The Shrewsbury and Telford Hospital NHS Trust

Paper 7

Recommendation ☐ **DECISION** ☑ **NOTE**	**Trust Board is asked to RECEIVE the draft Quality Account 2017/18**
Reporting to:	**Trust Board**
Date	25 May 2018
Paper Title	Quality Account 2017/18
Brief Description	The Trust Board is asked to receive the draft of the Quality Account for approval prior to completion and formatting. Points to note are: We have complied with the most recent amendment to the NHS regulation that requires us to include statutory statements relating to Learning from Deaths and an update about Seven Day Services. We have been visited by external auditors who have reviewed C Diff reporting and FFT data and will provide a report on receipt of the final draft. Some data is still outstanding but most is included. The report will be shared as required with external stakeholders including HOSC, CCG, Healthwatch. The report must be uploaded to NHS choices on or before 30 June 2018
Sponsoring Director	Deirdre Fowler, Director of Nursing, Midwifery and Quality
Author(s)	Dee Radford, Associate Director of Patient Safety
Recommended / escalated by	None
Previously considered by	Quality & Safety Assurance Committee (23 May 2018)
Link to strategic objectives	Patient and Family, Safest and Kindest
Link to Board Assurance Framework	
Outline of public/patient involvement	
Equality Impact Assessment	◉ **Stage 1 only (no negative impacts identified)** ○ **Stage 2 recommended (negative impacts identified)** *** EIA must be attached for Board Approval** ○ negative impacts have been mitigated

	○ negative impacts balanced against overall positive impacts
Freedom of Information Act (2000) status	◉ **This document is for full publication** ○ **This document includes FOIA exempt information** ○ **This whole document is exempt under the FOIA**

Quality Account 01 April 2017 – 31 March 2018

Section one: Introduction and Background

1.1 Chief Executive statement on quality

I am pleased to introduce Shrewsbury and Telford Hospital NHS Trust's Annual Quality Account. This report provides an overview of the quality of care delivered between April 2017 and March 2018 as well as our priorities of care for 2018-2019. There are relevant sections in the report detailing these and highlighting a selection of the many improvements made during the year as well as aspects of care that we will continue to work hard on to improve .

The Executive Directors and the Trust Board gain assurance around the work of all our staff to improve and sustain high levels of quality care through the systems and process put in place through the clinical teams and Care Groups. To support this work, within the governance structure of the Trust, there is a Quality and Safety Committee, chaired by a Non-Executive Director which is a formal committee of the board and which scrutinises the internal monitoring of care and the progress made of the plans to improve.

We are subject to, and indeed welcome, external scrutiny, and this year have been pleased to welcome visits from our regulators, our commissioners, organisations that represent the public and other health professionals who come to review specific services such as our Stroke Service. Without fail their comments and recommendations help us to improve the car that we provide and this year we have developed our Trust Quality Improvement Plan which has brought together all the different high level actions from such visits to ensure that they are monitored, actioned and measured for sustainability in a coherent way.

We have also put in detail following the receipt of the report following the Care Quality Commission inspection of our services in December 2016. At the time of writing the report this time last year, we had not had the formal written feedback but this has now been received and is part of the Improvement Plan I have mentioned above.

As in previous years we are delighted to continue our work with the Virginia Mason Institute in Seattle which is enabling us to identify and implement change which is sustainable and really has an impact on care.

Last year I wrote that we had experienced unprecedented demand on our services through a very busy winter. Well, this year has been even more challenging and for longer with the much colder weather and all the associated issues that brings. Our staff continue to demonstrate enormous commitment to being here at work to care for people when they really need it and to ensure that as far as possible they are kept safe and get home again as soon as their condition allows.

As last year, I commend this document to you. It reflects a positive whilst challenging year but also the enthusiasm to continue to develop and improve over the coming year.

Simon Wright, CEO

1.2 What is a Quality Account?

The Health Act 2009 required all healthcare providers to produce a Quality Account and the NHS (Quality Account) Regulations 2010 (and subsequent amendments) specify the requirements for the reports produced. Our Quality Account is an annual report produced by Shrewsbury and Telford Hospital NHS Trust and aims to give an overview of the quality of services provided by our organisation. We hope that the members of the public that read this report find it helpful and informative about the services that we provide.

1.3 About the Trust

The Shrewsbury and Telford Hospital NHS Trust is the main provider of district general hospital services for nearly half a million people in Shropshire, Telford and Wrekin and mid Wales.

The Trust has two main sites – the Princess Royal Hospital in Telford and the Royal Shrewsbury Hospital in Shrewsbury. Both hospitals provide a wide range of acute hospital services including Accident and Emergency, outpatients, diagnostics, inpatient medical care and critical care.

Together the hospitals have just over 700 beds and assessment and treatment trolleys.
Alongside our services at PRH and RSH we also provide community and outreach services such as:

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

With a turnover of £359.0 million relating to patient care activity and other operating income in 2017-2018 we saw contracted levels of activity as follows:

- 52,302 elective and day case spells
- 50,982 non-elective inpatient spells
- 7,044 maternity and transfer admissions
- 411,714 outpatient attendances
- 111,332 accident and emergency attendances

In 2015 we began an exciting partnership with the Virginia Mason Institute in Seattle as part of our journey of improvement with our aspiration being to provide the safest and kindest care in the NHS. In 2016 the Trust launched its own Transforming Care Institute which is leading the improvement work learned in the USA.

1.4 Our Strategy and Values

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

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

Our Values were shaped by our staff and patients to ensure we got them right. Our Values are not

just words on a page; they represent what we are about here at SaTH. They represent the behaviours and attitudes that we expect each of our staff to display when they are at work and representing our organisation. Since they were launched, we have continued to embed them throughout the Trust.

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

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

1.5 Our Partners in Care

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

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

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

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

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

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

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

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

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

Section two: Priorities for improvement and statements of assurance from the Board

In this section we aim to give detail about the progress we have made with the priorities for quality improvement that we identified for our quality account last year.

We are also providing detail about our Trust overarching Quality Improvement Plan which includes actions identified following the Care Quality Commission (CQC) visit to the Trust in December 2016. This plan is available via our website but for the purposes of this document is divided into the five domains of quality that the CQC use – Safe, Effective, Caring, Responsive and Well Led.

2.1 Progress against priorities for improvement 2017-2018

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

What is important is that these priorities are not only for one year – they are usually based on existing work and will continue into the future. Therefore we have said what we are going to be doing for the year ahead even where we have fully achieved what we said we would do in 2017-2018.

Priority One: Making sure that people are safely discharged from our hospitals NHS Outcomes Framework Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm Strategic Priority: To reduce harm, deliver best clinical outcomes and improve patient experience		
Why is this a priority for us?	**What will success look like?**	**How have we done?**
We know that leaving hospital after a period of ill health, whilst a happy time can also be a period of anxiety for patients, their families and their carers.	Patients will know what their expected date of discharge is so that they and their families have time to plan for them going home	The last national inpatient survey results published in May 2017 show that SaTH is "about the same" as other acute Trusts in helping people plan to go home
We need to make sure that when we discharge people from our services we do so in a way that means that they are confident they have everything they need to continue their treatment or recovery.	We will routinely use the principles of "Red to Green" (R2G) to ensure that we do not keep people waiting to go home unnecessarily. This is a way of seeing really quickly if we are doing all the things we need to do in a timely way to make sure people do not stay in	We also carry out monthly surveys when we ask patients "have you been told when you are going home – the overall average score increased from 58% to 63.4% saying that they had but this is not yet consistent over our Care Groups and the work continues

	hospital longer than they have to.	to ensure that everyone and their families know when they are due to go home.
We will make sure that we prepare people correctly before they go home – for example teaching them about new medication or ensuring that they can dress themselves or make a cup of tea safely	We will make sure that everything they need is ready for them, including medication, information and equipment which is part of the R2G work.	Patient journey facilitators continue to receive positive feedback from patients / relatives and the ward teams they are supporting. This team who were primarily refocusing and concentrating on 9 ward areas across both hospitals, a mix of care group wards, are also supporting other wards as capacity allows e.g. ward 21, and 22 S and R. The SAFER principles and Red2Green toolkit has been relaunched, along with monthly road shows to help embed the concept and fortnightly corporate induction presentations. We see less delays due to lack of medication or equipment that we are responsible for providing due, in part, to the work of the R2G trackers. The national inpatient survey tells us that we are "about the same" as other acute providers in this respect.
We want to make sure that we liaise correctly with other care providers so that people's needs are met when they go home and that they do not come to any harm because we have not done so	Where necessary we will speak to other providers (such as district nurses) who may be supporting people at home to make sure that they are ready	We aim to liaise with our colleagues in other care providing organisations such as Shropshire Community Health NHS Trust who provide district nursing care to ensure that people get the support that they need when they get home. The national inpatient survey reported in May 2017 tells us that our patients felt that they did not receive enough support from health and social care professionals as they needed when they got home.

		We will continue to work with our partners to ensure that everyone is discharged from hospital with a plan of care that is appropriate for their needs.
We want to make sure that people have as positive an experience as possible whilst in our care whether as an inpatient or when receiving outpatient treatment	We will reduce the number of complaints that we get about discharge processes.	We have not seen a reduction in the number of complaints about discharge processes as there were 90 complaints categorised as admission or discharge in 2016-2017 and 139 in 2017-2018. This is with an overall rise in complaints (422 in 2016/17 compared to 600 in 2017/18).
	Less people will come back into hospital because something went wrong with the discharge process	Awaiting readmission rates
	Finally we aim to reduce the number of times we have to have extra beds on our wards at times of high escalation which can lead to reduced patient safety and experience.	We know that over the winter of 2017-2018 we have had to care for more patients in additional beds on our wards than we would like to. We know that this is not a good experience for them and that privacy and dignity may be compromised.
	We will measure our progress through our Datix incident reporting system which we use to monitor both incidents and complaints. We will also measure our progress through feedback from our patients and their families—whether we got it right for them and if not, why not. We will measure how long people stay in with us and whether we could improve this for them by making sure we do	All the measures that we are putting into place to ensure that people are in hospital for the right amount of time for them, that they go home with the support that they need to recover and that they do not come back into hospital because those plans did not work will reduce the number of additional beds on our wards.

	everything we can to get them home safely at the right time. As part of this we will work closely with our colleagues in Shropshire Community Health NHS Trust and in the local authorities and CCGs.	

