of the acquired ulcers 1% was grade 3 or 4.
- Risk assessment of patients during a recent audit by Huntleigh showed 90% of patients were assessed within 6 hours of admission to the Trust.
- The utilisation of equipment in the Huntleigh audit showed that 98% of patients had their clinical needs met or exceeded...
- Feedback and training sessions to the band 7 meetings within the Trust plus the items outlined above have helped to raise the profile of pressure ulcers and the need to prevent any unavoidable pressure ulcers.

Continuing into 2012/2013

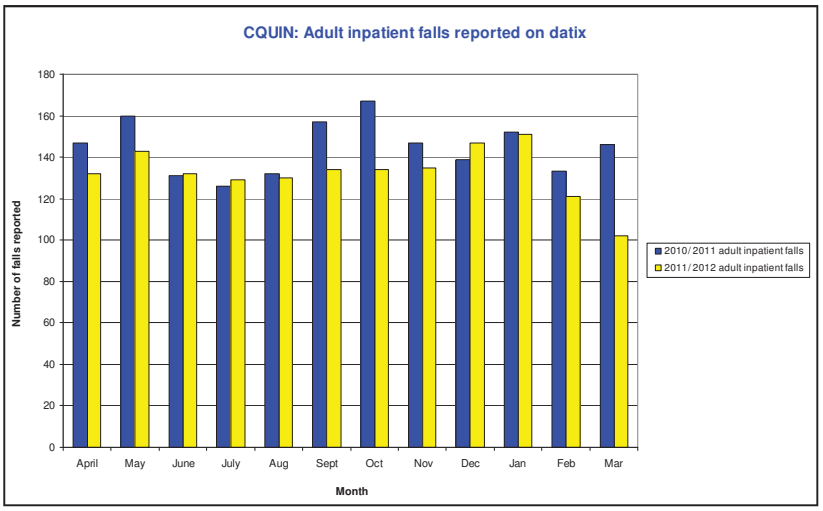
Keeping the focus in this area is vital. Through maintaining education and building on the existing skills of ward based nurses the goal of eradicating unavoidable pressure ulcer can be achieved. During 2012/13 the Trust will be using the following framework to reduce and then eradicate all grade 3 and 4 pressure ulcers;

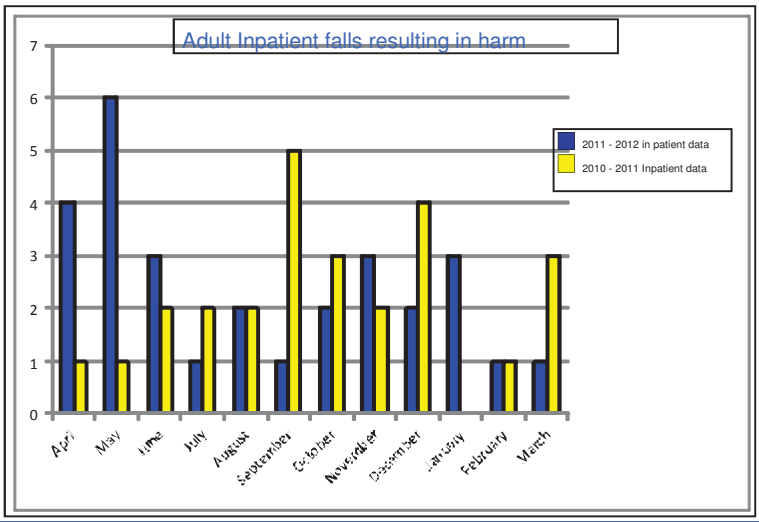
- 95% of registered nurses to evidence completion of the pressure ulcer workbook
- Additional mandatory training day on clinical updates including pressure ulcer prevention for registered nurses
- RCA meetings for all grade 2, 3 and 4 pressure ulcers
- Grade 3 and 4 ulcers treated as internal never events
- Partnership working with community trusts to share expert knowledge of nurse specialists
- Monitoring of pressure area assessment and management through the ward to board survey framework
-

3.2.3 Reducing Inpatient Falls

This year our CQUIN target was a year on year reduction of adult inpatient falls by 5% overall, and our in-house target was a 10% reduction. We also said that we would reduce falls resulting in serious injury by 50%

Last year we recorded a total of 1737 adult inpatient falls (noting that some patients may have fallen more than once). In the 12 months ending March 2012, this year we have recorded 1590, which gives an annual reduction of 8.5%.





In last year's account we outlined a number of measures which we were taking to reduce our patient's risk of falling. The focus for this year has been on embedding those measures firmly across the Trust. This includes a thorough root cause analysis investigation of any incident resulting in serious harm, which is conducted by the Ward Manager and Matron with input from our Patient Safety and Health & Safety Teams. In the year to date, we have reported 29 incidents resulting in significant injury to the Health and Safety Executive and the PCT, and each one has been subject to this process. Action plans following such investigations are monitored by the Trust's Falls Group, which oversees our improvement plans and provides a forum for learning from incidents, spreading best practice throughout the Trust.

Comparable data from 2010/11 shows that we had 26

falls which resulted in serious harm. Year on year, we have therefore increased the number of falls, which breaches our target of a 50% reduction.

We have also undertaken some trials of equipment, such as sensors which alert staff to attend quickly when a vulnerable patient may be trying to walk unaided. The early indications of that trial were that the devices may be of some help in further reducing the risk of falls, and so in the coming year we plan to run a more rigorous trial. We are also planning to evaluate other devices, such as non-slip foot mats and hip protectors, with a view to running further trials. This approach will ensure that we continue to introduce new measures which may reduce our patient's risk of serious injury.

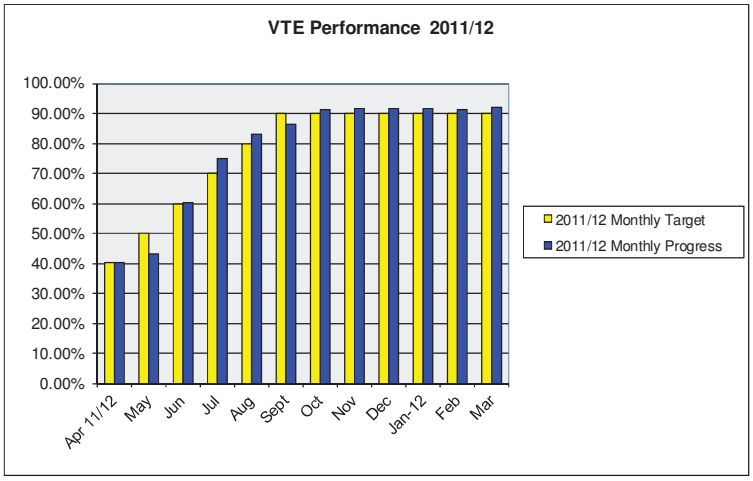
We recognise that we have not done enough to reduce the number of falls. 29 falls resulted in actual harm which we deeply regret and must improve on. We will work with each clinical team, patients and their families to ensure the right level of support and information and care is provided to make the significant reduction needed.

3.2.4 Preventing Venous Thromboembolism

What is the issue and why this is a priority?

At the end of 2011/12, although we were confident that the majority of patients who needed anti-coagulants to prevent blood clots while in hospital were prescribed this, we had failed to comply consistently with completing a risk assessment for required by NICE.

At the start of this year 40% of our patients had a risk assessment form completed against a requirement of 90% of patients having a form completed.



What were our goals for 2011/2012?

We set out at the start of this year to put in place processes and systems to ensure that we achieved the national target of 90% of all patients having a completed risk assessment and the required treatment prescribed.

What have we achieved?

The VitalPac application, which is the primary results recording application on the clinical wards has been developed to provide a simple means of recording that an assessment has been completed and what action was subsequently taken. This has been rolled out across all relevant areas of the Trust.

With senior Clinical leadership from the Medical Director and other Centre Chiefs a process to be followed by all medical staff has been implemented to ensure that assessments are recorded as being completed on VitalPac. In addition the means of monitoring adherence to the process has also been developed and has been rolled out appropriately.

As a result of this we are consistently achieving better than the 90% target required by NICE for all patients recorded as having an assessment for VTE

3.2.5 Improving Dignity in Care

Ensuring that all patients and members of the public using our services are treated with dignity and respect remains a top priority. We had identified a number of goals and key areas for development for example eradicating Same Sex Accommodation and ensuring patients receive adequate assistance at meal times

In 2011/12 we have made good progress in achieving our goals and addressing some of the key areas for development. Despite some significant achievements we still have some way to go before we are confident that all our goals have been reached and the key developments adequately addressed. This means some of the key developments will need to carried over into 2012/2013.

We have continued to raise awareness of the importance of dignity in care through education and by capturing the patient experience in surveys and clinical observations. We have implemented a number of strategies and process to address some of the key issues such as the introduction of Protected Meal Times for all patients and the creation of a Public Engagement and Involvement Board.

Despite a great deal of activity and investment to promote and preserve patients' dignity our overall scoring has remained largely unchanged. The Adult Inpatient Survey results for 2009, 2010 show that we scored 97% for the question *'Did you feel you were treated with respect and dignity while you were in the hospital?'* There was a slight dip in the overall result to 95% for 2011. Furthermore, evidence from the National Outpatient Department Survey (2011) reveal that we were in the bottom 20% of NHS Trust in other key areas such as communicating with patients for example providing patients with sufficient information about their condition and treatment.

Where are we now

Capturing the patient experience and monitoring the quality of care we provide remains a fundamental priority. We continue to use a range of strategies for capturing the patient experience these have included a monthly inpatient survey

Questions we ask as part of the Ward to Board Patient Experience Survey	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012
How clean is this ward (including toilets)?	95%	94%	91%	92%	97%	96%	94%
As far as you know do the staff wash or clean their hands between touching patients?	91%	92%	92%	91%	95%	94%	94%
Do you feel informed about potential medication side effects?	72%	58%	65%	71%	60%	75%	62%
Do you feel you have enough privacy when discussing your condition or treatment with staff?	91%	87%	82%	85%	86%	93%	85%
Do you feel that you have been treated with respect and dignity while you are on this ward?	97%	96%	96%	90%	95%	97%	95%
Do you feel involved in decisions about your treatment and care?	68%	77%	82%	80%	83%	72%	86%
Have hospital staff been available to talk about any worries or concerns you have?	84%	86%	90%	81%	90%	85%	84%
Do you get enough help from staff to eat your meals?	83%	86%	92%	83%	90%	89%	90%
Do you think hospital staff do everything they can to help control your pain?	96%	88%	90%	82%	90%	94%	89%
When you use the call buzzer is it answered?	77%	81%	90%	82%	83%	88%	80%
Have staff talked to you about your discharge from hospital?	32%	50%	61%	52%	55%	41%	62%
Total	**82%**	**83%**	**86%**	**82%**	**85%**	**86%**	**85%**

and detailed ward reviews. These measures have complemented other scheduled inspections and visits that monitor aspects of dignity.

As part of our on-going commitment to monitoring the quality and standards of care we have established the Public Engagement and Involvement Board this will complement existing strategies and process adding an important and independent dimension to the on-going monitoring of the patient experience, the standards and quality of care.
One key innovation has been the introduction of the Ward to Board reporting which commenced in September 2011, this is conducted monthly by Clinical Leads and Matrons. Part of this reporting focuses specifically on the patient experience and issues of dignity reveal that 97% of patients told us that while being cared for on a ward that they had been treated with dignity and respect. Data from the National Outpatient survey (2011) affirms that (94/100) patients receiving care within our outpatient departments stated they were treated with respect and dignity.

The issue of dignity is complex and we are committed to monitoring the nine domains of dignity (Autonomy, Communication, Eating and Drinking. Privacy, Personal Hygiene, Pain, Social Inclusion, Safety and End of life Care) that we have developed as part of our 'Privacy and Dignity Patient Survey.

Same Sex Accommodation

Throughout 2011/12 we have continued to adopt a zero tolerance to mixing men and women. This strategy in conjunction with other operational and environmental improvements has meant that we have achieved Same Sex Accommodation for our included patient areas. In our returns data to our commissioners, there have been no reported breaches and we have achieved 100% compliance in the year 2011/2012

Questions we ask as part of the Ward to Board Patient Experience Survey	Sept 2011	Oct 2011	Nov 2011	Dec 2011	Jan 2012	Feb 2012	Mar 2012
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	100%	99%	100%	97%	99%	97%	98%

Spiritual and religious beliefs

One cannot treat people with dignity and respect unless attention is given to the religious, spiritual and personal beliefs of

Very professional Staff. Sensitive to my need for dignity. Fully informed me of procedure. Excellent service, first class staff.
(Urodynamics and x-ray services)

the individual. Data from our monthly patient survey suggested that the area of religious and spiritual beliefs were being overlooked by staff. One measure taken to address this has been the inclusion of a question in our new nursing documentation that asks about religious, spiritual and personal belief.

During 2011 an internal evaluation of the Chaplaincy Department was undertaken. This review identified that the chaplaincy department are committed to supporting patients, staff and visitors in meeting their religious, spiritual and pastoral needs. However, the evaluation has highlighted areas for improvement such as the adoption of a more inclusive model of chaplaincy that reflects the diverse religious, spiritual and personal beliefs of our community. The review indicated the central role that the chaplaincy department could play in the monitoring and educating of staff in areas related to religious and spiritual care.

What are our goals for 2012/2013?