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

	not get their voices heard are able to do so	

Priority Three: Implementation of the Values Based Leadership and Cultural Development plan in the Women's and Children's Care Group NHS Outcomes Framework Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm Strategic Priority: Through our People Strategy develop, support and engage with our workforce to make our organisation a great place to work		
Why is this a priority for us?	What will success look like?	How have we done?
We want to make the women and children's care group the safest, kindest and most caring that we can. In order to do this we are developing a plan to implement Values-Based leadership and further develop the culture of continuous learning that already exists.	We will use staff feedback (such as the NHS staff survey, drop in sessions and through relationships with their representatives) to show where we need to improve to provide a better experience for our staff and to measure improvement.	The most recent NHS staff survey shows that within the Care Group the Staff Engagement Score has significantly increased, indicating a much improved experience for our staff.
We recognise that valued and supported staff who work in an environment of continuous learning and challenge will nurture a culture of openness, caring and compassion. Our plan is to develop a values based culture across our organisation so whilst this priority is specifically about the Women's and Children's Care Group the actions will also be relevant for the other services in the Trust.	We will see a reduction in complaints and PALs enquiries particularly in relation to communication, care and compassion. We will also help and support our staff to make changes where they need to. We will evidence that the requirements of the Duty of Candour will be met in 100% of incidents that require it to be met	We have not seen a reduction in complaints in relation to these areas – all have increased with the number of complaints overall Duty of Candour in place for 100% of Serious Incidents and High Risk Case Reviews.
The work will focus on organisational support to develop the Care Group Vision and Strategy, understand how the Trust values come to life in practice and provide the opportunity for staff to self-reflect and promote change through self-knowledge and understanding as individual leaders.		The national Maternity Survey published in January 2018 showed that: New mothers using our services felt that they were treated with respect and dignity, listened to and given the help they need. Women who raised concerns during their pregnancy or delivery had those concerns

		taken seriously and that they were spoken to in a way they could understand. We scored 8 out of 10 or higher in 42 out of the 51 categories relating to the care of mothers and babies. The Trust performed statistically better than most other trusts in 12 categories. Our Postnatal ward has just been awarded Diamond status in our Exemplar Programme – the first ward in the Trust to do so. Neonatal Critical Care peer review - NHSE recognised the hard work undertaken and confirmed that there were no immediate risks or serious concerns identified during this visit. National Maternity and Perinatal Report published March 2018 showed that: Caesarean section rate for the Trust is significantly lower than average Rates of haemorrhage and complicated tear are lower than average Women with a previous Caesarean section are as likely to achieve a successful vaginal birth compared to women in other units Lower episiotomy rate than national average Higher rate of spontaneous vaginal delivery

		Getting it Right First Time (GIRFT) triangulated with findings – inc - No brachial plexus injury recorded & Low instrumental delivery rate - 10.5% compared to England average of 15%

2.2 Our Safest and Kindest Quality Improvement Action Plan

The Trust uses the guiding principles of 'Safest' and 'Kindest' to represent the core values of the quality improvement plan. The 'Safest and Kindest Quality Improvement Plan' encompasses the vision and drive of the service.

'Safest and Kindest Quality Improvement Plan' brings together an update on fundamental action plans throughout all of our core services. The Quality and Safety Committee receive quarterly updates regarding progression and assurance.

The 'Safest and Kindest Every Day Plan' will evolve over the coming year in order to make a real difference to the organisation.

The CQC Trust action plan updates are now part of the continuous 'Safest and Kindest Quality Improvement Plan' update, and incorporates all the "must dos" and "should dos" including CQC regulations . Throughout each action plan there will be six overarching principals to drive forward progress and ensure a robust response:

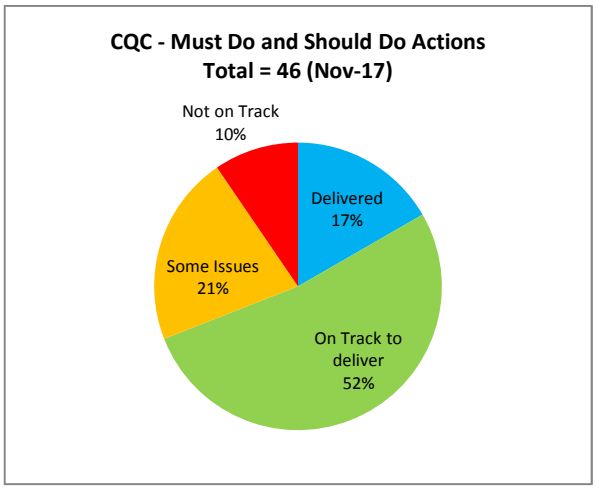
- Leadership nurtures cultures that ensure the delivery of continuously improving high quality, safe and compassionate care.
- Communication: raising awareness and understanding
- Audit - actions will be monitored through spot checks / audit
- Governance - Instilling a robust overarching governance process
- Education – identifying education requirements
- Training - provision and access to training

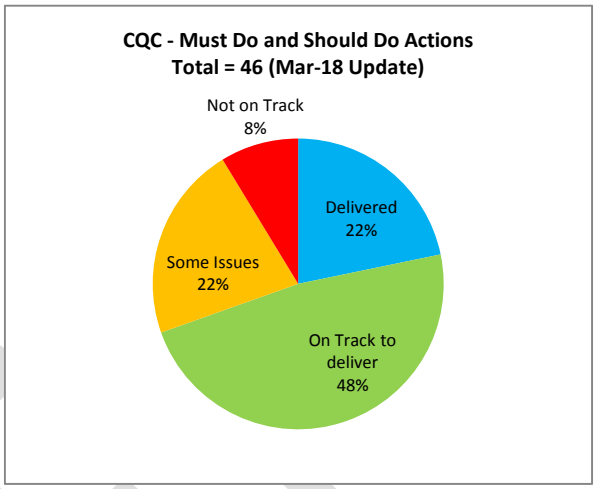
The 'Safest and Kindest Every Day Quality Improvement Strategy 2017-2018 identifies what Shrewsbury and Telford Hospital intends to achieve in terms of quality and safety. The 'Safest and Kindest Quality Improvement Plan' denotes how this will be achieved and a Standard Operating Procedure (SOP) has been devised to provide assurance of the process and individual responsibility. The Safest and Kindest Quality Improvement Plan includes:

- Trust overarching CQC plan
- Maternity and Gynaecology and Paediatrics
- Medicine
- Surgery
- Critical Care
- End of Life Care
- Children and safeguarding
- West Midlands Quality Review Service reviews.

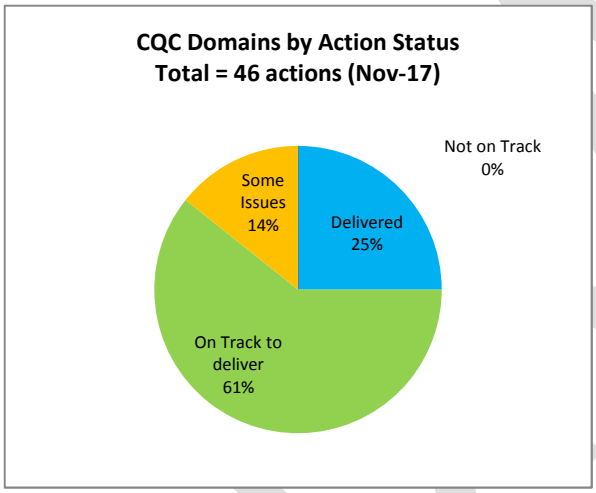
The Safest and Kindest Quality Improvement Plan incorporates the CQC domains which means that the Trust can identify and track how many actions relate to each domain and track progression in accordance with the domain. In addition, each action has been identified with a CQC theme so the Trust can identify trends and the top five themes.

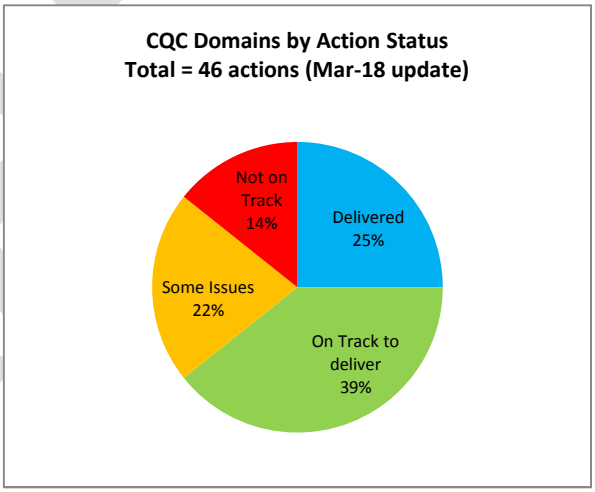
November v March comparison – CQC "Must do" and "Should do" actions by status