- Reintroduction of the Dignity Champions Programme so that the importance of dignity in care is cascaded across our organisation and embedded within our Clinical Centres and Departments
- Continue to raise awareness of the Department of Health (2006) 10 point Dignity Challenge monitoring our compliance
- Adherence to the 'Dignity Code' developed by the National Pensioners Convention (2012)
- On-going development of our workforce ensuring staff adopt professional attitudes and behaviours at all times in their interaction with patients and members of the public
- Continue to develop our strategies and processes for capturing and monitoring the patient experience ensuring these are robust and that all areas and departments are included
- On-going education and development of key staff into issues of dignity in care

3.2.6 Frailty Programme

The Vision

The aim of the Frailty Programme is to create an evidence-based integrated model of care for the frail older patient, that is community based, of excellent quality, and keeps to the principles set out below. The vision has been developed from our own experiences as health care professionals and managers, and also from main relevant national documents.

Last year our priority was to focus on Length of Stay for frail elderly patients and improve the patient experience. Work over the last year has focused on establishing the frailty programme and model of care across the health economy. As part of this work the Trust has now established a Frailty Team.

The Shropshire Frailty Programme, led by SaTH NHS Trust, will build partnerships and put in place the infrastructure and processes necessary to deliver integrated services. Key principles will underpin this project:

- Acutely ill, or medically decompensated, frail elder patients will have an individualised coordinated care pathway across the health and social care economy that supports seamless transfer of care between settings.
- Patients will have access to the right person, the right service, in the right setting, at the right time, every time.
- Frail older patients will have access to comprehensive geriatric assessment, including therapy, mental health, and social care services, whether that is in hospital or in the community.
- Whenever appropriate acute care hospitalisation will be avoided, and care delivered closer to or at the patient's home / place of residence.
- Avert crises by providing the right amount of care when needed.
- Reduce the length of a hospital stay when admission is necessary through ensuring rapid access to comprehensive geriatric assessment and management plans, and by coordinating services to ensure a timely, safe and sustainable discharge to the persons chosen place of residence.
- Reduce the need for complex care packages as a consequence of improved quality of service helping to prevent functional decline and dependency.
- Co-ordinate communication by providing a named person for all contact.
- Drive up the quality of care and efficiency of current services within existing resources and identify opportunities for targeted investment.

Improving the assessment and care for the Older Frail Patient admitted to hospital by establishing a frailty team

Care of older people differs from care of middle aged adults. Older people often have more complex multisystem problems, are at increased risk for morbidity and mortality, and need comprehensive interventions that take into account the health and social needs.

Under the leadership and guidance of two Consultant Geriatricians the members of the Frailty Team will identify Frail patients admitted to the Acute Medical Units at RSH and PRH and in a coordinated way undertake comprehensive assessments of these patients' needs. Thereby this team will support patient's medical management, help maintain their mobility, and facilitate their timely discharge. Members of the team include geriatricians, acute physicians,

physiotherapists, occupational therapists, integrated case managers, mental health liaison, and social workers. There will also be coordination of in-reach services provided by community physiotherapists and intermediate care teams.

The Frailty Tool and Comprehensive Assessment for frail older people

The tool has been devised to be used across the health economy to identify Frail patients. It is an easy to use scoring system that reflects patient's age, co-morbidity, polypharmacy, cognitive impairment, sensory deficits, ADL disability, and history of falls.
The components of the comprehensive assessment looks at each aspect of the medical, nursing,, therapist, social care, and environmental needs of the patients during their hospitalisation and for their timely discharge.

Objectives

The Frailty Teams will initially focus their resources on newly admitted Frail patients to the Acute Medical Units, and to those with an Estimated Date of Discharge of less than 72 hours. They will comprehensively assess the patient, devise a management plan, and support this case until discharge. Through effective team working and integration with community services we expect improved patient outcomes, in the form of reduced length of stay, reduced number of patients with greater than 14 day length of stay, and increased proportion successfully discharged within 72 hours. We also expect better identification of patients suitable for our Care of Elderly and rehabilitative wards.

SaTHs Achievements

- Agreed definition of frail elders and implemented frailty tool across health economy
- Introduced Frailty Team comprising of:-
  - ◊ Acute physician, Physio / OT, Social worker
  - ◊ Integrated case manager, Mental health
  - ◊ In-reach intermediate care; community physio
- Introduced daily MDT / board round at 12.00 Mon – Fri on AMU

We expect this team's experiences to be invaluable in helping us design and develop a better Care of the Elderly service for not only patients in SaTH but also for the whole health economy.

3.2.7 Improving the care delivered to patients with dementia or reduced capacity

What is the issue and why this is a priority?

There are currently 750,000 people with dementia in the United Kingdom. By 2021 it is estimated that there will be over 1 million people living with dementia. Our own local data indicates that approximately 68% of our inpatients are aged 65 or over with the majority falling in the 80+ years age bracket. Furthermore, it is estimated that 1 out of 5 of our patients present with some form of cognitive impairment this includes people living with dementia. Therefore, dementia presents us and our local health economy with a great challenge.

The Department of Health (2009) *'Living well with dementia: A National Dementia Strategy'* presents specific objectives required for enhancing the care people living with dementia and their carers should receive across the different health and social care sectors.

Objective 8 concerns us directly: Improved quality of care for people with dementia in general hospitals. Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals.
Findings from the National Audit of Dementia Care in General Hospitals (2011) reveal that hospitals like our own are failing to provide adequate care for people living with dementia and their carers.
We are aware that we have a great deal of work to undertake and despite some of the issues for improvement highlighted in the audit we are committed to ensuring that people living with dementia entering our hospital receive care that is person-centred and of the highest quality. This is not a small undertaking as it will necessitate us embarking on a programme of education and service improvement ensuring our workforce and services are designed so that we become a dementia friendly hospital.

Where are we now

Our priority is to achieve the objectives outlined in the National Dementia Strategy (2009) and those contained in the Shropshire National Dementia Strategy Steering and Implementation Group Priority Action Plan 2011-2013. We have signed up to the composite model of dementia care advocated by the West Midlands Strategic Health Authority
We have appointed a Professor in Dignity of Care for Older People as our Dementia Lead and the Trust's Clinical Lead for Elderly Care and Stroke Medicine has been identified as our senior clinician who will be leading on the quality improvement in dementia care.
A local Action and Implementation plan has been developed addressing the following key themes:

- Identification and screening of people with dementia
- pathway development: Minimising transfers of care

- a new model of care for people with dementia
- Use of volunteers to capture the patient and carer experience through patient stories
- Nutritional assessment and support
- Mental Health Liaison
- Awareness raising through posters, teaching sessions for staff and patient information

Education, Training and Information

We have laid the foundations for achieving the key priorities outlined in the local action and implementation plan. We appreciate that improving the care of people with dementia including, diagnosis, treatment and on-going care is complex and challenging requiring a multi-layered approach necessitating on-going collaboration with colleagues from across the full health economy. We realise that these improvements will take time, resource and a sustained commitment to change.

As part of our dementia care pathway we have agreed with the Shropshire health economy that we will all use the Wigan 'Passport – Who I am' to enable us to provide a coherent and coordinated person-centred approach to care. We have incorporated the 'The New Cross Hospital, Wolverhampton' dementia reach out care bundle standard within our hourly comfort rounds. The dementia reach out care bundle focuses staffs' attention on communication, eating and drinking and the environment ensuring that people with dementia receive a high standard of care that is inclusive and non- discriminatory.

As part of our objective to capture information on the number of people with a confirmed diagnosis of dementia and those who may have an undiagnosed dementia we have revised our nursing documentation. This now incorporates a section titled National Dementia Screening that asks specific questions about dementia and acute confusion.

Our desire to work more in partnership with carers is reflected in the revised nursing document which now contains a number of questions asking whether the carer of someone living with dementia would like to be involved in their care and the extent of that involvement.

During 2011 we embarked on a programme of education and training to raise awareness of dementia among our staff. We commissioned the Faculty Health, Staffordshire University, to run a number of half day and full day workshops at Royal Shrewsbury Hospital and Princess Royal Hospital. In addition, some nursing staff undertook a module titled 'Understanding Dementia' promoting knowledge and skills around caring for people with dementia and their carers. Attendance at the workshops has been varied but we are committed to finding innovative ways to raise awareness of our staff in the care of people with dementia.

An information leaflet has been designed and developed by colleagues within The Faculty of Health Staffordshire University, as part of our on-going campaign to break down barriers and dispel myths and misconceptions associated with dementia.

What we need to do more of

We now need to achieve all the key priorities presented in the local action and implementation plan in a timely and comprehensive manner. There is a need to establish a local steering group to oversee and monitor the local action and implementation plan.

We undertake to review the local action and implementation plan on a monthly basis and the current version will be placed on our website so that progress can be monitored and viewed by the general public.

Continue to work with colleagues across the Shropshire health economy to develop a seamless pathway of care for people living with dementia and their carers.

We have signed up to participate in the forth coming National Audit of Dementia Care in General Hospitals. This will enable us to review progress made and to benchmark ourselves against similar hospitals throughout England

Key areas for on-going development

We will establish a working group of key staff to develop a local policy for the transfer and discharge of people living with dementia.

Making environmental improvements that may facilitate the care of people living with dementia. Therefore, we will convene a Task and Finish group to explore the feasibility of adopting some of the environmental improvements undertaken at New Cross Hospital within our ward environments. We will continue to audit medical and nursing documentation to identify that nutritional assessments are being performed for all people with dementia and confusion and that a plan of care has been developed and implemented.

What are our goals for 2012/2013?

- Raise awareness of dementia challenging myths and misconceptions, in our own organisation, and the wider community.
- Ensure that people with dementia are treated in a person-centred way which supports their physical and cognitive well-being whilst in our care.
- Develop an explicit care pathway for the management and care of people with dementia
- Work with carers of people with dementia as partners in care ensuring that they feel involved in decision making and the caring relationship.
- Support the implementation of the Shropshire National Dementia Strategy Steering and Implementation Group Priority Action Plan 2011-2013.

3.2.8 Improving the Nutritional Status of Patients

What is the issue and why did we make this a priority?

National-Recognition in the Ombudsman report into the care of the older patient demonstrates that hospitals do not provide adequate nutritional and fluid support.

Local-We recognise that all patients need to be supported to maintain their fluid and nutritional intake whilst in hospital. This supports their recovery and outcomes.

About one in three adults (up to 50% surgical and 44% medical BAPEN – the British Association for Parenteral and Enteral Nutrition) show signs of malnutrition on admission to hospital, and their condition is often made worse while they are staying in hospital. Therefore we must do everything we can to ensure our patients are getting the right nutrition and hydration to help them get better.

Protect all patient meal times to ensure they get the support and time to enjoy their meals and drinks.

The trust made a commitment to introduce the protected mealtime philosophy which focuses not only on the quality and nutritional value of food, but also on the patients' experience of eating. The ward environment, presentation, colour, aroma, taste and texture of food are all important elements in encouraging patients to eat well, even those with the poorest appetites, but however high the quality of food the patient also needs peace and quiet and if unable to feed him/herself to have assistance.

The Trust introduced the protected mealtime service to help **all of our patients** to get the most from the food and drink they are given.

This new Protected Mealtime service was launched at the Royal Shrewsbury Hospital and Princess Royal Hospital on 6 February 2012 .

- Posters and leaflets were distributed and displayed to provide information to both patients, visitors and staff about the new protected mealtime service so that everyone is aware of how they can help to support this initiative.
- Staff have also be consulted regarding changes to ward routines to make sure that they had a full understanding of what was expected of them
- Photographic ward signs of the ward manager holding their protected mealtime for their wards are now on display at the ward entrances to let people know when a protected mealtime is taking place.
- A protected mealtime policy is now in place and is available to see
- The principles of protected mealtimes is now included in the induction and statutory training for staff.
- A code of Practice on Protected Mealtimes is displayed in each ward Kitchen

For patients who need assistance with their eating and drinking, we have not always supported them as much as we could do and need to ensure a consistent approach to how we support them

It is well documented that well hydrated and nourished patients get better more quickly and have a shorter length of stay in hospital.

We have a responsibility to make sure patients under our care are appropriately nourished and hydrated- Patients need food and drink which is fundamental to the care and recovery process.

We also need to make sure we are giving our patients the right environment in which to spend their mealtimes, and all the support they might need to eat or drink.

In order to introduce good Nutrition and Hydration practices it is necessary to know the patients at risk. Once Patients have been identified as being at risk, appropriate interventions can then be introduced and monitored.

Our intentions which are included in the Protected Mealtimes policy

- every patient who needs assistance with feeding is identified and receives their meal at the correct temperature
- the Menu card is ticked to identify assistance and support is needed
- **Red trays** are provided for patients requiring assistance. Food served on a red tray provides an effective signal to staff that the patient needs assistance with eating and drinking.

For patients that are identified as "at risk" we must ensure that a care plan to support their needs is in place

At the end of 2011/12, 79% of patients who were identified as at risk on our nutrition screening tool, had a care plan in place. This included a food record chart, provision of snacks, and a high energy menu.

What do we need to do next?

Since the introduction of Protected Mealtimes on the 6th February 2011 a number of protected mealtimes audits have been carried out to monitor compliance and identify areas that can be highlighted as examples of best practice, and areas that may need to make improvements. These audits will continue as part of an on-going monitoring programme. This process will allow the Trust to make sure the new system is working effectively and that our patients are getting the care and support they require in the right environment.

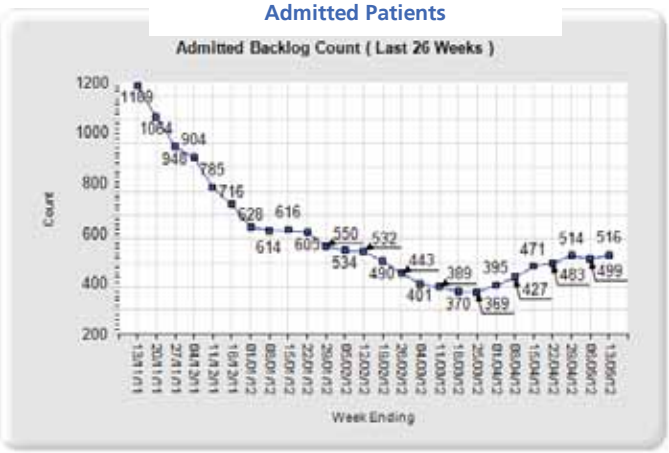
A summary report on Protected Mealtimes will be produced annually which will be shared across the clinical centres and with the Quality and Safety Committee

As part of this monitoring process, patient representatives from the PEIP will be joining the audit team assisting in the protected mealtimes audits as specified in the panel work plan which will include actively seeking patient feedback.

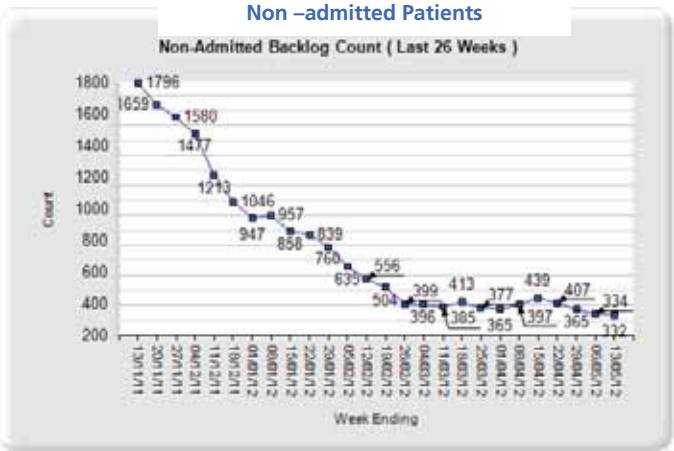
3.2.9 Improving Access and Waiting Times

Why was this a priority?

Admitted Patients



Non –admitted Patients



The Trust recognised through discussions with our Clinicians and on reviewing the number of complaints relating to access and waiting times that patients were waiting for unacceptably long times for appointments, treatment and procedures. We committed to reducing this to achieve national waiting time requirements.

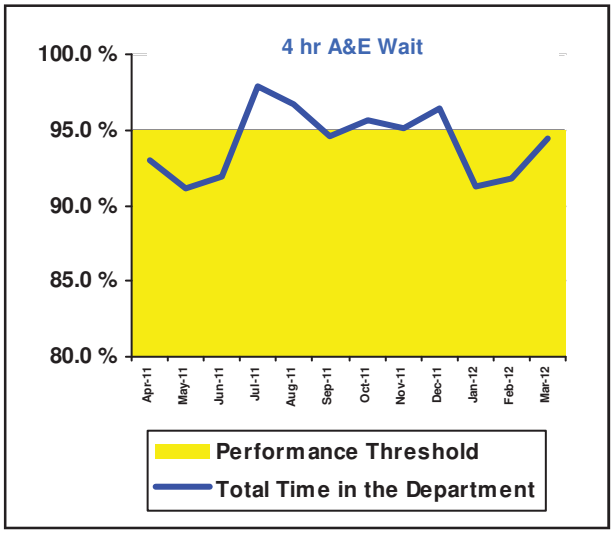
The centres have worked with the Intensive Support Team to review and increase the capacity required to deliver the Referral to Treatment Time 18 week target. The first stage of delivering this target was to treat patients from the backlog that had built up.

Outpatients

The Non Admitted (Outpatient) backlog at it height 2011 was over 4000 patients.
The chart below shows the progress made over the six months in treating and reducing the number of patients who are waiting an unacceptably long time for their outpatient's appointment.

The centres have worked with the 18 week team to improve the systems that are used to track patient's pathways of care and to ensure that waiting times are kept to a minimum.

Throughout 2011/12 there has been an increase in the outpatient capacity. We achieved the outpatient 18 week target by the end of March 2012.



Inpatients

The Admitted (Inpatient) backlog at it height in 2011 was over 1500 patients.
The chart below shows the progress made over the six months in treating and reducing the number of patients who are waiting an unacceptably long time for their Inpatient admission and treatment.

Through 2011/12 there has been an increase in the inpatient capacity.

Future Work

Work will continue with the Intensive Support Team to further develop and refine the capacity and demand models with each of the centres to ensure there is the correct balance between the capacity of the service and the demands in terms of the number of patients requiring services.
The programme of work has already started on ensuring we have the most robust administration systems possible to track patient pathways will continue. The next phase of this work is to develop a diagnostic tracker to ensure patients receive their diagnostic test at the right time.

I owe an enormous debt of gratitude to the consultant and his entire team of surgeons, doctors and nurses and I shall never forget the extraordinary kindness and consideration they showed towards me during my two weeks on their ward. Thank you – each and every one of you. (ITU and W28)

3.2.10 Reducing Delayed Transfers of Care

Why is this a priority?

We aimed to reduce the number of delayed transfers of care during 2011/12 in comparison to 2009/10.. By reducing the delays in our acute environment we aim to improve patient outcomes and experience and assist in improving flow through the hospital, ensuring patients benefit from being treated in the right place for their clinical needs.

Where are we now?

We are working more closely with local health and social care partners, and have reduced the delayed transfers of care by 50%. Between July and October 2011 we achieved the national target of no more than 3.5% of inpatients and improving flow through the our hospitals. Between October 2011 and March 2012 we did not achieve the national target, however we have rectified this reduction in performance and now comply again with the national target.
There is greater emphasis and understanding by hospital staff of the need for robust discharge planning, with more patient family involvement, underpinned by the implementation of the BED bundle, the key themes of which are:-

Board round—by the senior doctor on every ward
Expected date of discharge—that is discussed and agreed with the patient and clinical teams
Discharge before 10am—which ensures capacity on the wards for patients requiring admission

The Frailty Team are developing pathways for the assessment and treatment of acutely ill frail elders, improving co-ordination with community services to support timely discharge/transfers of care, where appropriate.

Our delayed transfers of care rates have reduced significantly during 2011/12 to an average of 33 compared with 61 in 2010/11

What are our plans for 2012/13?

Ensure implementation of 7 day planning for discharge.
Ensure the discharge process is clear for the patients and their families by reviewing our discharge policy and patient information leaflets

What will this work achieve?

Reduce the number of patient moves within the hospital as flow improves
Continue to reduce the numbers of delayed transfers of care, improving the discharge experience for patients and their families

My mother suffered a stroke and was unable to respond, talk or move. Thanks to the quick thinking and treatment provided by the RSH my mother is going to be walking out with only a little attention needed to her speech and language….. The experience of the RSH has been exceptional, without exception all members of the stroke team from the Consultants to nurses, Physios, OT, Speech and language etc. have been incredible! I cannot thank them enough. (Ward 22S – Medicine)

3.3 Other Quality Monitoring and Improvement Measures in 2011/12

3.3.1 Hospital Standardised Mortality Ratio (HMSR)

Understanding mortality and how do we measure it?

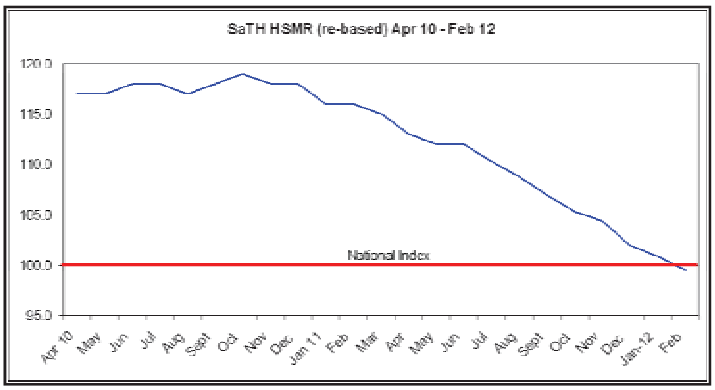
With the type of acute care a hospital such as ours provides it is expected that some patients will die. We actively monitor our mortality rates using three measures:

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

Standard Hospital Mortality Indicator (SHMI)		
2011/12	**Jul 10-Jun 11**	**Oct 10 - Sept 11**
111.21	110.51	108.6

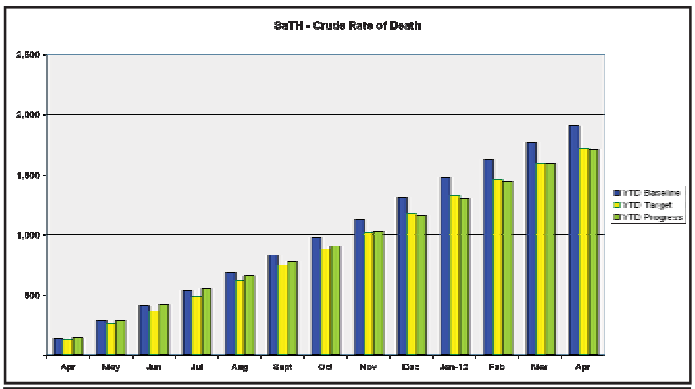
Table. Standard Hospital Mortality Indicator (first 2 data points)

Graph. Trust Progress — Hospital Standardised Mortality Ratio



(1) The Hospital Standardised Mortality Ratio (HSMR) compares the number of expected deaths with the number of actual deaths. The HSMR is based on the diagnosis that lead to 80 percent of all deaths and are adjusted for factors statistically associated with hospital death rates. Severity of illness is an important factor and methodologies allow for this by using a measure of co-morbidity (Charlston index) which looks at a number of secondary diagnosis and scores them according to severity.

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



Graph. Progress v target — Crude Rate of Death

What were our goals during 2011/12

During 2009/10 we identified that our Trust had a significant increase in the HSMR and were highlighted as an outlier in the 2011 Dr Foster hospital guide. In the 2010/11 quality account we reported that mortality was a priority for the Trust and that significant Improvements had been made, but that there was still much to do.
In early 2011 we set ourselves 2 objectives:

- Reduce our HSMR to the National index by October 2012
- Reduce our crude mortality by 20% by June 2013

Where are we now?

We have made significant progress in reducing mortality at Shrewsbury and Telford Hospitals and this is evidenced across both Trust Board reported measures, in addition the new SHMI measure is also following in line with the HSMR downward trend.

The crude rate of death has been reduced by 11.3% year to date against the same period last year. This equates to 185 less deaths than last year and is ahead of our target for this year. The progress against our HSMR objective is also very positive with our last HSMR being 102 against a national index of 100. This indicates that we are well on track to achieve our objective ahead of schedule. It is early days to derive meaningful trends from the new SHMI measure but it is in line with our HSMR for the last data point and we expect this to reduce in line with our HSMR.

What more can we do?

Although the evidence above is indicating that we have made significant improvements over the last year we must continue to improve. The key measures of HSMR and SHMI are both measures against a national benchmark so is therefore set against a continually improving mortality rate Nationally. The Trust must improve further just to maintain the position we have now achieved.
The main areas of focus will be:

Systematic review of all in hospital deaths.

Over the last year we have completed a number of separate reviews of patient deaths in order to ensure we understand areas of improvement. As a result of this many changes have been made including the provision of a much more Consultant delivered service, especially out of hours as well as improvements that enable the right care to be delivered at the right place by the right person.

By the end of March 2012 we will have completed a pilot for a process that enables us to review 100% of our in hospital deaths in a systematic way. The aim is to have rolled this mortality review process out across the hospital by the end of April 2012.

Clinical "Bundles".

Reviewing 100% of our in hospital deaths will enable us to target specific areas for improvements. The approach we will take to deliver these improvements will be through the use of clinical bundles. These bundles are specific actions that need to take place to treat specific clinical diagnosis and have been proved to be very effective when used elsewhere.

Co-ordinated approach across the West Midlands

It has been agreed that mortality will be a focus across the whole of the West Midlands area. Led by the Medical Director for the SHA and supported by the Cluster Medical Directors we will co-ordinate our approaches to reducing mortality and share learning that is derived. To enable this there are bi-monthly forums where all acute providers meet to share and learn from each other.

3.3.2 Reducing Healthcare Associated Infections

Healthcare associated infections go to the heart of public confidence in the NHS and it remains a focus for the Trust. The Trust was successful in achieving its target for Methicillin Resistant Staphylococcus Aureus (MRSA) bloodstream infection during 2011/12, however it is vital that this issue is still given the highest priority in our hospitals.

Whilst we did achieve our target for Clostridium difficile (C.diff), we recognised that we could make further progress to achieve "zero preventable infections".

It is more difficult for hospitals providing emergency care to completely eradicate infections such as MRSA bloodstream infections. This is because some patients may be admitted as an emergency who have an infection already. However, when this happens it is vital that we provide them with dedicated care that treats their infection and reduces the risk of spread to other patients.

What were our goals during 2011/12?

Our goals during 2011/12 were to continue to improve infection prevention and control, and specifically:

- To reduce the annual number of post 48 hour MRSA bloodstream infections to no more than 2
- To reduce the annual number of C.diff infections in patients over age 2 to no more than 56
- Following the extension of MRSA screening, review the impact of this programme and make plans to extend this further
- Maintain our focus on hand hygiene, building on the progress to date, and continue our involvement in hand hygiene projects
- We will maintain our registration with the Care Quality Commission and continue to build on our own internal programme of environmental compliance monitoring to identify and share best practice.

What we did well

We continued to focus on key interventions to prevent cases of healthcare associated infections.