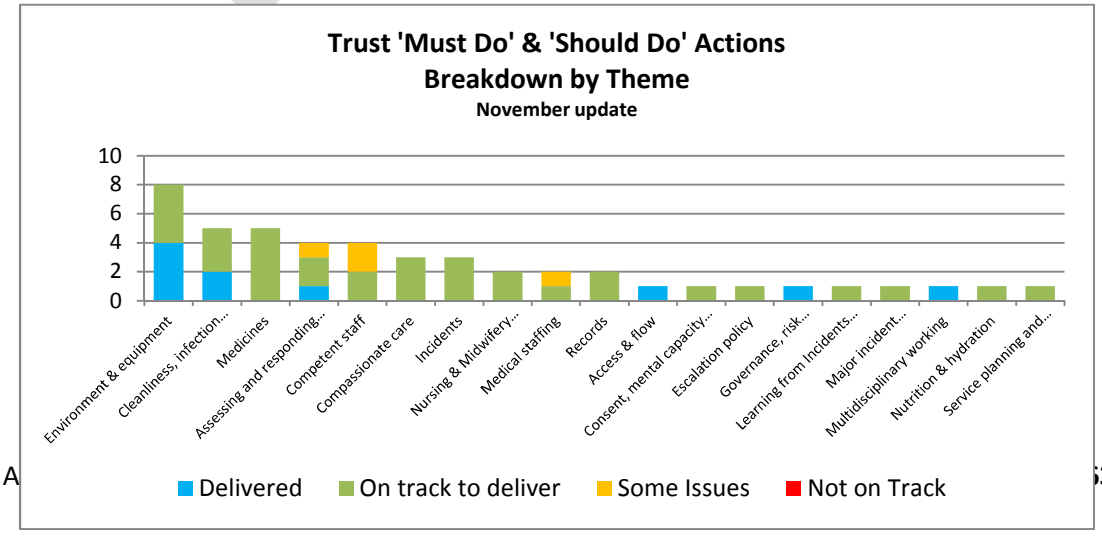


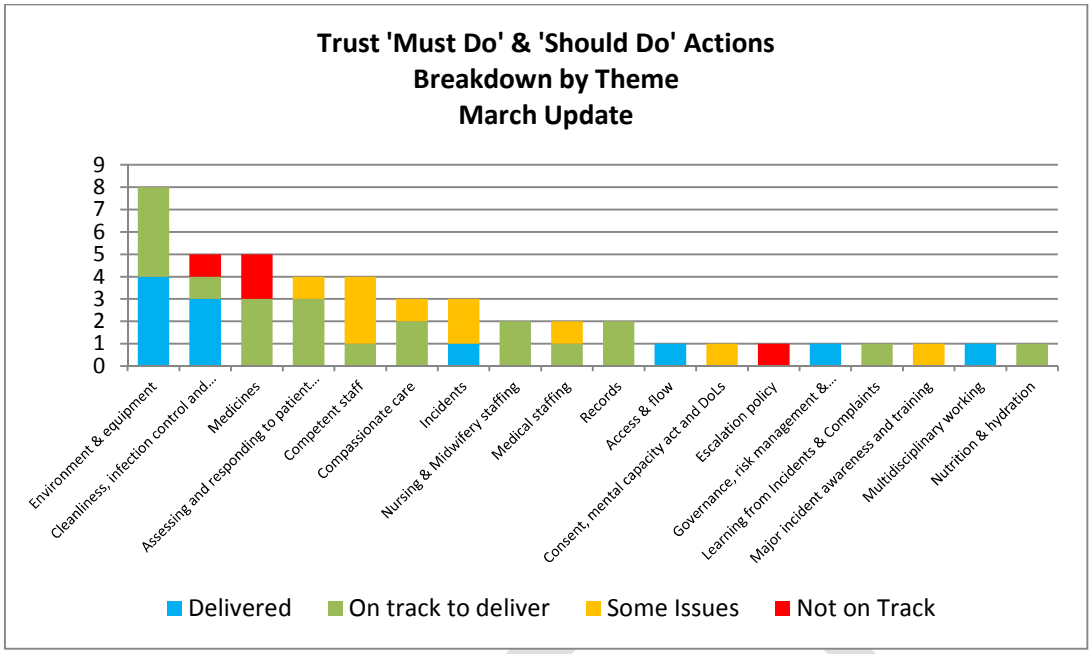
November v March comparison – CQC Domains by Actions status





"Must do" and "Should do" Actions by Theme (and Action Status)





Reasons for increase in "Not on Track":

Medicines management, missed temperature checks of refrigerators:
A number of actions have been implemented and acted upon but beyond the original target date of December 2017. However since the last update we have received assurance from Pharmacy that audit results are now being actioned and shared with Ward Managers and Matrons and that the RATE audit tool is now in place with all ward areas reviewing their results monthly.

Maternity – ensure midwives consistently prescribe medicines given in labour in line with Nursing and Midwifery Council practise standards
A policy has been produced awaiting implementation. Pharmacy is developing a self-adhesive sheet to assist midwives with dispensing, following which the policy can be amended and implemented.

Escalation Policy:
Ensure accurate monitoring of maternity escalation policy for all areas including Wrekin MLU:
Recommendations being incorporated into policy (which has been produced) once checked for factual accuracy, hence delay.

Control and detecting the spread of infections in the mortuary – decontaminating and deep clean arrangements:
Target for installation of washer-disinfector at RSH was Nov-17 (no longer needed at PRH). However, delay due to funding issues and alternative sources of funding being pursued. Currently on Risk Register and further application for funding made in April, awaiting outcome.

Summary:
Overall, although a number of actions are showing as being "Not on Track" or "Some Issues", the Trust Action Plan is closely monitored and updated on a monthly basis, with updates regularly sought from the responsible leads and escalated where insufficient evidence of progress has been given, with the majority having demonstrated progress towards achieving their targets.

2.3 National Quality Indicator results

In addition to the quality priorities and improvements identified by the Trust, reporting against a list of 11 quality indicators set by NHS England (NHSE) is mandated in this Quality Account. The layout of the table below is set by NHSE relating to the source of the information and the narrative and explanation. For most of the indicators the information is provided by the Health and Social Care Information Centre for the reporting period 2017 – 2018.

Awaiting data from informatics

Indicator	2017/18	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17
The value and banding of the summary hospital level mortality indicator (SHMI) for the trust for the reporting period					Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: this figure falls within the xxx category Shrewsbury and Telford Hospital NHS Trust has taken the actions highlighted elsewhere in this Quality Account to improve services and therefore this rate.	64
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period					Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: xx Shrewsbury and Telford Hospital NHS Trust has taken the actions xxx	21.27
The Trust's reported outcome measure scores for: Groin hernia surgery Varicose vein surgery Hip replacement surgery Knee replacement surgery					Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: Patient Reported Outcome Measures are an important way that we measure how well a patient feels the procedure went and how it has impacted on their life Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this indicator and so the quality of services by: encouraging patients to complete the questionnaires following the procedure and using the information to develop our services further	 0.159 0.152 0.563 0.434
The percentage of patients aged: 0-15 and 16 and over Readmitted to a hospital which forms					Shrewsbury and Telford Hospital NHS Trust considers that these percentages are as described for the following reasons: In common with other Trusts, a large number of readmissions are not related to the previous episode of care. The Trust has taken the following actions to improve these percentages and so the quality of its	 9.90 7.66

Indicator	2017/18	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17
part of the trust within 28 days of the being discharged from a hospital which forms part of the Trust					services: By individualised care pathway management to ensure that people go home at the right time with the right support in place	
The Trust's responsiveness to the personal needs of its patients during the reporting period *(Most recent data available on the HSCIC website dated May 2017)*					Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: The score is a composite of five of the areas explored in the inpatient survey commissioned by the CQC every year. Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve the indicator and percentage and so the quality of its services by collecting and analysing information across a range of services and patient groups and taking action where indicated.	
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends					Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: the percentage of staff from the survey has increased Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage and so the quality of its services, by xxx Paula Dabbs	
Friends and Family Test – Patient. The data made available by NHS Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)					Shrewsbury and Telford Hospital NHS Trust considers this data is as described for the following reasons: the percentage of people responding to the Friends and Family Test is monitored by the Trust on a monthly basis. Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage and so the quality of its services by supporting our patients to feedback about the service. We will continue to develop different ways that people can complete this survey and therefore increase the response rate.	
The percentage of patients who were admitted to hospital and who were risk assessed for venous					Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: VTE assessment is embedded practice that is closely monitored and followed up	

Indicator	2017/18	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17
thromboembolism during the reporting period					routinely by the clinical teams. Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage and so the quality of its services by continuing with the monitoring of compliance and ensuring that clinical teams are aware of the requirement to continue with this to ensure we comply	
The rate per 100,000 bed days of cases of C Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period					Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: xxx Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage and so the quality of its services by continued vigilance around infection prevention and control processes and mandatory training for staff	
The number and where available rate of patient safety incidents reported within the Trust during the reporting period, and with the number and percentage of patient safety incidents that resulted in severe harm or death.					Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: The Trust continues to develop an improving reporting culture Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve the indicator and percentage and so the quality of its services by: incident reporting and investigating is discussed weekly at the Executive Rapid Review meetings and is also part of the TCI Value Stream #5 particularly in relation to sharing of outcomes and learning through safety huddles.	

2.4 Looking forward to our Priorities for Quality Improvement for 2018-2019

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

We have made sure that the Quality Priorities reflect our operational plan for the coming year as well as our values and strategic objectives. We have also mapped the priorities against the NHS Outcomes Framework (the priorities set out by the Department of Health for all NHS healthcare providers) against which we are measured and compared with our peers.

We have mapped our Quality Priorities against the three domains of Quality – Patient Safety, Clinical Effectiveness and Patient Experience. We have put a lot more information about how we aim to improve against these domains in our Quality Strategy "Safest and Kindest Every Day" about which you can read more on page…

Domain	What do we want to do better?	How are we going to do that?	How will we know when we have?
Safety	**NHS Outcomes Framework:** Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm **SaTH Strategic Objective 2018-2019:** SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care		
	Learning faster and better - to improve the learning from incidents especially those considered to be near miss or low harm to reduce the number of moderate and severe harm incidents	Complete the review of all incidents that have not been reviewed over winter 2017-2018 and develop clarity of understanding of themes and trends Increase incident reporting across the Trust Value Stream #5 will develop incident reporting by improving processes	Reduction of moderate and severe harm caused compared to 2017-2018 5% reduction in the number of reported: • High risk medication errors • Falls resulting in moderate or severe harm • Hospital acquired pressure ulcers
	All wards and clinical areas have safety huddles embedded as practice	Carry out baseline assessment of each ward and clinical areas practice of huddles to get a view of current state and to develop implementation plan Implement huddles in all clinical areas with agreed standard items for discussion Ensure learning from Value Stream #5 is rolled out in PDSA process	Reduction in incidents Improved patient experience scores Staff report better feedback from incidents