MRSA

Identifying any gaps or weaknesses through continued Root Cause Analysis on each case of MRSA bloodstream infection. This has lead, for example, to alerting clinicians to the importance of correct antibiotic use before surgery in patients with a history of past MRSA carriage.

We are reducing all MRSA infections, not just the bloodstream infections, by reducing the chances of patients picking up the bacteria in the first place.
We do this by screening all our emergency and elective admissions for MRSA apart from those in very low risk groups such as most paediatric and obstetric patients.

Clostridium difficile

Tight control on antibiotic prescribing helps us reduce resistance. All prescriptions of antibiotics are audited against the antibiotic policy by ward pharmacists, and any non compliance is brought to the attention of the prescribing doctor. The two antibiotic pharmacists take part in the C.difficile ward rounds with the consultant microbiologists

Hand Hygiene

All areas carry out Hand Hygiene audits at least fortnightly.
These audits are reported monthly and shared with the rest of the Trust. Hand hygiene compliance is a key performance measure and is displayed on ward notice boards.
The Trust has regularly achieved its 95% target score for hand hygiene compliance.

What more do we need to do

Each year, the Infection Prevention and Control team produce, and work to, a clear programme of work. For the coming year, our focus will be on:

- Monitor compliance against MRSA screening, providing local support to areas of poor performance..
- Look in detail at root causes in order to reduce the annual number of post 48hr MSSA bloodstream infections
- Look in detail at root causes in order to reduce the annual number of post 48hr E.coli bloodstream infections
- Focus on decontamination of instruments/equipment outside of CSSD

3.3.3 Patient Services

Staff were so caring, with a 'nothing too much trouble' attitude. It gave one an "at home" feeling which is quite special I think, following an operation.... I have to say the level of care given at your Hospital was exemplary and in my wife's and my opinion is the model that any other hospital should aspire to..(Surgery)

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

In 2010/11 it was reported that the complaints process was being developed to focus on becoming more patient-centred. More complainants were offered and accepted opportunities to attend meetings to discuss their concerns. Work has continued through 2011/12 to provide a more robust and timely complaints process with the focus being on the quality of responses and increased expectations on Clinical Centres (created in October 2011) to assist in the resolution of complaints. The aim is to provide a more consistent approach to complaint investigations and to find new ways of successfully handling complaints.

In addition to offering meetings to discuss the outcome of complaints, more cases are being identified as likely to benefit from an early meeting, pre-dating a written reply. These cases are picked up at the point of triage and include cases where there is a recent bereavement, on-going inpatient care, post-natal issues and complex admissions. Whilst it is a challenge to arrange meetings at short notice, this is proving to be a helpful approach and can also aid the on-going investigation as issues are clarified and prioritised at the meeting, and some issues are immediately resolved.

In respect of the quality of responses, a two-fold quality assurance process has been introduced that seeks to identify both grammatical and contextual inconsistencies in the response as well as any issues with clinical rationale. This process is helping to identify the areas of investigation and case handling that require improvement and has indicated that some cases would have benefitted from a single clinical overview to consolidate conflicting clinical opinion. In addition, some cases re-opened as unresolved, have benefited from a case review that has retrospectively identified shortcomings in the investigation process further informing the changes being made to the complaints process.

2011/12 has involved an increase of 3.5% in the number of complaints accepted for investigation compared with 2010/11. It was apparent that a backlog was building during 2011 as the closure rate fell behind the level of new cases received and staffing in the Patient Services team was insufficient to manage the active caseload efficiently. Following a number of changes in process and additions to the team, the closure rate for complaints has picked up significantly in Quarter 4 achieving a significant improvement on previous quarters. 222 cases were closed in Quarter 4 compared with 156 in the same period in 2010/11, an increase of 42%. 81 cases were closed in March 2012, which was the highest level of closures achieved in 2011/12. In the last three months of 2011/12 the closure rate has been consistently increased by the Patient Services team.

As was reported in 2010/11, when investigated, the root cause of many issues complained about continue to involve communication problems that have resulted in misunderstandings and unnecessary anxiety. Many of these concerns relate to mismanaged expectations about when a patient will be seen or reviewed by clinicians and in respect of information about diagnosis and treatment. On-going training needs around communication is regularly included as part of the outcome of complaint investigations and is key to avoiding a repeat of these complaints.

Feedback also continues to be received via a number of avenues, including the Trust's website, patient feedback websites, the complaints email address (which was introduced in late 2011) and via the PALS team (Patient Advice and Liaison Service). Feedback consists of not only complaints but also comments and suggestions, concerns and compliments. All feedback is disseminated to the relevant staff for their information and action as required and is acknowledged by either the Patient Services team or the Chief Executive.

Comments and Compliments

In 2011/12 1,962 contacts were handled by the PALS staff and about 800 compliments were received during each Quarter.

	2010/11	2011/12
Total number of complaints	712	737
Response within 6 months (26 weeks)***	98.5%* (95.4%)**	99%* (96.8%)**
Cases referred to PHSO	41	47
For (on-going/further) local resolution	10	14
No Further Action – confirmed	28	24
Referrals resolved with intervention	2	0
Referrals accepted for investigation	1	0
PHSO referrals upheld against the Trust	0	1 (2010 investigation)

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

There are a number of reasons why a complaint may not result in a substantive response within six months of receipt. In respect of timescales in general, there needs to be a scale that allows for prompt turnaround of straightforward concerns and longer more detailed investigation for complex cases.

Top 3 Complaint categories	2010/11		2011/12
Inadequate medical care	104	Care, monitoring, review delays	153
Waiting times for appointment	93	Appointment problems	126
Attitude	78	Communication with patients/carers	80

Top 3 Areas for complaint	2010/11		2011/12
Outpatients	196	Outpatients	190
A&E	63	A&E	78
MAU RSH	30	Car Park	25

Ratio of complaints to activity

Quarter 1	2010/11	2011/12
Patient Activity	131,231	207,057
Number of Complaints	172	164
Rate per 1,000 spells	1.31	0.79
Quarter 2		
Patient Activity	132,692	213,717
Number of Complaints	201	171
Rate per 1,000 spells	1.51	0.80
Quarter 3		
Patient Activity	131,626	216,492
Number of Complaints	157	200
Rate per 1,000 spells	1.19	0.92
Quarter 4		
Patient Activity	138,279	221,181
Number of Complaints	172	202
Rate per 1,000 spells	1.24	0.91

Complaints activity compared to overall patient activity is reported slightly differently in this year's Quality Account as it is reported in relation to patient spells rather than finished consultant episodes, which accounts for the variance in year on year data

Education and training continue to be a priority

Education and training of staff, remains a priority. Privacy and Dignity training has been provide and established as a central component of the Health Care Assistant Study Days. It has been introduced to the medical staff and provided as part of the Foundation Year 1 Training programme. Privacy and Dignity training has been provided to wards on request. All the training raises awareness of dignity in care encouraging staff to reflect upon their own attitudes and behaviours.

We continue to raise our profile and commitment to this area an on 12th May 2011 we held a very successful conference 'Dignity in Care Conference: Because it Matters' at the Shropshire Education and Conference Centre with over 200 delegates attending. They listened to experts in the field of dignity in care to Angela Rippon reflect upon on her experiences of caring for her mother with dementia. The conference was well evaluated and achieved an important aim of raising awareness of dignity among our own staff and others working in health and social care.

What we need to do more of

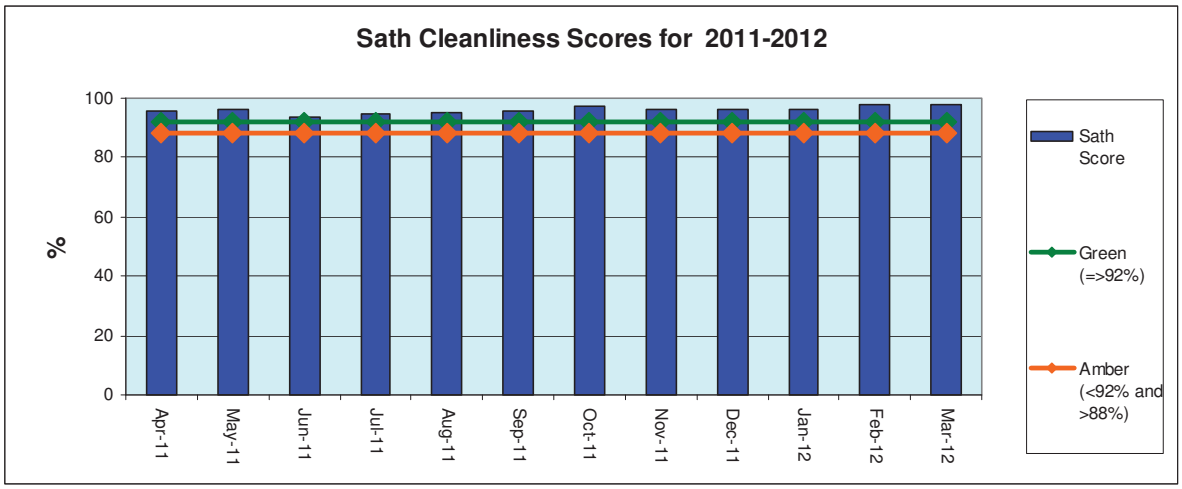
Ratings from a variety of external sources reveal that we continue to score similar to other hospitals across England. Yet, despite a great deal of progress and some significant improvement we need to continue to strive for excellence so that everyone using our services feels that they are always treated with dignity and respect.

We are acutely aware that staff are our most valuable resource and that they need to feel valued and that they feel treated with dignity and respect. Therefore, we need to continue to listen to their concerns and respond to the questions that they raise, fostering an open and supportive culture where everyone feels valued and their contribution to the care of patients recognised and respected.

Key areas for on-going development

We will reintroduction the Dignity Champions Programme across all our clinical centres and departments' ensuring that dignity continues to be embedded within our culture.
Review outstanding improvements from the 2010/2011 Quality Account ensuring these are addressed as a priority during the coming year. Areas to be addressed are; introducing measures to reduce the disturbance of noise at night for patients; ensuring patients have an opportunity to talk to a doctor about their condition; for patients to feel involved in decisions about their care; discharge planning and having sufficient information.
We will explore other strategies for awareness raising and disseminating good practice. Therefore, we will revisit the workshop material developed by the Health and Social Care Advisory Service to establish whether the self-directed study guide can be completed by all key frontline staff working in our organisation
Ensure that the eight (nine) domains of the privacy and dignity survey are monitored monthly through the ward to board reports and that an in-depth quarterly Inpatient Privacy and Dignity survey is completed.
There is a need to ensure that the result of all our dignity surveys are acted upon, meaning action plans are developed, remedial action taken and feedback provided to all our stakeholders and user groups.
We need to ensure that all our patient experience data that addressed dignity in care are reviewed and integrated. This will remove duplicity and ensure that all the different elements and work streams diverge providing an in-depth insight into the overall quality of the patient experience and standards of patient care.

2011 - 2012											
Quarter 1			Quarter 2			Quarter 3			Quarter 4		
Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12
95.51	96.44	93.78	94.41	95.09	95.92	97.41	96.27	96.51	96.41	97.83	97.74



Patient Environment Action Team (PEAT) Inspections

Cleanliness, food and privacy and dignity will continue to be monitored via our monthly PEAT inspection programme which

Area of Performance:	Environment and Cleanliness
Metric (Method of Calculating Performance):	Environments/Cleanliness as assessed by the Environment Action Team (PEAT) including a Patient Representative and PEAT Validator

We are pleased to report the following scores for Environment, Food and Privacy and Dignity for 2011 for each of our sites

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

will include a representative from the Patient Experience and Involvement Panel.

Cleanliness and Hygiene

Audits of environmental cleanliness standards in wards and other hospital areas are undertaken by the Domestic Services Monitoring Team. Our cleanliness scores are measured against the National Standards of Cleanliness and have remained high at 96.11% for the year. A breakdown of the scores can be found below:-

3.3.4 Patient Safety

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

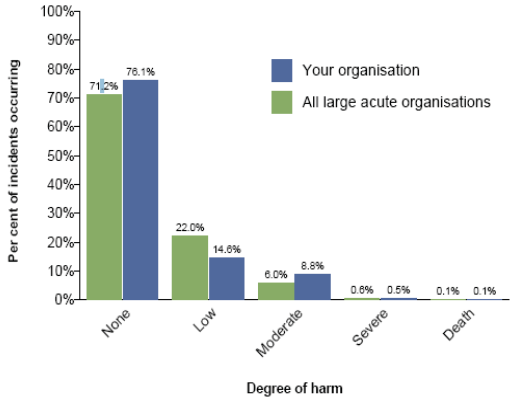
Many of these trends and themes have now been placed as priorities for improvement in this and previous Quality Accounts. Some of these are in are the improvements required with patient falls, reducing pressure ulcers and other patient safety issues such as timely response to the deteriorating patient, waiting and access times for treatment.

Nationally, 71% of incidents are reported as no harm and just under 1% as severe harm or death. However, not all organisations apply the national coding of degree of harm in a consistent way which can make comparisons of harm profiles of organisations unreliable. SaTH has a reporting rate of 76% of incidents being reported as 'no harm'. The reporting of severe harm or death is consistent with national reporting.

In 2011/12 reporting to the National Patient Safety Agency (NPSA—via the NRLS) is a voluntary system (except for certain categories of very serious incidents), but is considered good practice. The Trust reports incidents to the NRLS regularly throughout the year. This allows the Trust to compare SaTH's reporting rate to other Trusts within the large Acute Trust cluster.

The number of incidents uploaded to the NRLS has reduced slightly from the previous report however, this is a national trend. The Trust has overall, improved performance in reporting compared to other large Acute Trusts demonstrating a shift from the bottom third of reporters to the top third.

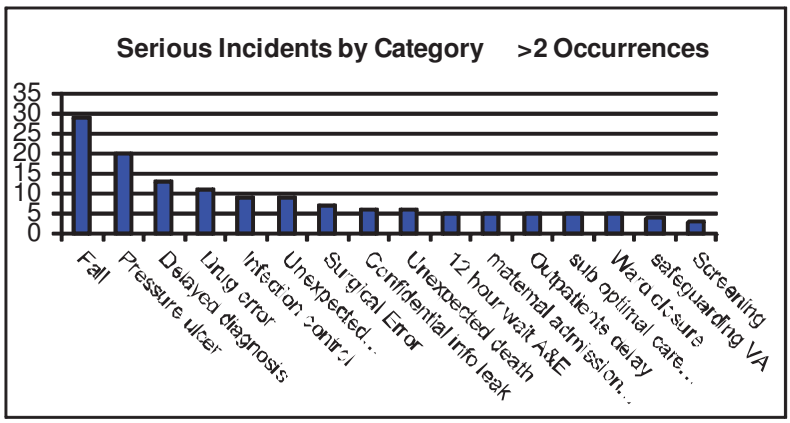
Figure 3: Incidents reported by degree of harm for large acute organisations



Your figures:	None	Low	Moderate	Severe	Death
	2,830	543	327	17	3

Serious Incidents

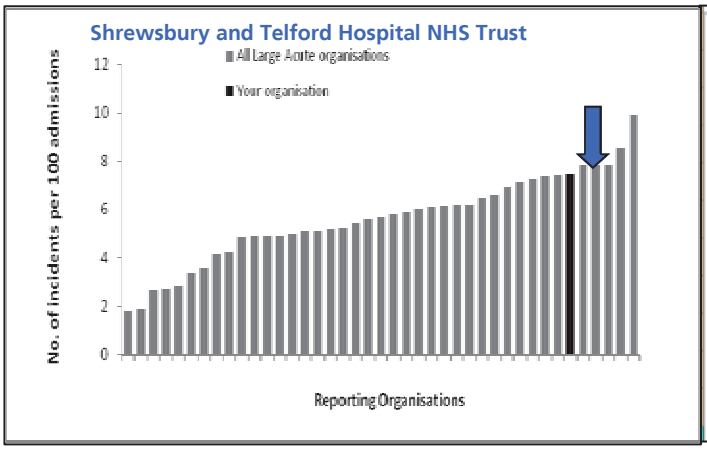
Since January 2011 the Trust has encouraged the reporting all incidents using the Datix system and emphasised the importance of reporting Serious Incidents (SI). This has been reflected in an increase in the number of SI's reported year-on-year. Trends and themes within the Serious Incidents are monitored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



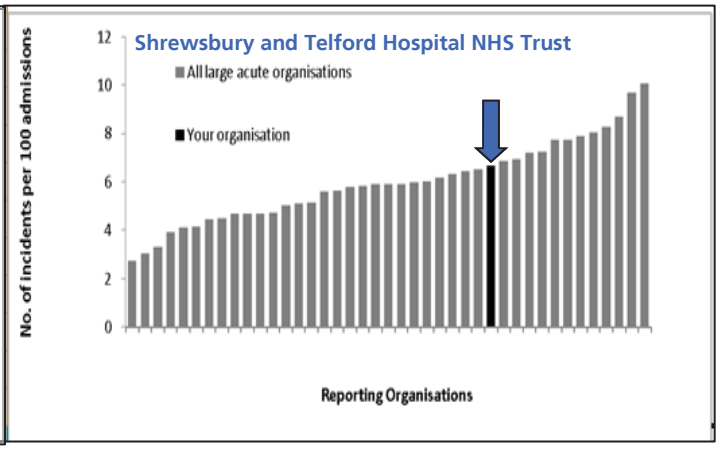
In 2011/12 the Trust reported 158 (**up to End Feb 2012) Serious Incidents of which 7 have been categorised as Never Events (1 to be discussed with PCT/SHA for downgrading). The increase in Never Events is consistent with a national trend and is linked to an increase in the number of categories of Never Events from 8 to 25. There has however been an unusual trend in the reporting of wrong lens implantation at the Wrekin Community Clinic (ICAT) which has resulted in a very direct and focussed approach to addressing concerns and influencing safer practice.

In line with policy each Serious Incident is investigated fully with an RCA and action plan for improvement.

2010/11 Incidents per 100 Admissions



2011/12 Incidents per 100 Admissions



3.3.5 Cancer Value Stream

If cancer is suspected, this can be a very anxious time. Rapid access to diagnosis and tests not only reduces the period of uncertainty, but there is also evidence that early diagnosis can improve outcomes.

This is why last year one of our goals was to improve the trust's performance against cancer waiting times standards. The national requirements against which the trust are monitored on are as follows:

- **Any cancer suspicious patient, or patient with Breast Symptoms will be seen within 2 weeks of referral.**
- **Any cancer treatment will occur within 31 days of a decision to treat.**
- **62 day standard referral to treatment target can begin at: GP Referral, Cancer Screening Referral or Consultant Upgrade.**

In the past financial year the trust has become compliant with all of the cancer waiting times targets for the first time since they were changed in 2009.

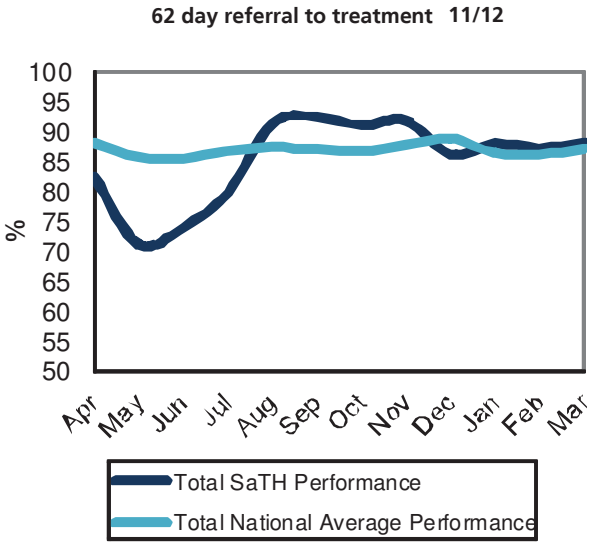
There is a graph below to show our performance against the 62 day GP referral to treatment target for the last 12 months, which historically the trust has found most difficult to achieve, against the average performance across the country:

How did we do this?

Firstly we have improved our ability to track patients through their pathway, with more robust information available to the clinical teams. As a result of being able to provide this information the teams have been able to improve the time scales treatments and tests are available to patients. There have been significant improvements in waits for suspected cancer patients in almost all areas of the trust.

In the past 12 months we have introduced an escalation policy to highlight areas of concern to the timeliness of treatments for cancer patients. This has been implemented with great success and has seen a significant improvement in performance.

The clinical teams have over the last year been able to review their cancer pathways in order to identify unnecessary delay in patient journeys.



Some Clinical teams have held 'around the table' talks, looking at the patient pathway from G.P. referral to treatment. The teams identified which steps benefit the patient and add value to the pathway. The outcome is a more streamlined patient pathway.

The trust is participating in the national cancer patient experience survey for 2011-12 and will compare these results with the previous survey to highlight areas of achievement and share across disciplines but also consider areas of concern and work toward improvement. We expect to receive these results during the summer of 2012.

The Cancer Clinical Nurse Specialists within the trust work closely with patient support groups and regularly assess local patient experience as part of the Peer Review process.

Tracking Team Discussing an Escalated Patient

What are the Cancer Value Stream's Aims for the Next 12 Months?

As a department we are aiming to:

- Further Improve Waiting Times to be consistently above the national average
- Implement internal targets related to patient's diagnosis
- Improve data quality.
- Improve information available to the clinical teams
- To participate in the national Peer Review process and address issues identified in the course of this quality evaluation.
- To work with the Clinical Commissioning Groups (CCG) to continue to provide a safe, high quality, cost effective service for cancer patients.

Within the trust we are working closely with Macmillan Cancer Support on developing our delivery of patient information and will be appointing a Macmillan Patient Information Manager in the near future.

Throughout all of my visits to the Chemo and Radiotherapy units, I always found the staff to be most courteous and respectful. They were both very highly motivated teams that were obviously very happy in their work and nothing was too much trouble to them.(Oncology)

Linear Accelerator (LINAC)

The Radiotherapy Department requires two Linear Accelerators in order to meet current demand however the 2100CD is approaching the end of its clinical life (10 years) in June 2012.

In Shropshire, the population is growing by about 0.6% per year and that demand for radiotherapy is increasing. The Radiotherapy Department requires two Linear Accelerators in order to meet current demand. One of the existing machines requires replacement so that Trust undertook a full options appraisal exercise to evaluate future options. In order to meet the objectives of the Improving Outcomes: A Strategy for Cancer, healthcare provision in Shropshire must deliver access to the highest quality of cancer treatment and ensure that capacity plans meet requirements to achieve access targets for cancer services.

A replacement Linear Accelerator has been approved and will be funded through the Trust's capital programme in 2011/12 and part from 2012/13. This new machine will not only provide additional capacity but will also provide an enhanced level of service through the provision of Intensity Modulated Radiotherapy (IMRT) and Image Guided Radiotherapy (IGRT).

Intensity Modulated Radiotherapy (IMRT)

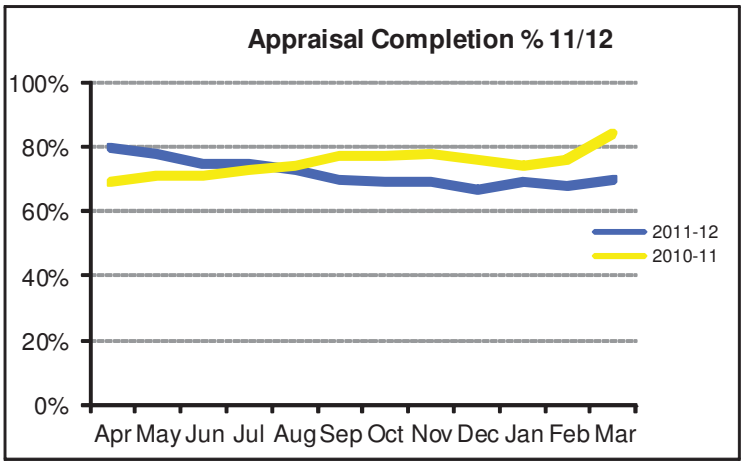
This is an advanced type of high-precision radiotherapy that utilises radiation producing equipment, such as Linear Accelerators to deliver precise radiation doses to a malignant tumour. Treatment is planned using CT images to create several intensity modulated beams coming from different directions to produce a tailored dose distribution that maximises the dose to the tumour and prevents damage to adjacent normal tissues. The intensity of the radiation dose can also be varied within the tumour volume, to create complex dose distributions. With IMRT, the ratio of dose received to normal tissues to tumour dose is reduced to a minimum; this may allow higher, and therefore potentially more effective, radiation doses to be safely delivered to tumours with fewer side effects compared with conventional radiotherapy techniques. This now means that 97% of all Linear Accelerators in England have the technical capability and licences to deliver IMRT.

Image Guided Radiotherapy (IGRT)

NRAG technical development subgroup recommended that four-dimensional (4D) Adaptive Radiotherapy is the future standard of care for radical radiotherapy treatment. 4D radiotherapy takes into account tumour volume in three dimensions and changes with time (4th dimension). Image acquisition during treatment sessions (IGRT) may help to reduce uncertainties about changes in tumour geometry Adaptive therapy allows the treatment set-up and dose delivered to be changed as necessary during a course of treatment. Intensity modulated radiotherapy (IMRT) is likely to be used in conjunction with 4D adaptive radiotherapy.

New Cancer Centre

The Lingen Davies Centre for Oncology and Haematology will be completed in autumn 2012. This £4.8m Centre, funded entirely by public subscription will provide state-of-the-art facilities for patients in Shropshire and mid-Wales. The Oncology Day Centre opened in April 2012 and has capacity to provide 24 treatment stations. The Haematology Day Centre opens in August 2012 and has capacity to provide 10 treatment stations. This will facilitate the planned migration from inpatient to day treatment and from hospital-based to community-based treatment wherever possible.



3.3.6 Workforce

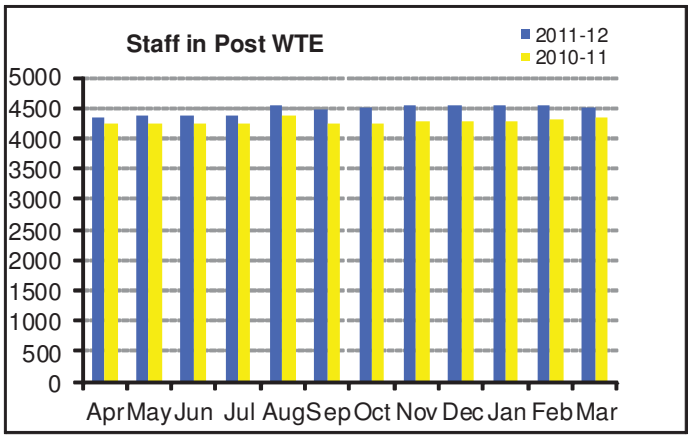
Over the last twelve months, following extensive consultation with all staff, a clinically-led Centre management structure was introduced which puts clinical leadership at the heart of the Trust and supports our guiding principle that "everything we do is organised around putting patients first". This structure has been designed to ensure that high quality patient care is our priority and that all of our resources and efforts are focussed on that principle. Whilst still in its infancy, we are able to demonstrate that this structure has a positive impact on patient care.