Domain	What do we want to do better?	How are we going to do that?	How will we know when we have?
Effectiveness	**NHS Outcomes Framework:** Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm Domain 3: Helping people to recover from episodes of ill health or following injury **SaTH Strategic Objective 2018-2019:** **PATIENT AND FAMILY** Listening to and working with our patients and families to improve healthcare **SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care**		
	Eliminate the practice of additional patients being placed inappropriately	Timely, safe discharge before lunchtime so that beds are available for patients coming into the hospital	Reduction in additional patients Improved satisfaction Reduced complaints
	We have less patients who are in hospital for more than 7 days (Reduction of stranded patients)	Discharge planning begins on admission with an estimated date of discharge agreed Links to collaborative working with the patient and their family	Length of stay Patient feedback Reduction in patients medically fit but still in hospital

Domain	What do we want to do better?	How are we going to do that?	How will we know when we have?
Experience	**NHS Outcomes Framework:** Domain 4: Ensuring that people have a positive experience of care **SaTH Strategic Objective 2018-2019:** **PATIENT AND FAMILY** Listening to and working with our patients and families to improve healthcare		
	Coproduction is business as usual within the Trust	In 2018-2019 develop the links with the patient panel and agree on process for coproduction across areas of the Trust including service development, attendance on committees and groups, taking part in Exemplar and other clinical	The Patient Panel new group will be set up ToR agreed Areas of responsibility agreed Examples of outputs

		walkabouts	
	Support for Carers	Work collaboratively with the carers of people with long term conditions and who are at the end of their lives to develop strategies to help them whilst their family member is in hospital	Agreed strategies will be achieved and examples can be given.
	Improved communication on the wards so that patients and their carers are aware of and are fully involved in their plans of care and the arrangements for discharge	Knowing who the ward manager is on the ward they are on Nurse in charge of the shift does rounds of patients at least twice a shift including when visitors are there so that they can answer any questions and ensure that planning is collaborative	Point prevalent survey to measure effectiveness FFT responses In patient survey
	Improved experience of ED	Better flow through the department Reduce 12 hour waits Ensure regular rounds when in ED	Measure experience of patients in ED

2.5 Statements of Assurance

This section of the Quality Account includes mandatory statements as instructed by the Department of Health. The aim of this is to provide information to the public that is common to Quality Accounts across all Trusts. These statements demonstrate whether the organisation is:

- Performing to essential standards
- Measuring clinical processes and performance
- Involved in national projects and initiatives aimed at improving quality

During 2017-2018 Shrewsbury and Telford Hospital NHS Trust provided and/or subcontracted the full range of services for which it is registered (these are detailed in the Annual Account and on our website).

The Trust has reviewed all the data available to it on the quality of care in 100% of these services.

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

Participation in Clinical Audits

Clinical audit is a method of improving our services by measuring what we do against national standards to ensure that we comply with them. If we find that we do not then we identify actions to address shortfalls and then measure again to see if they have worked. There are two main types of audit that we participate in:

National Clinical Audit and the Patient Outcome Programme (NCEPOP)

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

During 2017-2018 there were 64 national clinical audits and national confidential enquiries that covered services that Shrewsbury and Telford Hospital NHS Trust provides.

During that period Shrewsbury and Telford Hospital NHS Trust participated in 54 national clinical audits and five national confidential enquiries in which it was eligible to participate.

Key:

Eligible to participate in audit | Not applicable to SaTH | Eligible but not participating

***Audits on HQIP List 2017/18**

National Clinical Audit or Confidential Enquiry		*Eligible*	*Participating*	*Submission rate (%) / Comment*
Acute Myocardial Infarction (MINAP)*		✓	✓	100%
Adult Cardiac surgery*		×	N/A	Not applicable
ANS and BSCN standards for intraoperative monitoring (IOM) for Spinal Deformity Surgery		×	N/A	Not applicable
Anxiety and Depression*		×	N/A	Not applicable
British Association of Urological Surgeons	Cystectomy*	✓	✓	100%
	Nephrectomy audit*	✓	✓	100%
	Percutaneous Nephrolithotomy (PCNL)*	✓	×	Awaiting reply
	Radical Prostatectomy Audit*	✓	✓	100%
	Female Stress Urinary Incontinence Audit*	×	N/A	Not applicable
	Urethroplasty Audit*	×	N/A	Not applicable
British Thoracic Society (BTS)	Asthma (adult) - BTS	✓	✓	100%
	Bronchiectasis (adult)	✓	✓	100%
	Bronchiectasis (paediatric)	✓	×	Problems with identification of patients
	Bronchoscopy	✓	✓	89% PRH; 97% RSH
Breast and Cosmetic Implant Registry (BCIR)		✓	✓	100%
Cardiac Rhythm Management Audit (CRM)*		✓	✓	100%
Care in Emergency Departments (CEM)	Asthma (adult & paediatric)	✓	✓	100%
	Consultant sign-off in the A&E Department	✓	✓	100%
	Fractured Neck of Femur	✓	×	These audits cost £2000 year, and due to financial

National Clinical Audit or Confidential Enquiry		*Eligible*	*Participating*	*Submission rate (%) / Comment*
				constraints the Trust will no longer be able to submit data to the national audits, although they will still be carried out locally
	Pain in Children*	✓	×	Financial constraints
	Procedural Sedation in Adults*	✓	×	Financial constraints
	Severe sepsis & septic shock	✓	✓	100%
Case Mix Programme (CMP)*		✓	✓	100%
Child Health Clinical Outcome Review Programme (NCEPOD)	Cancer in Children, Teens and Young Adults*	✓	×	No eligible cases
	Children with Chronic Neurodisability*	✓	✓	100%
	Young People's Mental Health*	✓	✓	83%
Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Primary Care*	×	N/A	Not applicable
	Pulmonary rehabilitation*	×	N/A	Not applicable
	Secondary Care*	✓	×	Did not participate due to financial constraints
Congenital Heart Disease (CHD)		×	N/A	Not applicable
Dementia in General Hospitals*		✓	✓	100%
Elective surgery (National Proms Programme)*		✓	✓	100%
Endocrine and Thyroid National Audit*		✓	✓	100%
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database*	✓	×	Did not participate due to lack of resources, time constraints and workload
	Inpatient Falls*	✓	✓	100%
	National Hip Fracture Database (NHFD)*	✓	✓	On-going
GIRFT (Getting It Right First Time) Surgical Site Infection		✓	×	Data presented locally due to problem submitting data to GIRFT and lack of advice regarding this
Head & Neck cancer (Saving Faces)*		✓	✓	On-going
Heart Failure Audit*		✓	✓	100%
Inflammatory bowel disease (IBD) Registry, Biological Therapies Audit*		✓	×	Did not participate due to lack of admin support, and financial constraints
Investigation and Detection of urological Neoplasia in patients referred with suspected Urinary Tract Cancer (IDENTIFY)		✓	×	Consultants not aware of audit
Learning Disability Mortality Review Programme (LeDeR)*		✓	✓	100%
Major Trauma Audit (TARN)*		✓	✓	100%
Management of Intra-abdominal sepsis - one-off audit		✓	×	Lead surgeon and Research manager not aware of this research project
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Maternal mortality surveillance and mortality confidential enquiries*	TBC	TBC	Awaiting reply
	Perinatal Mortality Surveillance*	✓	✓	100%

National Clinical Audit or Confidential Enquiry		*Eligible*	*Participating*	*Submission rate (%) / Comment*
	Maternal morbidity confidential enquiries*	TBC	TBC	Awaiting reply
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Acute Heart Failure*	✓	✓	100%
	Non-invasive ventilation*	✓	✓	33%
	Perioperative diabetes*	✓	✓	Currently submitting data
Mental Health Clinical Outcome Review Programme	Safer Care for Patients with Personality Disorder (NCISH)*	×	N/A	Not applicable
	Suicide in children and young people (CYP) (NCISH)*	×	N/A	Not applicable
	Suicide, Homicide & Sudden Unexplained Death (NCISH)*	×	N/A	Not applicable
	The Assessment of Risk and Safety in Mental Health Services (NCISH)*	×	N/A	Not applicable
National Audit of Breast Cancer in Older People (NABCOP)*		✓	✓	On-going
National Audit of Care at the End of Life (NACEL)		✓	✓	Currently collecting data
National Audit of Intermediate Care (NAIC)*		×	N/A	Not applicable
National Bariatric Surgery Registry (NBSR)*		✓	✓	100%
National Bowel Cancer (NBOCA)*		✓	✓	100%
National Cancer Diagnosis Audit (NCDA)		×	N/A	Not applicable
National Cardiac Arrest Audit (NCAA)*		✓	✓	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)*		×	N/A	Not applicable
National Clinical Audit of Psychosis	core audit*	×	N/A	Not applicable
	EIP spotlight audit*	×	N/A	Not applicable
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)*		×	N/A	Not applicable
National Comparative Audit of Blood Transfusion programme	Audit of Transfusion Associated Circulatory Overload (TACO)*	✓	✓	100%
	Audit of Patient Blood Management in Scheduled Surgery*	✓	✓	100%
	Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients*	✓	✓	100%
National Diabetes Audit - Adult	Core Diabetes Audit*	✓	×	The information required cannot be extracted from our existing databases
	Foot Care Audit*	✓	×	Lack of resources, time constraints and workload.
	Inpatient Audit (NaDia) 2016*	✓	✓	100%
	Inpatient Audit (NaDia) 2017*	✓	✓	100%