Following the appointment of a Workforce Director in October 2012, the Trust has taken steps to ensure that we are able to provide a positive employment experience for all our staff throughout the employment cycle. To support our service aims and to ensure the future sustainability of SaTH as a Foundation Trust, we are currently developing a Workforce Strategy which will enable the Trust to recruit and retain a well motivated workforce whose values and behaviours support our principles. Key features of our strategy will centre around further strengthening our leadership capability and capacity, putting in place health and wellbeing programmes and improved staff engagement processes (Listening into Action).

The Trust's Staff Survey results this year were not good compared to the national average and we aim to address this in the

next year. In March we are carrying out an Organisational Culture Assessment which will involve asking every employee to comment on what they think about the way we all behave, relate to one another and organise ourselves. The results of this will help to inform us about where we are now and where we would like to be in the future. We can then put in place initiatives that address those priorities that are important to our staff.

Significant work has been put into ensuring we improve patient flow within our hospitals and at the interface with primary care. The Trust has recognised that the number of inpatient beds we hold is high when compared to the top performing trusts in the country and has a strategy in place to improve patient flow (Bed Bundle), which will facilitate improved patient care, better use of resources and a permanent reduction in the number of beds. As part of this ward establishment work we are reviewing our nurse to bed ratios, using dependency and acuity rates as part of this assessment. A detailed workforce plan has been developed for this project which identifies a reduction in the number of nurses and nursing support staff required. Work is already on-going to achieve this reduction, with staff being allocated to vacant posts elsewhere in the Trust, supported by training and buddying programmes. We are working closely with our staff-side colleagues and have a detailed communications plan in place to support this.



We are continuing our work to develop the Trust's full business case for the reconfiguration of hospital services within the County by April 2014. If approved, this will mean significant changes in Women, Children's and Surgical services, directly affecting around 630 employees and indirectly impacting on a further 1230. A detailed workforce plan is being developed as part of the full business case which will highlight the implications and risks to delivery of the plan. Again, we are working closely with our staff-side colleagues and with those affected by these changes to ensure that the workforce is well supported and remains well motivated. We have in place communication and engagement strategies and the Trust is running a series of workshops designed to help those who manage and are affected by change to respond and deal with it more effectively.

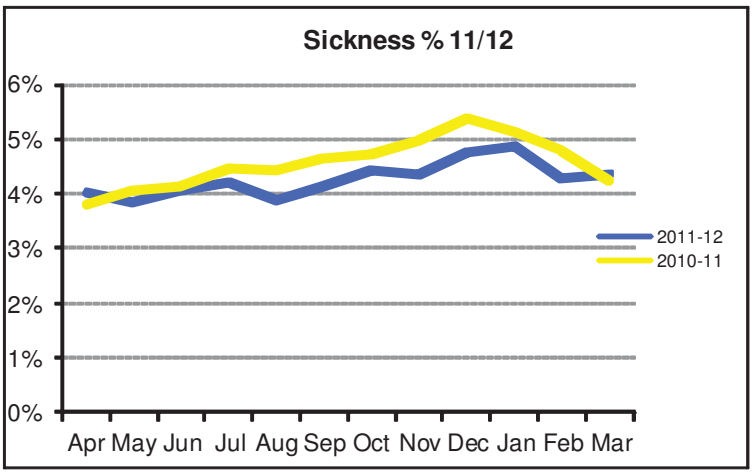
In order to ensure that the impact of bed reconfiguration and reconfiguration of hospital services on other clinical services is taken into account, a multi-professional approach has been taken with the engagement of representatives from all areas, as well as our staff-side colleagues.

We are using a range of tools to help to ensure that we have the right workforce in place to deliver high quality patient care. We have used Quality Impact Assessment to ensure that proposed changes in our workforce numbers and skill mix do not in anyway compromise the quality and safety of our services and have used a number of nationally recognised and internally developed tools to assist in development of our workforce plans. These include:

- Birthrate Plus
- Standards for Nurse Staffing in Critical Care
- Standards for hospitals providing neonatal intensive and high dependency care
- Department of Health (DH) (2009) Toolkit for high quality neonatal services.
- National Institute of Clinical Excellence (2010) Standards for Specialist Neonatal Care.
- Royal College of Nursing (2003) Defining Staffing Levels for Children's and Young People's Services.
- Royal College of Nursing (2010) Guidance on Safe Nurse Staffing Levels in the UK

Royal College of Obstetricians and Gynaecologists (RCOG) (2008) Standards for maternity care: report of a working party. Available from www.rcog.org.uk
Royal College of Paediatrics and Child Health (2011) Facing the Future: A Review of Paediatric Services. Available from www.rcpch.ac.uk

The appointment of a Workforce Planning and Transformation Manager (due to start April 2012) will also enhance the Trust's ability to ensure effective workforce planning and assurance, aligned with patient safety, quality care and financial performance.



Reduction in the levels of sickness management is a high priority for the Trust over the next year. Our current sickness absence rate is 4.26% (down from 4.57% last year) and we have set a target of 3.39% to be achieved by 31st March 2013. A number of strategies are being used including health and

wellbeing programmes, improved staff engagement processes (Listening into Action) and a revised sickness management policy. We also have strategies in place to reduce agency spend, including the roll out of E-rostering to enable better deployment of ward staff and the introduction of the Trinity electronic bank management system. Improvements in patient flow and the bed reduction programme will increase nursing capacity, enable better use of resources and reduce reliance on agency staff

Training and Development

Staff education and training continues to be a key component in the organisation's ability to ensure consistently high quality patient outcomes.
During 2011 we:

- Introduced a Leadership Academy with tailored programmes for senior and middle grade leaders
- Introduced Centre Knowledge Hubs to ensure that staff had improved access to data and information and research about developments in clinical care
- Improved our ability to provide line managers with accurate data about staff take up of statutory and mandatory training
- Enabled approximately 80% of staff to take up opportunities for work-related training and development
- enabled approximately 140 staff to complete vocational qualifications in subjects such as Care, Physiotherapy and Occupational Therapy support

During 2012 we will:

- provide tailored training courses and materials to support staff through change
- continue to improve our attendance at patient and personal safety related training
- Launch the National Learning Management System to enable staff to access e-learning more easily
- review our training and development provision and link it more explicitly to our Trust values of Putting Patients First
- Support medical staff to prepare for their new revalidation process
- Introduce a coaching skills programme to improve line manager skills
- Support the introduction of new clinical roles with underpinning training and competency frameworks

		CQC Inpatient Survey 2011		CQC Inpatient Survey 2010
		Published April 2012		Published April 2011
		502 patients who were inpatients in June, July or August 2011		444 patients who were inpatients in June, July or August 2010
	Score	Comparison with other Trusts in England	Score	Comparison with other Trusts in England
The Emergency/ A&E Department	8/10	ABOUT THE SAME	7.6/10	ABOUT THE SAME
Waiting lists and planned admissions	6.3/10	ABOUT THE SAME	6.4/10	ABOUT THE SAME
Waiting to get a bed on a ward	8.3/10	ABOUT THE SAME	7.7/10	ABOUT THE SAME
The hospital and ward	8/10	ABOUT THE SAME	8.1/10	ABOUT THE SAME
Doctors	8.3/10	ABOUT THE SAME	8.4/10	ABOUT THE SAME
Nurses	8.4/10	ABOUT THE SAME	8.4/10	ABOUT THE SAME
Care and treatment	7.3/10	ABOUT THE SAME	7.2/10	ABOUT THE SAME
Operations and procedures	8.2/10	ABOUT THE SAME	8.3/10	ABOUT THE SAME
Leaving a hospital	6.5/10	ABOUT THE SAME	6.7/10	ABOUT THE SAME
Overall views and experiences	5.6/10	ABOUT THE SAME	6.4/10	ABOUT THE SAME

3.3.7 CQC Annual Inpatient Survey

An initial review of the ratings we have achieved show that we are about the same as other hospitals in England . We have shown significant improvement in two areas both relating to how quickly we move patients into a bed on a ward
There are four areas where we need to demonstrate improvement, relating to the patient bedside environment, the quality of the food, information we give to our patients about their medication and who to contact if a patients condition deteriorates after discharge.
Whilst in some areas our performance had declined or improved our overall trust performance was still "about the same" as other hospitals.

The key areas for development are :

- Ensuring patients are given the opportunity to discuss their discharge with a member of clinical staff
- Ensure patients are given information about their medication and potential side effects
- Ensure that the patients are given information about what to do and who to contact if their condition deteriorates after discharge
- Improve the quality of the patient experience in relation to the food offered at mealtimes

There are a number of initiatives which have started or will start during 2012 which aim to improve the patient experience at SATH.
These include:

- Observations of Protected mealtime on ward areas
- Observation of both the implementation of protected mealtime on a ward and the whole patient experience relating to the food service, which will form part of an on-going monitoring programme
- Real time patient feedback— The Matrons collect real time feedback from patients on our wards on a monthly basis ,

From the very beginning to my discharge the next day I was overwhelmed by the care, dedication and absolute professionalism given not only to me but also to every other patient, some very elderly and very ill indeed…….. I salute them all and wish them to know how proud the people who have actually received their care are of our NHS – unbeatable in my opinion and their efforts valued beyond words. Thank you. (Emergency and Critical Care)

using a collection of patient experience and nursing care indicator metrics called the ward to board framework.

- The following question is asked of 10% of our patients at the time of patients discharge. " Would you recommend this service to friends and or family? "
- Observations of care
- Teams of 2 including PEIP members and Corporate Nursing observing care delivered in clinical areas. Providing direct feedback on positive experiences as well as any issues which may need to be addressed. Feedback will go directly to the clinical department and a summary to the Quality and Safety Committee
- Patient Environment Action Teams (PEAT) Inspections
- A monthly review of patient environments , against nationally agreed standards . Identifying areas of good practice and acting on those that require improvement
- A comprehensive review of the nursing documentation has taken place which will serve to better inform the patient experience and ensure that a patients dis charge is informed , timely and effective. New documentation and care plans will be embedded across our wards by September 2102 .
- The re introduction to the trust of a Patient Information Panel , which applies robust processes and quality assurance monitoring to all written information provided to patients

3.3.8 CQC Annual Outpatient Survey

The national CQC Outpatient survey conducted for 2011 was reported February 2012.
The trust overall performance in relation the eight domains questioned was about the same as other trusts in England , and the overall performance had also improved to 8.7/10 in 2011 compared with 8.5/10 in the 2009 survey.

Overall the trust performance has remained largely constant but some domains surrounding patient information, patient choice and involvement in care have shown a downward shift since the last survey. Key themes surrounding the engagement of the patient in the outpatient process have emerged

- Patient information
- Information about waiting times in the Outpatients Department
- Involvement in care choice/treatment
- Explanations given to patient about tests
- and treatments

In considering an improvement plan it is proposed that the next step will be to disseminate results across the organisation and to draw up a Corporate and Clinical Centre action plans to address the areas of concern.
There are a number of initiatives which have started or are planned for 2012 which aim to improve the quality agenda in terms of the Outpatient patient experience at the Shrewsbury and Telford Hospital NHS Trust.
These include:-

- Environmental audit conducted by Audiology Outpatient department
- This will deliver improved patient signage and a visual standard for notice boards within the department
- Real Time patient feedback in the Outpatients
- Department the Royal Shrewsbury Hospital and Princess Royal Hospitals
- Patients will be asked to tell us "how are we doing " in relation to the Dignity Challenge by using a graffiti board
- OPD Unannounced Observation of Care conducted at Royal Shrewsbury Hospital
- Report given to OPD Matron for delivery of action plan to address issues raised OPD Patient experience has been included in the Booking and Scheduling programme to deliver improvements to the patient environment.
- Including improved signage across OPD
- Real time waiting time displays for patient information
- Improved patient facilities such as increased number of water fountains and possible vending machines
- Patient Information standards developed for all patient information displayed
- An action plan to address the key themes identified in the survey will be developed which will encompass the steps taken so far and the actions required to deliver the improvements to patient care

CQC Outpatient Survey 2011 Published February 2012 500 patients who attended an outpatient appointment in April and May 2011		
	Score	**Comparison with other Trusts in England**
Before the appointment	7.2/10	
Waiting in hospital	4.8/10	
Hospital environment and facilities	8.7/10	
Tests and treatment	7.9/10	
Seeing a doctor	8.5/10	
Seeing another professional	8.6/10	
Overall about the appointment	8.1/10	
Leaving the outpatients department	6.3/10	
Overall impression	8.8/10	

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

Shropshire Local Involvement Network

The Shropshire LINk welcomes this Quality Account as a commendably clear and honest report of the excellent improvement work carried out by the Trust during 2011/12. Huge progress has been made to address difficulties with patient waiting times and mortality rates, which are now in line with national expectations.

The Trust's priorities for the coming year are focused on patient safety, patient experience and clinical effectiveness. The LINk recognises that this work will led inevitably to better outcomes for patients and we therefore strongly support it.

We look forward to involvement in the Trust's work to improve care of vulnerable patients, including those with dementia or learning disabilities.

We note that many, though not all, measures of patient experience have improved during the last year and we look forward to seeing further work to address some areas of concern.

The LINk is passionate about patients being involved in service design from the beginning, and in Trusts engaging with patients by facilitating the provision of feedback, such as through Patient Opinion online, to improve services. We look forward to progress in this area.

Overall, we believe the Trust has made real improvements in the care and treatment of the people of Shropshire in 2011-12.