National Clinical Audit or Confidential Enquiry		*Eligible*	*Participating*	*Submission rate (%) / Comment*
	Pregnancy in Diabetes	✓	✓	100%
	Transition*	TBC	TBC	Awaiting reply
National Emergency Laparotomy audit (NELA)*		✓	✓	100%
National Joint Registry (NJR)*		✓	✓	100%
National Lung Cancer Audit (NLCA)*		✓	✓	100%
National Maternity and Perinatal Audit (NMPA)*		✓	✓	100%
National Maternity Survey 2017		✓	✓	46.2% return rate
National Paediatric Diabetes Audit (NPDA)*		✓	✓	Awaiting reply
National Vascular Registry*		✓	✓	100%
Neonatal intensive and special care (NNAP)*		✓	✓	Numbers are variable depending on the audit indicator
Neurosurgical Audit Programme*		×	N/A	Not applicable
Oesophago-gastric Cancer (NAOGC)*		✓	✓	100%
Ophthalmology Audit (cataract)*		✓	✓	100%
Paediatric intensive care (PICaNet)*		×	N/A	Not applicable
Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)*		×	N/A	Not applicable
Perioperative Quality Improvement Programme		×	N/A	Not applicable
Prescribing Observatory for Mental Health (POMH-UK)	Assessment of side effects of depot and LA antipsychotic medication*	×	N/A	Not applicable
	Monitoring of patients prescribed lithium*	×	N/A	Not applicable
	Prescribing antipsychotics for people with dementia*	×	N/A	Not applicable
	Prescribing for bipolar disorder (use of sodium valproate)*	×	N/A	Not applicable
	Prescribing high-dose and combined antipsychotics on adult psychiatric wards*	×	N/A	Not applicable
	Prescribing Clozapine*	×	N/A	Not applicable
	Rapid tranquilisation*	×	N/A	Not applicable
	Use of depot/LA antipsychotics for relapse prevention*	×	N/A	Not applicable
Prostate Cancer Audit*		✓	✓	100%
Pulmonary Hypertension		×	N/A	Not applicable
Seizures and Epilepsies in Children and Young People (Epilepsy12)*		✓	✓	Awaiting reply
Sentinel Stroke National Audit Programme (SSNAP) *		✓	✓	On-going
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme*		✓	✓	100%
Seven Day Hospital Services Self-Assessment Survey		✓	✓	100%
Surgical Site Infection Surveillance Service		✓	✓	100%
UK Cystic Fibrosis Registry		×	N/A	Not applicable

National Clinical Audit or Confidential Enquiry	*Eligible*	*Participating*	*Submission rate (%) / Comment*
UK Parkinson's Audit*	✓	✓	100%
6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK	✓	×	No eligible cases

The reports of 34 national clinical audits and one national confidential enquiry were reviewed by the provider in 2017-2018 and Shrewsbury and Telford NHS Trust intends to take the following actions to improve the quality of healthcare provided:

Examples of actions taken following national audits		
Title		***Action***
Care in Emergency Departments (CEM)	Asthma (adult & paediatric)	• The outcomes of the audit were discussed at a cross site Consultant meeting • At the present moment in time due to the pressures of ambulance arrivals, space in the department, staffing levels it has not been possible to ensure that Salbutamol is given within 10 minutes, although in severe asthma requiring resuscitation this does occur.
	Consultant sign-off in the A&E Department	• New Cas card completed which includes consultant sign-off. These are now in use.
	Severe sepsis & septic shock	• We have 98% of staff that have completed the sepsis booklet with the remaining either on long term sick or maternity leave at present. • There has been a sepsis training session over 3 days that covered all of the staff including regular bank staff
Dementia in General Hospitals*		• A trial to introduce and promote the use of Butterfly boxes (snack boxes) is currently taking place and is planned to be rolled out throughout the Trust. • To ensure all staff are using an appropriate pain assessment (Abbey pain scale) where appropriate a video has been uploaded on to the intranet page, training undertaken on wards and newsletters have been developed to include this. • To improve the Patient living with Dementia and carers experience, we plan to engage with carer's networks and hand out carer's information packs /discharge leaflet. • To become a Dementia Friendly Community & Environment, we are planning to introduce dementia friends training on a monthly basis
Learning Disability Mortality Review Programme (LeDeR)*		• Increased training in Capacity Assessment and documentation. • Reported via Trust Mortality Group to Quality and Safety Committee
Major Trauma Audit (TARN)*		• Junior doctors teaching includes major trauma assessment. • Silver trauma issues communicated with all ED STAFF and speciality doctors including surgical and orthopaedic team.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Perinatal Mortality Surveillance*	A detailed action plan has been developed, and progress with this is updated on a quarterly basis. Some of the action points include: • All maternity staff received additional training around symphyseal fundal height measurement in the identification of FGR during 2016/17. A workbook with assessment has been developed and will be launched in April 2018 in order to reinforce their training

Examples of actions taken following national audits		
Title		***Action***
		• SaTH are in the process of recruiting two WTE in order to enable the 3rd trimester scan recommendations within RCOG guidance. • Educating women to contact maternity services and attend promptly if they are concerned about a reduction and/or a change in the pattern of in fetal movements has been prioritised. • 'How active is your baby' leaflet is now provided within the midtrimester information pack (24-28 weeks gestation) to all women. • Midwives have been educated on both the reduction **and** change in pattern of fetal movements. • There has been a complete review of fetal monitoring in labour since 2016 with an emphasis on improved training. All staff members required to assess CTGs are trained in the relevant aspects of CTG interpretation • Consistent and regular monitoring of the fetal heart during the transfer from an MLU to the Consultant Unit since 2017. • Initiation of a Birth Options clinic since January 2018 that allows exploration of women's views around their birth choice and then a clear record of agreed decisions. • Improved alignment of midwifery and medical handovers with an improvement in the quality and completeness of clinical information shared at handover. Further work around the improved use of SBAR will take place in 2018.
National Diabetes Audit - Adult	Inpatient Audit (NaDia) 2016*	• Intervention and education taking place through diabetes in reach • Online modules for the safe use of insulin are now available.
National Lung Cancer Audit (NLCA)*		A detailed action plan has been developed, which includes the following actions: • Performance status assessment and potential radiological diagnoses of lung cancer to be documented during the MDT • A deep dive audit is planned to further investigate patients whose potential performance status deterioration impacted on ability to undergo anti-cancer treatment • To investigate ways in which patients diagnosed via emergency routes can be reduced, there will be a meeting with CCG's to discuss the possibility of piloting CT screening of targeted populations locally • To implement the National Optimal Lung Cancer Pathway (NOLDP) the following actions will be undertaken: - Set up working group to process map current pathway and identify areas that would need addressing in order to meet requirements - Business case for two additional lung cancer nurse specialists to meet this part of requirements - Set up Nurse Led Follow-Up Clinics - Develop nodule pathways
Neonatal intensive and special care (NNAP)*		• Plan for improvement in admission temperature and 2 year follow-up rates. These domains have shown substantial improvement in 2017 compared to 2016.

Examples of actions taken following national audits	
Title	***Action***
	• Need to increase rate of Magnesium sulphate administration to mothers of babies delivering before 30 weeks of gestation. This has been highlighted to the Obstetric team (who are responsible for the delivery of this intervention to mothers).
Surgical Site Infection Surveillance Service	• All Surgical Site Infections: A review of the patient is carried out, looking at pre, intra and post operation risk factors, once completed the consultant and ward mangers are asked to comment. • High Infection rates are reviewed over time, looking for common links and trends.

Reviewing reports of local clinical audits

The reports of 153 local clinical audits were reviewed by the provider in 2017-2018 and Shrewsbury and Telford Hospital NHS Trust intends to take actions to improve the quality of healthcare provided. Some examples of local clinical audits are shown below.

Summary of examples of actions taken following local audits		
Audit Title		***Recommendations / Actions***
CLINICAL SUPPORT - PATHOLOGY & RADIOLOGY		
	Anatomical Marker, Jul-Dec 2017 (3982)	• RSH x-ray department has purchased generic anatomical markers for every general x-ray room • Findings of the audit were discussed at staff meetings to encourage the use of anatomical markers • A re-audit is planned to ensure improvements have been made
	Ankle Audit 2017 (3981)	• Written positioning techniques and suggested improvements were produced and emailed to every Radiographer. A hard copy is available for reference in each general department • A pictorial 5 point checklist was emailed to Radiographers
	CT Doses re-audit (3791)	• A Diagnostic Reference Level (DRL) for SaTH Low Dose Lung nodule CT will be included within 6 months
	CT KUB imaging (3939)	• Poster showing accepted levels for the scan has been produced and displayed in the department • A re-audit has been undertaken
	Familial hypercholesterolaemia – NICE Quality Standard 41 (3828)	• Staff were reminded to annotate in notes when dietary literature is given to patients and to discuss with females who are on medication re potential pregnancy • A re-audit is planned as per NICE 5 year rolling programme
	Hand Imaging 2016 (3980)	• Written positioning techniques highlighting the appropriate anatomy imaged were produced and emailed to every Radiographer. A hard copy is available in each general department • Examples of images showing optimum and poor position were produced and emailed to every Radiographer • A separate audit of general use of anatomical markers was produced
	Reporting times for major trauma 2017 (3918)	• Significant improvement since last year. • Outsourced reporting has now commenced therefore a re-audit is planned for next year for comparison.

Summary of examples of actions taken following local audits		
Audit Title		*Recommendations / Actions*
CLINICAL SUPPORT - PHARMACY		
	Are in-patients provided with enough information about their medicines? re-audit (3323)	• Discussion with pharmacist educational interventions program (PEIP) staff and questions amended • Further study/research to be undertaken by Aston Undergraduate to further understand the barriers
CLINICAL SUPPORT - THERAPIES		
	Dietitian Home Enteral Feeding (HEF) service for children (3439)	• Referrals to clinic have been reviewed and prioritised • A re-audit is planned
	Physiotherapy assessment of all patients aged 65 and over, and all patients aged 50-64 deemed high risk of falling on Medical Wards at the Royal Shrewsbury Hospital, NICE Clinical Guideline CG161 (3882)	• Training has been provided to all physiotherapy staff on Medicine on the correct completion of social histories. This training is on-going and is now provided to all new starters. • A plan to produce a 'user guide' for therapists in the frailty team, which will include referral pathways, such as falls services • Training to the physiotherapy medical team at RSH is planned and will include a rotational training program • A re-audit is planned
CORPORATE – TRUST WIDE		
	DCT and AND Audit – 2017 (3752)	• On-going educational sessions are planned to promote use of MCA form 1 &2 to evidence capacity decisions in training across the Trust • Further discussions are to be held to consider the implementation of ReSPECT across the healthcare economy. • A re-audit has been undertaken
	Deprivation of Liberty Safeguards – referrals (3957)	• The practice of safe bays within the Trust on some wards has not significantly reduced the Deprivation of Liberty Safeguards referrals for urgent authorisations. There will be continuous monitoring through re-audit
	End of Life 2017 (3821)	• A new version of the End of Life Care Plan will be implemented in Spring 2018 • A re-audit is planned following implementation of the new documentation
SCHEDULED - ANAESTHETICS, THEATRES & CRITICAL CARE		
	Deaths following anaesthesia (2156)	• The Trust has commenced a new mortality review process. Any anaesthesia-related issues will be highlighted in the new process by the respective care group.
	Epidural/Dural Tap re-audit 2016 (3809)	• A questionnaire has been designed, in consultation with the labour ward manager and the postnatal ward manager, and with the other obstetric anaesthetists. It is implemented, and a box is on the postnatal ward for this purpose.
	Handover of post op patients to recovery staff (3782)	• Feedback to anaesthetics team that recovery staff would like slightly more information on anaesthetics problems, intra-operative problems and the post-operative plan particularly for frail and complex patients • A re-audit is planned
	Management of Accidental Dural puncture and its outcome in obstetrics re-audit (3722)	• A questionnaire has been designed, in consultation with the labour ward manager and the postnatal ward manager, and with the other obstetric anaesthetists. It is implemented, and a box is on the postnatal ward for this purpose.

Summary of examples of actions taken following local audits		
Audit Title		*Recommendations / Actions*
SCHEDULED - HEAD, NECK AND OPHTHALMOLOGY		
	Dental abscess management (3697)	• Further advanced airway management training is in place to support the anaesthetists
	NHSLA Casenote & Stamp Max Fax 2016 (3692)	• Systematic checking of notes ideally to ensure that entries are as consistent and detailed as possible • A re-audit is in-progress
	Surgical management of OME – NICE Clinical Guideline CG60 (3398)	• Encouraging examination of general ENT health and developmental status in children with OME is now part of CPD • A proforma for use in clinic to ensure NICE guidelines are met is under development • A re-audit is planned as per NICE 5 year rolling programme
	Timing of audiometry before middle ear surgery (3432)	• A check at pre-assessment with a trigger to refer to audiology if >3months since last audiogram has been introduced • Arrangements are underway for morning slots for patients on the day of surgery are being
SCHEDULED - MSK		
	Accuracy of hip fracture classification for National Hip Fracture database (NHFD) (3598)	• A hip fracture poster and NHFD categories poster has been displayed in the T&O meeting room & theatre coffee room • A local teaching session with junior doctors and nurses responsible for NHFD coding, focus teaching on areas identified has taken place • A re-audit is planned
	Outcomes against National Hip Fracture Database (NHFD) (3614)	• A single page guideline for the management of hypotension based on NICE guidelines to guide junior doctors called to see patients with fractured neck of femur has been produced • During winter additional physiotherapy will be available at weekends from November to April
	Telephone follow up hip and knee arthroplasty (3967)	• Telephone follow up has proven safe and effective, and arrangements have been made for this service to continue
	Transfusion rate in hemiarthroplasty for hip fracture – NICE Clinical Guideline CG124 (3732)	• There is now an extended Trauma theatre session on a Thursday evening to accommodate these patients in accordance with national guidelines
SCHEDULED - SURGERY, ONCOLOGY & HAEMATOLOGY		
	Bladder CBCTS – 109 (3891)	• Bladder protocol and associated documentation have been reviewed • A re-audit is planned
	CT 7 3 2d1R – 95 (3797)	• T quality system has been fully updated to conform to changes in BSI standard
	Endoscopy Unit Patient Satisfaction Questionnaire (10) - re-audit (3768)	• Bookings have now become centralised at RSH and under one management who have the overall responsibility of all endoscopy bookings. Endoscopy unit managers and the bookings teams work closely together to ensure an efficient service • Unit managers have reviewed patient information leaflets sent regarding delays and dietary advice
	Management of Suspected Neutropenic Sepsis against NICE Guidance and Trust Policy (3348)	• The Acute Oncology Team are developing a risk assessment tool recommending when to change from IV to oral antibiotics in low risk patients
	NHSBSP guidelines and use of vacuum-assisted excision (VAE) for B3 pathology - a 5 year audit	• This audit demonstrates that this saves money and reduces the steps in the patient's pathway. Therefore full

Summary of examples of actions taken following local audits		
Audit Title		*Recommendations / Actions*
	(3715)	implementation is planned
	Surgical Casenote Audit 2017 (3723)	• Senior review of medical notes during and after ward rounds to take place • Regular reminders to staff members about GMC guidelines with results that failed to meet standards • An annual re-audit is planned
	Use of biphosphonates in patients with newly diagnosed multiple myeloma - re-audit (3807)	• Document reasons for choice of bisphosphonate in letters/notes if NOT using zolendronic acid • Documenting creatinine clearance and dose adjustments in notes is on-going
	Weekend Handover of Surgical Inpatients (3765)	• Rota change implemented to move "twilight" junior doctors shifts (across all junior doctor grades) back to Fridays to allow more effective clinical handover between staff directly involved in weekend on call shifts • Implementation of new handover process and documentation is planned
UNSCHEDULED – EMERGENCY ASSESSMENT & MEDICINE		
	Assess completion of diabetic foot examinations within 24 hours of admission (3501)	• Nursing admission document has been amended to include foot assessment in patients with diabetes • A teaching session has been added to the FY1 and FY2 training programme and raised at governance. • A re-audit is planned
	Headaches – NICE Clinical Guideline CG150 (3829)	• Creation of a Headache letter template • A re-audit is planned as per Trust NICE 5 year rolling programme
	HPA Urine Compliance - 2016 PRH (3607)	• ED Cas Cards have been updated to include a section for urine dip stick testing
	Mental Health in Emergency Department (3859)	• ED Cas Cards have been updated to include a Mental Health section
	Think Glucose - patient experience survey 2014 - re-audit (3052)	• On-going ward nurse training is reinforced by study days, general training and opportunistic ward teaching
	VTE Assessments on AMU: A Snapshot Audit (3822)	• Two consultant acute physicians on both sites do a full ward round of the AMU and ensure the VTE assessment is done on seeing the patient • New care bundle (post take ward round bundle) has been placed in the post take ward round section of the medical assessment document to ensure it has been completed
WOMEN & CHILDREN'S		
	Child Protection 2016 re-audit (3676)	• Regular checks on documentation will now form part of a quality improvement programme • A re-audit is planned
	Completion of Local Safety Standards for Invasive Procedures (LOCSSIPs) in gynaecology clinics 2017 (3741)	• Juniors were given a short teaching session on the correct completion of gynaecology LOCSSIPs forms • A re-audit has been planned
	Compliance of completion of Local Safety Standards for Invasive Procedures (LocSSIP) documentation (3840)	• Results have been displayed on the communication board on the neonatal unit and presented to Neonatal-Maternity Governance • The proforma has been modified and has now been implemented
	Failed Outpatient Hysteroscopy (3671)	• To identify likely difficult patients (using TCI form) –

Summary of examples of actions taken following local audits		
Audit Title		***Recommendations / Actions***
		procedure to be assigned to a particular clinician/ allocate extra time for this patient /book for hysteroscopy under GA. This is done at present due to increase awareness • A re-audit is planned
	Infants at risk of perinatal transmission of blood-borne viruses (3813)	• Maternity are in the process of streamlining neonatal alerts for Hep C in 'high risk' women
	Inotrope treatment episodes NNU Time to treat & choice of treatment (3837)	• Education for neonatal team for persistent pulmonary hypertension (PPHN) & inotrope use is to be scheduled in teaching programme • Pharmacy have amended the labels to include time of prescription. This is in the process of being implemented • To ensure urgent medications and emergency situations are prioritised during handover periods, this has been shared as a message of the week (newsletter)
	Initiation of enteral feeds in very-low-birth weight preterm infants (3418)	• The Nutrition Guideline has been updated and is now on the intranet. • Liaison with SaTH Infant Feeding Advisor with regards to facilitating early expressing in mothers post delivery - SaTH has achieved Stage 3 Baby Friendly Accreditation from UNICEF
	Ovarian cancer - Initial management (3869)	• There has been a change in local practice following a serious case review, it is now compulsory that all patients have a documented Risk of Malignancy Index (RMI).
	Sedation in children (3739)	• Play therapy leaflet for parents to be designed • Support for innovative Play concepts has been implemented • This project has been accepted for the MRPS meeting in Birmingham Children's Hospital for a poster presentation • A re-audit has been planned
	Unplanned extubation in the Newborn (3786)	• The 10 point plan has been introduced in the neonatal unit

Research and Development

The number of patients receiving relevant health services provided or subcontracted by Shrewsbury and Telford Hospital NHS Trust in 2017-2018 that were recruited during this period to participate in research approved by a research ethics committee was 1736 against a target of 1674. The target is set by the National Institute of Health Research (NIHR) Clinical Research Network based upon the funding we receive from them.

Research ultimately is about developing and delivering more effective and more efficient care to patients. There is good evidence that organisations that are research active routinely have improved patient outcomes, with benefits not restricted to just those who participate in research activities.

SaTH is committed to active participation in Clinical Research in order to improve the quality of care we offer our patients, and also to make a contribution to wider health improvement. In doing so our clinical staff stay abreast of the latest possible treatment regimens and active participation in research provides the evidence base for improving care and health outcomes.

Our value which we promote is that research is a core part of the NHS. NHS patients therefore can expect to be informed of approved research that is relevant to their health and care, and offered a trial as part of their care pathway. Our Research and Innovation (R&I) team provide the essential

infrastructure for all specialties to have the opportunity to offer their patients appropriate participation.

For the year 2016 -2017 the Trust was featured in the NIHR League table in 76th place (down one place) for the total number of participants recruited into clinical trials and 56th place (down one place) for the total number of recruiting clinical trials.

Due to the funding cut and recruitment freeze in previous years the above was achieved with 4WTE less across the team than the previous year.

The number of actively recruiting Principal Investigators has stayed at 61, with some new clinicians recruiting. We have more non-Medic Principal Investigators recruiting significantly into studies, and we are recruiting into more specialties than ever before.

We are proud to be involved in the 100,000 Genomes project and we recruited our 100th patients into the Rare Disease cohort in March 2018. Recruitment into the Cancer cohort will commence in April 2018.