Telford and Wrekin Local Involvement Network

We agree that this is one of the most important documents that the Trust produces and so are very pleased that it has succeeded in capturing the energy and focus that has been applied by the Trust to drive quality improvement in the last twelve months. In our view the Trust has succeeded in presenting complex information about services in ways that can be more readily understood than in previous year's reports. It also manages to convey a sense of urgency and a determination to improve the quality of care provided.

The effort that has been put into this third Quality Account is appreciated as the way the information is presented and the attention paid to using plain English and avoidance of terminology and acronyms, has resulted in a report that most people will be able to read with relative ease. However although considerably more accessible, in our view it is still likely to be too challenging for the general public to read from cover to cover and we would ask the Trust to produce not only a summary version but also an Easy Read summary.

In order to engage the public in the debate we feel that the report would be of greater interest if it could provide a more coherent overview of the range of services provided, in addition to the priorities for improvement and the CQUINN targets. A few key facts that help to illustrate the scale of operations e.g. how many outpatients and inpatients passed through its doors, the number of babies born, the range of services available etc. and some 'human interest' stories which highlight the difference made to the quality of life for the local community would also aid readability and engagement as well as inform discussion about the impact - and the ethics - of how diminishing resources are being prioritised.

Over the last twelve months the Trust has also worked hard to involve more patients in helping it identify and resolve more issues; our representatives feel that they are listened to and valued. The Patient Experience and Involvement Panel is performing a very important role making it crucial that it involves a broad range of community interests. In next year's Quality Account we would like to see evidence that the PEIP is involving young people, parents of young families (especially young parents), family carers, people from black and minority ethnic groups and people who are lesbian, gay, bi-sexual and transgender which we would be pleased to work with the Trust to help overcome the barriers to involvement that these groups can sometimes experience..

We can confirm that in the last twelve months several mechanisms have been introduced to improve safety and quality and that these seem to be working well particularly LIPs, comfort rounds, protected mealtimes and ward to board reports. We have been impressed with the openness and transparency displayed by the Trust, its willingness to investigate concerns and receptiveness to review its practices where feedback suggests that a different approach may improve outcomes.

We were pleased to see that the Trust has set some ambitious and challenging targets including the elimination of preventable pressures sores by March 2013 and significant reductions in the number of falls, especially those which result in serious harm as it was disappointing to know that the targets set last year hadn't been achieved. We understand that this may be in part due to improved reporting but would have liked to be told more about why pressure sores and falls are continuing to occur at all given that they are preventable. We are concerned that this may be due to lack of basic nursing skills and/or limited capacity as patients often report that it takes too long for assistance to arrive when they call for help. However, we know that the Trust now carries out risk assessments to identify patients and risk and has also reviewed nursing practices. We are therefore assured that more is being done to improve the care of frail elderly patients and others at risk and look forward to seeing the difference that these robust assurance processes will make in the year ahead.

The number of frail, elderly and often confused people being placed in wards that weren't intended to provide for older patients with complex needs and long term conditions has also been identified as an issue, so we are pleased to hear that the Trust has set up a task group to consider this.

In regard to the reconfiguration of services we believe that the Trust has worked hard to reassure the public that the relocation of major surgery to RSH will deliver better services. We look forward to seeing the evidence that the promised improvements and efficiencies have materialised is included in next years Quality Account, including improved public transport links, which the Trust committed to resolving.

We are pleased that specific mention is made of the role played by LINk Authorised Representatives from Telford and also Shropshire in providing independent scrutiny and feedback from patients as our visitors reports have led to a safeguarding investigation, prompted a review of staffing levels as well as releasing additional resources for equipment. This is a good example of how the Trust listens to and works with LINks to improve quality and patient safety and demonstrate.

The feedback we have received from patients indicates that the Trust needs to focus on improving

- the communication skills of all staff - especially doctors and consultants
- provision of information to visually impaired people in their preferred format - especially in relation to appointments and test results
- personal care needs being met in a timely manner
- bedside information packs for all patients outlining services and facilities available and details of the standard of care they should expect to receive – which is provided in a range of alternative formats to meet the needs of older people with macular degeneration.
- awareness of the availability diabetic snack boxes as staff seem not to know about them - despite the Think Glucose campaign

The emphasis given to improving staff morale as well as competencies is welcomed as we were very concerned to read that so few staff would recommend the hospital to their family or friends. We look forward to seeing an improvement in this score when the staff survey is repeated.

West Mercia Cluster

West Mercia Cluster monitors the quality and performance of the services delivered by the Trust reviewing all data through the monthly Clinical Quality Review meetings which are attended by members of the CCGs, Senior Managers and members of the Quality Team.

We believe that the Quality Account is reflective of the achievements within the year and demonstrate the challenges faced and the Trust's commitment to strive for excellence across all clinical services.

We continue to recognise the improvements to quality and innovation within the Trust as a result of the contractually agreed 'Commissioning for Quality and Innovation (CQUIN) Scheme for 2011/12'. The agreed CQUIN scheme for 2012/13 reflects the continued ethos of partnership working to improve patient safety, clinical effectiveness and patient experience as a key priority of the organisation and commissioners. We are also assured that the Quality Account clearly identifies key priorities for 2012/13.

The Serious Incidents are managed within a robust governance framework and although it is extremely unfortunate that a significant number of Never Events have occurred in the Trust, it is reassuring that these have been responded to in a timely and appropriate manner with a collaborative and clinically led review of the Root Cause Analyses. This has resulted in the recommendations being embedded throughout the Trust to ensure the on-going safety of patients.

The document also makes reference to the Strategic Health Authority Ambitions 2012/13 including the elimination of avoidable grade 2, 3, 4 pressure ulcers and increasing the quality of patient experience and customer care. The timeframes expressed by the Trust are not in line with the SHA Ambition to eliminate Pressure Ulcers and whilst the Cluster recognises the work the Trust has undertaken over the last 2 years to address this fundamental quality of care measurement, there remains an expectation that the Trust will strive to meet the SHA deadline.

We continue to welcome the opportunity to have involvement at an earlier stage in the development of the Quality Account for 2012/13 in line with the planned changes outlined jointly by the Department of Health and Monitor Independent Regulator of NHS Foundation Trusts.

Accuracy of information

West Mercia Cluster in conjunction with local NHS Commissioners has taken the opportunity to check the accuracy of information provided within the Quality Account in relation to the services commissioned from the Trust and believes it is a true reflection.

Shropshire Council Health Overview and Scrutiny Committee

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

Members were disappointed that the elimination of grade 4 pressure ulcers had not been achieved through last year's priorities, and would support the Trust's commitment to achieve this as a priority through 2012/13. The Panel note the other targets in relation to pressure ulcers appear ambitious, and believe this is positive.

The Panel was assured that although the Trust did not achieve its target to reduce falls through last year's priorities, it did exceed the 5% target set by the CQUIN framework. It was noted that falls leading to serious injury increased by 11.5% in 2011/12, and the Panel would like to see a marked decrease in this figure, but recognise that reporting all falls be seen as good practice. Members considered the introduction of nurse's stations being placed within patient bays, and the implementation of 100% of patients receiving comfort rounds 1 – 2 hourly, are excellent initiatives, and should help improve patient safety.

The Panel was please to see the Trust was increasing the amount of training delivered to staff in relation to the collection of blood samples, and pleased to see the a target of 90% being set as a standard for the coming year. The Panel are reassured on the safety checks in place to assure patient safety.

Diabetes Care – The Panel stressed the importance of training for medical and surgical nursing staff in respect of care of diabetic patients, and that the continuity of medication is essential when a patient is admitted to hospital for treatment, and are please to see a target of 80% set for relevant nursing staff.

The initiatives for improvements to a patient's journey, and the proposed achievements, including at 90% target to communicate adult inpatients estimated date of discharge, were excellent.

It was positive to see the Patient Engagement and Involvement Panel will be delivering a comprehensive work plan of monitoring, reviewing and visits, and the inclusion of the net promoter question was an excellent way of involving patients in service review.

The Panel would like to see the target increased to 100% for frail elderly patients admitted as an emergency or for unplanned care, to receive a frailty assessment on admission, but were assured that the other targets in respect of this priority were suitable, and achievable. The Panel note the Trust's commitment to improve targets in future years in respect of frail elderly patients.

The Healthy Communities Scrutiny Committee request that the Trust provide a regular quarterly update on progress, to enable the Committee to monitor the key priorities, and investigate any areas of concern, if they arise.

The Trust has received several inspections throughout the year from the CQC and other bodies, and the Panel comment specifically on the CQC Responsive Review inspection held during November 2011, and were impressed with the outcomes and responses to areas of concern identified through this review, and were pleased to see that the Trust was now compliant.

The Panel are please that the number of complaints recorded per 1000 episodes are acceptable, and pleased to see that complaints are monitored on a regular basis and at the present time appear to be satisfactory

The Panel are pleased they were able to comment on the Quality Account and look forward to monitoring the Trust's progress through a quarterly report, and working with the Trust in the future, and would like to take this opportunity of giving their support in the Trust's ambition to become a Foundation Trust.

Telford & Wrekin Council Overview and Scrutiny Committee

Comments on the priorities and work reflected in the Quality Account

- The Committee would like to comment favourably on the great strides that the Trust has taken to improve communication with, and the involvement of, staff, partners, patients and the public in the development of the Quality Account and the on-going work of the Trust.

- The Committee appreciated the open and honest way in which areas performing less well had been recognised and reported in the Quality Account.

- There was overall agreement with the priorities for 2012/13, but the Committee would like to make the following comments:

- That improving care delivered to patients with Dementia or reduced capacity should have been given a more explicit priority for 2012/13.

- The report should make it clear to the public that although some of the 2011/12 priorities were not chosen as priorities for 2012/13, this does not mean that they are being "dropped" and that work will continue in these areas.

- Members were concerned that training must be given to the right staff in the right way as key to improving clinical effectiveness, patient safety and the patient experience. It is suggested that a target for training should be set and reported in future Quality Accounts so that progress can be monitored. This should ensure that:

- Nurses below sister level receive appropriate training, in particular Dementia and Diabetes, and blood handling for appropriate staff
- That the Trust should join up with the South Staffordshire & Shropshire Healthcare NHS Foundation Trust (the mental

health trust) to develop reciprocal training e.g. Dementia training for hospital staff and intravenous procedures for the mental health staff at Shelton.

- That nursing staff at all levels should be aware of how to access the training they need and what is available
- That e-learning should be supported and supplemented by access to qualified staff to address the learner's questions

Comments on the presentation of the Quality Account as a public document

- Statistical performance information should be presented in a meaningful way for the public, for example by explaining how the measures are set and monitored, and by indicating what percentages mean in terms of actual patient or other target group numbers.

- As an example, the Hand Hygiene target for 2011/12 was reported as 95% with an actual outcome of 98%. However, there is no explanation as to how the target is set and monitored, and whether the target applies to patients, staff and visitors. Members of the Committee who had used outpatient services had observed poor hand hygiene practice and could not understand how this related to a 98% achievement rating. Members further suggested that in order to improve hand hygiene, anti-bacterial hand wash dispensers should be clearly sign-posted for out-patients and other visitors as well as staff.

- The report includes several graphs and charts which are very small and the text difficult to read.

- The CQUIN Goal tables on the second page of section 2.2.4 were confusing and should be clearly labelled.

- It was understood that Trust would provide colour copies of the Quality Account on request, but more effort should be made to ensure colour coding is clear when printed in black and white e.g. to distinguish between green and amber on "traffic light" rated information.

- The inclusion of the Glossary to the Quality Account is very welcome, but this should include all acronyms used throughout the document e.g. PALS, PEAT, NRLS.

- Where links to further information on websites are provided, it should be ensured that the documents on the websites are up to date.

Montgomeryshire Community Health Council

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

During 2011/12 Montgomery Community Health Council has continued to review the Trusts health service provision to Powys residents through CHC monitoring visits; inspections; and feedback from patients. The Trust has continued to send a senior representative to CHC Full Council meetings to respond to questions raised by CHC members. The Trust has responded to CHC concerns and recommendations, which have influenced their plans and priorities for improvement, including the Quality Improvement Strategy; Quality monitoring and improvement measures; and Quality Priorities for 2012/13.
Montgomery CHC has welcomed the opportunity to be part of the Trusts Patient Experience Involvement Panel, and the development of the work programme to support the review of patient care.

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

Trusts response to feedback from stakeholders

In response to comments from external stakeholders, the Trust has made a small number of amendments to this year's Quality Account.
On page 39 we clarified how we had captured complaints data slightly differently this year, which had resulted in a variance in year on year figures.
We have updated the glossary to reflect additional abbreviations used within the Quality Account.
We have produced a summary version of the Quality Account, which is available on request.

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

4 Looking Ahead

Our third Quality Account aims to offer a transparent and open approach to encourage scrutiny of the quality of our services and our progress towards the improvements we said we would make.

We recognise that we have not achieved all of the improvements we set out in out 2010/11 account and are committed to doing this by the end of 2012. However, we have achieved a significant number of improvements through the hard work and commitment of our workforce and through the support and involvement of our patients through the Patient Experience and Involvement Panel, complaints, comments and other feedback.

Developing our third Quality Account has been a valuable learning experience for the Trust and we view each year's account as an opportunity to improve and inform our stakeholders and the public about the quality of care and services we provide. We will endeavour to further develop the accounts year on year, and we actively encourage your feedback. Please let us know your views, to help us enhance patient experience, safety and effectiveness.