Some of the successes of 2017-18

- SaTH received 2 highly commended awards at the CRN awards earlier this year for Commercial studies delivering to time and target and Best Overall performance.
- One of our clinicians has been appointed the Chief Investigator to a suite of 3 commercial studies involving Ulcerative Colitis
- The top recruiting site in the UK for a commercial study evaluating productivity loss and associated costs in cardiovascular patients.
- In the top 10 recruiting sites in the country for an observational commercial cancer study.
- SaTH 4th top recruiter in the UK into the STAMPEDE study for newly diagnosed advanced prostate cancer
- SaTH 3rd top recruiter out of 20 into an observational study looking at the treatment pathways of men with prostate cancer.
- A 101 year old patient was recruited into a study here at SaTH!

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

A proportion of our income in 2017-2018 was conditional on achieving quality improvement and innovation goals agreed between our commissioners through the CQUIN framework. Some CQUIN schemes are nationally agreed as they reflect national priorities and best practice and others reflect local priorities that aim to support and encourage improvement and innovation. These are the CQUINS that were agreed during 2017-2018:

Detail will not be known until 31 May

Priority	Number	Scheme	Have we achieved the CQUIN?
National	1a	Improvement of Health and Wellbeing of NHS staff	
National	1b	Healthy food for NHS staff, visitors and patients	
National	1c	Improving the uptake of flu vaccinations for front line clinical staff	
National	2a	Timely identification of sepsis in emergency departments and acute	

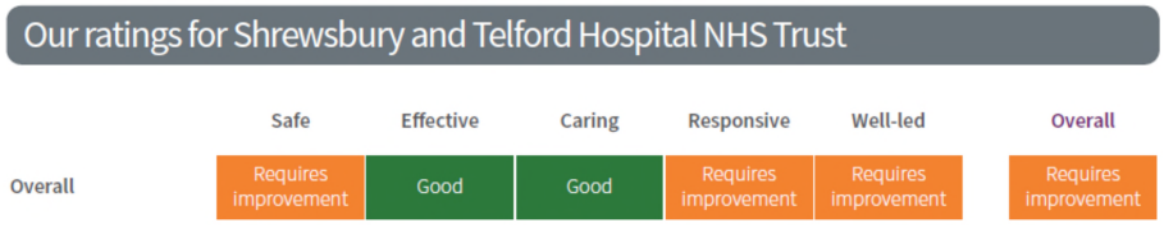
Priority	Number	Scheme	Have we achieved the CQUIN?
		inpatient settings	
National	2b	Timely treatment of sepsis in emergency departments and acute inpatient settings	
National	2c	Antibiotic Review	
National	2d	Reduction in antibiotic consumption per 1000 admissions	
National	4	Improving services for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

Statements from the Care Quality Commission

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

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

The CQC carried out a planned inspection of our services in December 2016. This inspection was to review how we had progressed since the previous inspection the CQC carried out in 2014 particularly against the areas where they felt we most needed to improve. We received the report of the inspection in 2017 and the overall finding of the CQC was that the Trust "requires improvement".



Our ratings for Royal Shrewsbury Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Our ratings for Princess Royal Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Staff were identified as caring and compassionate in their care of patients and all SaTH's services have been rated as good under the category of "caring". The inspectors identified a number of areas of outstanding practice including:

- Openness and transparency about safety was encouraged. Incident reporting was embedded among all staff, and feedback was given. Staff were aware of their role in Duty of Candour.

- In every interaction they saw between nurses, doctors and patients, the patients were treated with dignity and respect. Staff were highly motivated and passionate about the care they delivered.

- There were clearly defined and embedded systems, processes and standard operating procedures to keep people safe and safeguarded from abuse.

- Treatment was planned and delivered in line with national guidelines and best practice recommendations

Inspectors said they saw examples of good care on every ward and department they visited. But a number of areas for improvement are also highlighted. These include poor medical staffing levels and failing to achieve the Department of Health's target of discharging, admitting or transferring 95% of A&E patients within four hours. These are areas the Trust expects to improve once the proposed strategic service redesign is delivered.

The Trust recognises the report as being fair and balanced and will be working closely with the CQC to ensure that they return to our hospitals to visit areas that they did not see in December 2016 where we know we have made significant improvement.

The Trust was also given an overall score of "good" for effective care – an example of improvement is in the care given to patients at the end of their lives with the introduction of the Swan Scheme which was recognised by inspectors as outstanding practice.

Our commitment to Data Quality

Information Governance Toolkit Attainment Levels
The Information Governance Toolkit Assessment (IGT) supports the delivery of high quality care by promoting the effective and appropriate use of information.

The Data Security and Protection Toolkit (DSPT) will replace the current IG toolkit from April 2018 as the standard for cyber and data security for healthcare organisations.

Compliance with the DSP Toolkit requires organisations to demonstrate that they are implementing the ten data security standards recommended by the National Data Guardian Review as well as complying with the requirements of the General Data Protection Requirements (GDPR).

Overall Score: 70%

Initiatives	Level achieved 2018	Grade
Information Governance Management	80%	Satisfactory
Confidentiality and Data Protection Assurance	75%	Satisfactory
Information Security Assurance	66%	Satisfactory
Clinical Information Assurance	66%	Satisfactory
Secondary Use Assurance	70%	Satisfactory
Corporate Information Assurance	66%	Satisfactory

Awaited
- Clinical coding error rate
- Data Quality improvements

Part three: Quality at the Heart of the Organisation - review of quality performance

3.1 Transforming Care Production System in partnership with Virginia Mason Institute (VMI Seattle, USA)

The Trust commenced the partnership with VMI in 2015 and applying our own version of the methodology, the Transforming Care Production System (TCPS), to our processes in SaTH from early 2016. The journey to embed one improvement system into the Trust, to a point where doing the work, and improving the work every day is just how all staff work throughout the organisation, requires consistent focus and effort.

Nearly 2,700 staff have been educated (30 minutes or more) in the key concepts of the Transforming Care methodology, demonstrating great engagement and commitment to improving the service offered to patients and their families. The Kaizen Promotion Office (KPO) team are responsible for the delivery of the associated training from induction to Advanced Lean Training (ALT) and accreditation for Team Lead and Workshop Leads for the improvement events. The KPO team are on course to educate 5000 staff within 5 years to support the culture change, and supporting a 1000 of these staff members through TCPS education during 2018/19.

However, this transformation journey is far more than the teaching of lean tools; embedding a culture change and a world class management approach are also fundamental to the philosophy of TCPS that will support continuous improvement. To support this culture change, all staff who are line managing one or more staff will be required to undertake Lean for Leaders training. Over 100 SaTH leaders have currently completed, or are actively engaged in the Lean for Leaders programme, and the 2018/19 objective is to support a further 50 staff to Lean Leader accreditation.
Lean Leaders are central to the implementation of TCPS, embedding standard work for leaders in their daily management. One element, the People Link boards, support managers in joining the dots from the organisational strategy through to the everyday work, and describe the department's role in delivering key Trust objectives, making the work transparent. Lean Leaders have the skills to support their teams with every day continuous improvement, and coach their teams to understand the impact of the changes.

The Executive level support and leadership for this work is essential to its success, and is guided via the Transformational Guiding Team meetings, with input from NHSI, non-executive Director, Brian Newman and VMI Executive Sensei, Deborah Dollard. This group, with wider staff involvement have helped focus the value stream work on key organisational priorities, promoting the use of the methodology to investigate performance variation and Trust challenges.

One key lean tool of the Transforming Care Production System is 5S; this is a tool used to increase the organisation and safety of our physical environment. Over 70 areas across the Trust have demonstrated successful implementation of this approach, and in 2018/19 the KPO Team are looking to expand the application of this approach further through Lean for Leaders training, and also increasing the number of 5S training workshops being offered.

Current value streams include:

Respiratory Discharge Value Stream which has implemented over 13 improvements, leading to a two day reduction in the length of stay and an increase in the numbers of patients cared for in our two respiratory wards. During 2018-2019 the Unscheduled Care Group, now owning this work, will spread the learning across all wards in the Care Group and monitor the impact through measurement.

The **Sepsis Value Stream** Sponsor Team will spread their learning during 2018-2019 to standardise the approach to diagnosing and treating sepsis. Their improvement workshops have demonstrated the potential to significantly reduce the time taken to deliver this life saving treatment, but also the complexity of implementing and sustaining standard work to a disease process that develops very quickly.

The **Outpatient Ophthalmology Value Stream** work has focused on the experience of patients attending the eye clinics. Central to their success has been the involvement of patients in co-designing changes to the environments and the improvements to processes. In 2018-2019 the team will continue this approach, taking every opportunity to gain feedback from patients and their families. It is anticipated that the value stream will transition over to the operational team this year.

Recruitment processes (non- medical and medical). The **Recruitment Value Stream** Team have had significant success in reducing the time taken to recruit into posts and reducing the overall vacancy priority for the organisation.

Patient Safety (investigation and learning from incidents) Value Stream Team has introduced safety huddles within the Women and Children's Care Group and will spread this approach Trust-wide during 2018/19. The work is focusing on how, as a Trust, we can maximise the opportunity to learn from incidents, improve the way in which we feedback to staff, patients and their families, and reduce the possibility of similar incidents. In line with our approach to the work in the other value streams, the Patient Safety Value Stream Team has patient representation.

Emergency Department Pathway and Radiology Process Value Streams: Colorectal urgent referral for MRI scan, are the two new Value Streams recently launched, and will have their improvement workshops during 2018/19. All values streams have overarching target metric that influence the selection of topics for the rapid process improvement workshops.

3.2 Patient Safety

Incident Reporting
Patient Safety Incidents are routinely reported, monitored and reviewed to identify learning that may help to prevent recurrence.

In the report following the visit in December 2016, the CQC noted that openness and transparency about safety was encouraged and that there were clearly embedded systems, processes and standard operating procedures to keep people safe. However, they also noted that there is a need to continue to drive improvement in the way we report and investigate incidents and share the learning that results. This has been one of our priorities in 2017-2018 and as such we have introduced two major initiatives to ensure that we improve on how we learn all the time.