Your Feedback Counts

We welcome your feedback on our Quality Account. You can let us know in a variety of ways:

By email to consultation@sath.nhs.uk – please put "Quality Account" as the subject of your email

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

By post to Quality Account, c/o Chief Nurse/Director of Quality & Safety, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury SY3 8XQ

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

- What do you think are our biggest opportunities for making progress on the Quality Priorities listed in Section 2.1?
- What actions should we be taking to improve quality in these areas?
- How should we involve patients and communities in our work to improve the quality of the services we provide?
- Do you have any comments or suggestions on the format of our Quality Account?
- What else would like to see in our quality accounts?

Looking further ahead, we welcome your suggestions for our Quality Priorities in 2012/13 – we will select three to six top priority issues across the three dimensions of quality (patient experience, safety, effectiveness).

Acknowledgements

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

Head of Business Information
Clinical Governance Manager
R&D/Clinical Trials Manager
Contracts and Performance Manager
Data Quality Manager
Information Governance Manager
Tissue Viability Nurse Specialist
Health and Safety Manager
Patient Services Manager
Centre Manager—Oncology
Head of Education
Consultant Endocrinology Physician
Dietetic Manager
Medical Performance Manager
Professor for Privacy and Dignity in Care for Older People
Programme Manager for Unscheduled Care
Hygiene and Compliance Officer
Associate Director of Quality and Patient Experience
Interim Associate Director of Operational Performance
Improvement Manager—Infection Prevention and Control
Patient Safety Team Manager
Business Manager—Estates and Facilities
Deputy Head of Human Resources
Specialist Practitioner in Blood Transfusion
Diabetic Clinical Nurse Specialist

Glossary

Guidance on Quality Accounts requires that we include detailed information about national and local clinical audits (see Section 2.2.2.). This section contains a large number of abbreviations and technical terms, and we regret that it is not possible to provide a definition in each case within the brief Glossary to the Quality Account.

18 weeks	A target for the NHS in England was that by December 2008 no patient should wait longer than 18 weeks from GP referral to consultant-led treatment. See www.18weeks.nhs.uk/endwaiting
A&E	Accident and Emergency. A range of services that provide care for people following accidents and emergencies. This includes local Minor Injuries Units in community hospitals as well as regional trauma centres that provide urgent treatment following major accidents.
Acute Care	Medical or surgical treatment usually provided in a district general hospital (also called an acute hospital).
Annual Health Check	An annual assessment of the Quality of Services and the Quality of Financial Management of NHS organisations, undertaken by the Care Quality Commission. See www.cqc.org.uk
CHC: Community Health Council	Community Health Councils in Wales have a statutory role to represent the interests of the public in the health services in their district. See www.wales.nhs.uk/chc
Clinical Audit	Information about clinical audit, including a definition, is available in Section 2.2.2. See www.hqip.org.uk
Clinical Governance	Clinical Governance is defined as: "A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (A First Class Service: Quality in the New NHS, 1998).
Clinical Governance Executive / Clinical Governance Forums	Our Clinical Governance Executive is a committee of the Trust Board, chaired by the Trust Medical Director and with representation from the Non Executive Directors. It is responsible for coordinating Clinical Governance activity throughout the Trust and providing assurance to the Trust Board that Clinical Governance processes deliver safe, high quality patient centred care. It acts as the focus for wider review through Clinical Governance Forums in Divisions and Service Delivery Units.
Clinical Governance Strategy	This sets out our overall approach to clinical governance in the organisation.
Clinical Trials	A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients or people in good health, or both. Small studies produce less reliable results so studies often have to be carried out on a large number of people before the results are considered reliable. See www.nhs.uk/Conditions/Clinical-trials and www.nihr.ac.uk
Commissioners	Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Primary Care Trusts (PCTs) in England and Local Health Boards (LHBs) in Wales are the key organisations responsible for commissioning healthcare services for their area. Shropshire County Primary Care Trust, Telford and Wrekin Primary Care Trust and Powys Teaching Health Board purchase acute hospital services from The Shrewsbury and Telford Hospital NHS Trust for the population of Shropshire, Telford & Wrekin and mid Wales. See www.shropshire.nhs.uk, www.telford.nhs.uk and www.powysthb.wales.nhs.uk
Community Engagement Forum	This is a regular meeting with patient and community representatives to help shape Trust policy and priorities.
CPA: Clinical Pathology Accreditation	Clinical Pathology Accreditation: An external audit and assessment process for pathology services. See www.cpa-uk.co.uk
CQC: Care Quality Commission	The Care Quality Commission is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. See www.cqc.org.uk
CQUIN: Commissioning for Quality and Innovation	A new payment framework introduced in the NHS in 2009/10 which means that a proportion of the income of providers of NHS services is conditional on meeting agreed targets for improving quality and innovation. See www.institute.nhs.uk/cquin

EDD	Expected Date of Discharge. A date which is provided to patients to enable them to plan their discharge from hospital
DH: Department of Health	The Department of Health is a department of the UK government with responsibility for government policy in England on health, social care and the NHS. See www.dh.gov.uk
Dimensions of Quality	In the NHS we normally refer to three dimensions of quality: patient experience (the experience of patients and their carers using our services), safety (protecting patients from harm) and effectiveness (using techniques and procedures that are proven to have benefit at a fair cost to the public purse).
HRG: Healthcare Resource Group	A Healthcare Resource Group (HRG) is a group of clinically similar treatments and care that require similar levels of healthcare resource. It forms part of the Payment by Results system by which providers of NHS services receive income from commissioners for the services they provide to patients. The sophistication of this system increases from year to year. Version 4 (HRG4) was introduced in 2009/10, including c.1400 HRGs. This replaced version 3.5 (HRG3.5) which contained c.400 HRGs.
Incident Review Group	This is a twice monthly meeting in the Trust to review incidents, claims, complaints and 'soft' intelligence to identify early trends and take corrective action.
Information Governance Toolkit	This is an tool to support NHS organisations to assess and improve the way they manage information, including patient information See www.igt.connectingforhealth.nhs.uk
Integrated Performance Report	This is a "dashboard" of quality and operational performance information reviewed at meetings of the Trust Board, Management Executive, Finance & Performance Committee. It contains a set of key measures of the services we provide, and encourages scrutiny with the aim of maintaining and improving service standards. See examples in our Trust Board papers at www.sath.nhs.uk
LHB: Local Health Board	See "Commissioners"
LINk: Local Involvement Network	Local Involvement Networks in England are made up of individuals and community groups working together to improve local services. Their job is to find out what the public like and dislike about local health and social care. They will then work with the people who plan and run these services to improve them. This may involve talking directly to healthcare professionals about a service that is not being offered or suggesting ways in which an existing service could be made better. See also CHC. See www.cinch.org.uk and www.telfordandwrekinlink.org.uk
National Confidential Enquiries	These are enquiries that seek to improve health and health care by collecting evidence on aspects of care, identifying any shortfalls in this, and disseminating recommendations based on these findings. Examples include the Centre for Maternal and Child Enquiries (CMACE) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD). e.g. see www.ncepod.org.uk
NICE: National Institute for Health and Clinical Excellence	The National Institute for Health and Clinical Excellence (NICE) provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. It makes recommendations to the NHS on new and existing medicines, treatments and procedures, and on treating and caring for people with specific diseases and conditions. It also makes recommendations to the NHS, local authorities and other organisations in the public, private, voluntary and community sectors on how to improve people's health and prevent illness and disease. See www.nice.org.uk
NPSA: National Patient Safety Agency	The National Patient Safety Agency is an arm's length body of the Department of Health, responsible for promoting patient safety wherever the NHS provides care. See www.npsa.nhs.uk
OPCS	OPCS is an abbreviation for the Office of Population, Censuses and Surveys Classification of Surgical Operations and Procedures (4th revision). This statistical classification translates operations and surgical procedures into codes. Classifications like OPCS-4 must be reviewed continuously to ensure they evolve with NHS policy, changing healthcare provisions, and the coding structures used in electronic health records. OPCS Version 4.5 was introduced in the Trust in 2009/10. See www.connectingforhealth.nhs.uk

Overview and Scrutiny Committees	Overview and Scrutiny Committees in local authorities have statutory roles and powers to review local health services. See www.shropshire.gov.uk and www.telford.gov.uk
Partnership Forum	This is a quarterly meeting between representatives of the Trust and partner organisations (e.g. local authorities, PCTs). The meeting was established as part of our plans to become an NHS Foundation Trust, but we also discuss much wider issues including the development of our Quality Account.
Patient Experience Reporting	We ask our patients to tell us about their experience of our services in a variety of ways. These include the CQC Annual Inpatient Survey (see 3.3.1), our own internal surveys (e.g. see Section 3.1, Priority B) and the complaints and compliments we receive from patients and carers.
PEAT	Patient Environment Action Team
PEIP	This stands for Patient Experience and Involvement Panel. This group brings together patients, carers, patient representatives and senior staff to make on-going improvements to patient care and experience.
Periodic Reviews	Periodic Reviews are reviews of health services carried out by the Care Quality Commission. The term "review" refers to an assessment of the quality of a service of the impact of a range of commissioned services, using the information that the CQC holds about them, including the views of people who use those services.
Pressure Ulcers	Pressure ulcers are also known as pressure sores, or bed sores. They occur when the skin and underlying tissue becomes damaged. In very serious cases, the underlying muscle and bone can also be damaged. See www.nhs.uk/conditions/pressure-ulcers
QIPP	This stands for Quality, Innovation, Productivity and Prevention. It is a programme where NHS organisations work together – and with patients, communities and other key partners – to improve quality, encourage innovation, increase productivity and ensure preventative approaches that improve health and reduce health inequalities,
Quality Account	Please see page 3 for a definition of a Quality Account.
Quality and Safety Assurance Framework	This framework sets out how aspects of governance and safety are to be integrated into the Trust's arrangements and how quality will be continually improved and monitored.
Quality Priorities	Every year we set between three and six quality priorities. More information can be found in Section 2.1.1.
RCA	Root Cause Analysis. An investigation which takes place to find out the cause of a problem which has occured
Registration	From April 2009, every NHS Trust that provides healthcare directly to patients must be registered with the Care Quality Commission. In 2009/10, the CQC registered Trusts on the basis of their performance in infection control. From April 2010 the registration process is a based on a much broader assessment of the services provided by the organisation.
Risk Management systems	These enable staff across the organisation to identify and report risks to the quality of care. The organisation is then better able to manage these risks, focusing on addressing those issues that are more likely to have a greater adverse impact on patient experience, safety and effectiveness.
SaTH: The Shrewsbury and Telford Hospital NHS Trust	The Shrewsbury and Telford Hospital NHS Trust, the NHS organisation responsible for hospital services at the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury. We are the main provider of acute hospital services for around half a million people in Shropshire, Telford & Wrekin and mid Wales. See www.sath.nhs.uk

SHA	Strategic Health Authority
SHMI	Summary Hospital-Level Mortality Indicator
Special Review	A special review is carried out by the Care Quality Commission. Each special review looks at themes in health and social care. They focus on services, pathways or care groups of people. A review will usually result in assessments by the CQC of local health and social care organisations, as well as supporting the identification of national findings.
SUS: Secondary Uses Service	SUS provides anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
TIA: Transient Ischaemic Attack	A transient ischaemic attack (TIA), or 'mini-stroke', is caused by a temporary fall in the blood supply to part of the brain which results in a lack of oxygen to the brain. This can cause symptoms that are similar to a stroke, although they don't last as long. TIA lasts only a few minutes and is usually resolved within 24 hours. See www.nhs.uk/conditions/transient-ischaemic-attack
Trust Board	The Trust Board takes corporate responsibility for the organisation's strategies and actions. The chair and non-executive directors are lay people drawn from the local community and are accountable to the Secretary of State. The chief executive is responsible for ensuring that the board is empowered to govern the organisation and to deliver its objectives.
VTE: Venous Thromboembolism	Venous thromboembolism (VTE) is a term that covers both Deep Vein Thrombosis (DVT, a blood clot in one of the deep veins in the body) and pulmonary embolism (where a piece of blood clot breaks off into the bloodstream and blocks one of the blood vessels in the lungs). See www.nhs.uk/conditions/deep-vein-thrombosis
WAG: Welsh Assembly Government	The Welsh Assembly Government is responsible for health policy for Wales. See www.wales.gov.uk

www.cqc.org.uk	**The Care Quality Commission:** Checks whether hospitals, care homes and care services are meeting government standards
www.nhs.uk	**NHS Choices**: NHS Choices is the online 'front door' to the NHS. It is the country's biggest health website and provides information about the NHS, services, conditions, treatments, and how to look after yourself.
www.sath.nhs.uk	**The Shrewsbury and Telford Hospital NHS Trust**: Our website provides information about the services we offer.
www.shropshire.nhs.uk	**Shropshire County PCT:** Find information about health and health services in Shropshire.
www.telford.nhs.uk	**Telford & Wrekin PCT:** Find information about health and health services in Telford & Wrekin.
www.powysthb.wales.nhs.uk	**Powys Teaching Health Board:** Find information about health and health services in Powys.

Appendix 1.

Statement of directors' responsibilities in respect of the Quality Account

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

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

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

By order of the Board:

Date: ...29th June 2012..... Chair: .....

Date: ...29th June 2012..... Chief Executive: .....

Appendix 2.

KPMG Limited Assurance Audit report

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

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

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 National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

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

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

The Directors 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 consistent with the requirements set out in the Regulations.

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

This report is made solely to the Board of Directors of The Shrewsbury and Telford Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. Our limited assurance procedures included:

– making enquiries of management;

– comparing the content of the Quality Account to the requirements of the Regulations.

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

The scope of our assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

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. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

KPMG LLP

KPMG LLP

Chartered Accountants

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Snow Hill Queensway

Birmingham

B4 6GH

29 June 2012