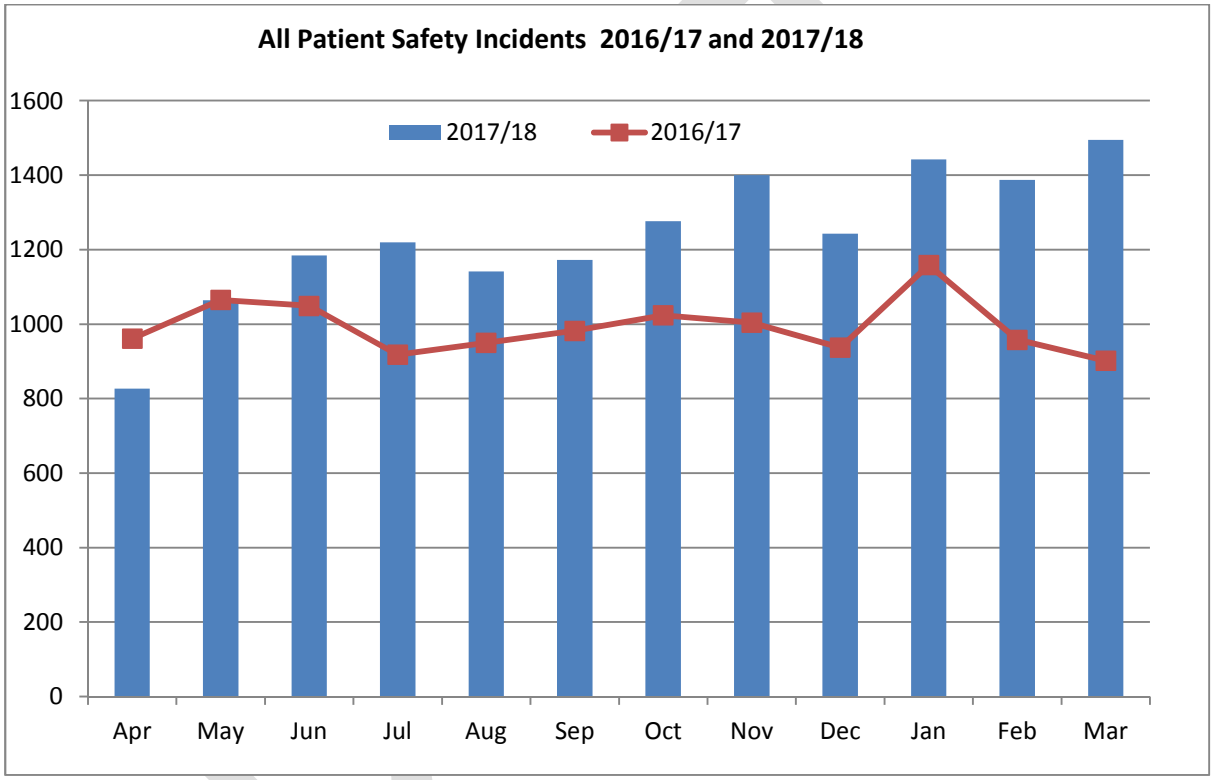
One of these is the Executive Rapid Review – a meeting that is held weekly and which looks at all moderate and severe harm incidents from the previous seven days along with all complaints from the same time period. This ensures that we are identifying trends early, that the right processes are in place, that incidents are graded correctly and where applicable the Duty of Candour is applied.

The other, touched on above in the section about the Transforming Care Institute is Value Stream #5 – Patient Safety. This exciting initiative which has been running since December 2017 uses the tried and tested methodology learned from the work with the Virginia Mason Institute to explore in depth specific areas of patient safety – for example, reporting and learning from incidents. This will be rolled out further in 2018-2019 and we look forward to reporting our progress with this work.

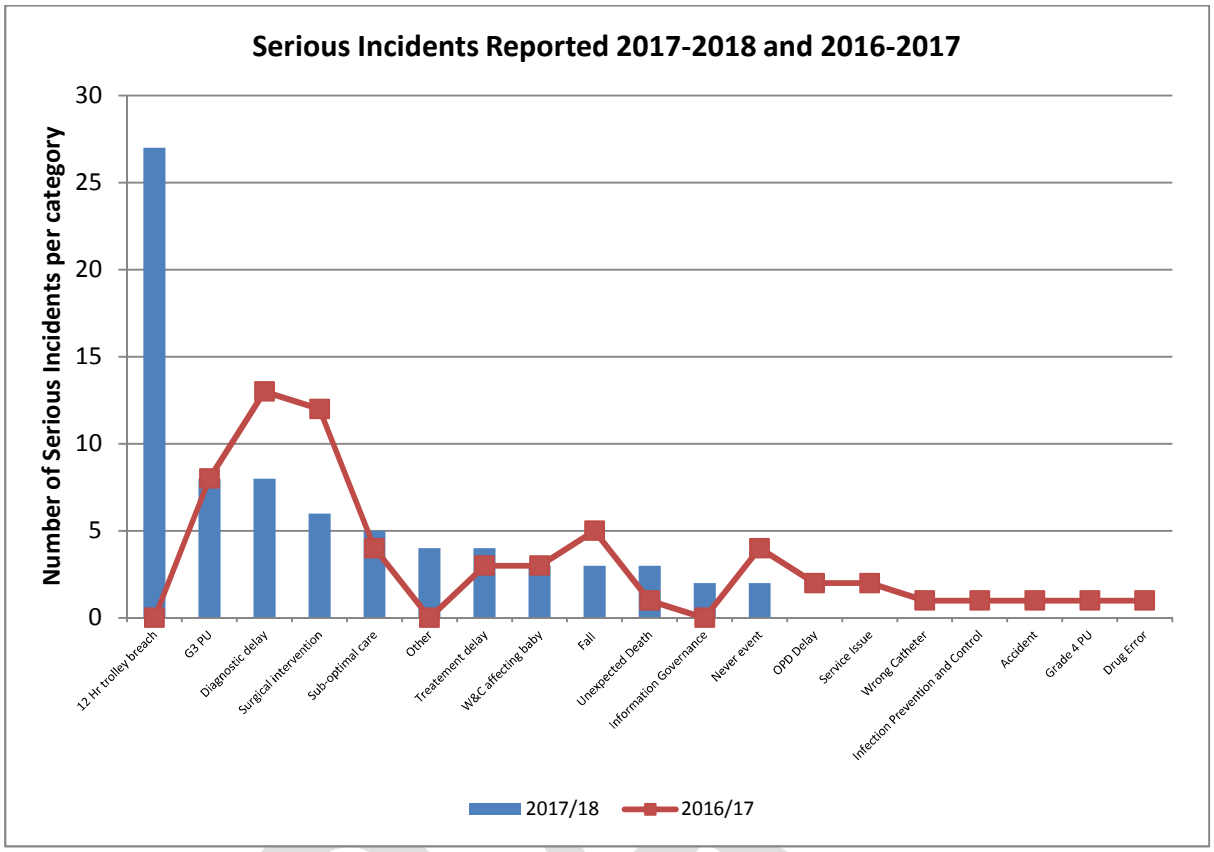
The Trust has reported two Never Events (nationally defined) in 2017-2018 one of which occurred in our operating theatres and the other in one of our emergency departments. One was in October 2017 and the other in February 2018. The investigation for the most recent Never Event is in progress at the time of writing this Quality Account and the investigation of the other shows that there are lessons relating to process and procedures that should be learned. An example of this is around the use of software that the Trust uses in such procedures. Completion of actions are monitored by the Care Group Board and through them the Quality and Safety Committee.

We use an electronic risk management system called Datix that we use to report all Patient Safety Incidents. The reporting activity is monitored as part of the Quality Performance Report which is submitted to the Board having been discussed at the Quality and Safety Committee.

During 2017-2018 we saw an increase in the total number of incidents being reported compared to the year before which demonstrates that staff are confident to report concerns and know how to.



There were 75 Serious Incidents reported in 2017-2018 compared to 62 in 2016-2017 as shown below:



The chart shows that in 2016-2017 we did not report 12 hour trolley breaches (when a patient is delayed in our emergency departments for more than 12 hours once the decision has been made that they need to be admitted) as this became a requirement of our commissioners during 2017-2018. The actual number of trolley breaches is higher than 27 as several incidents may be reported on each report.

We are pleased to note that we have not reported any avoidable grade four (the most serious) pressure ulcers during the year and have not increased the number of grade three pressure ulcers. We have also recorded less patients experiencing severe harm following a fall in our care.

We have reviewed the way that we investigate incidents during 2017-2018 and have commissioned external training provision for the Trust to ensure that the staff that lead investigations receive the level of training that they need. This has resulted in a core of Lead Investigators across the different areas of the Trust who can be called upon to lead an investigation supported by specialists from within the Care Group where the investigation has occurred. This process now needs to be embedded and a revised Incident Management Policy has been written which will support this going forward into 2018 and beyond.

Duty of Candour

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

The Duty of Candour has been implemented across the Trust and the existing policy is in the process of being revised to ensure that staff are clear of their responsibilities in relation to it.

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

We are also making sure that clinicians implement the Duty of Candour for those incidents resulting in what is described as moderate harm. We want to make sure that the communication with patients, their families or carers is of the highest standards whether it is verbal or written. During 2017 we have improved how we monitor this through the weekly Executive Rapid Review meeting which, should an incident be confirmed as being moderate, Duty of Candour evidence will be required. We have also produced patient leaflets to give to patients to ensure that they understand the process.

Patient Safety Alerts

Through the analysis of reports of serious incidents and new safety information from elsewhere NHS Improvement develops advice for the NHS that can help to ensure the safety of patients, visitors and staff.

As information becomes available, NHS Improvement then issues alerts on potential (and known) risks to patient safety. At SaTH these are coordinated and monitored by the Patient Safety Manager who disseminates the alerts to the appropriate clinical teams who ensure that we are already compliant or that there is an action plan to ensure we become so. This process is monitored every time our Clinical Governance Executive meets to make sure it remains at a high level of visibility. The table below shows the alerts that we have received during 2017-2018 and our progress against them. We fully complied with the compliance deadlines for those that have already passed although one has not yet reached its compliance target date.

Alert identifier	Alert Title	Date received - circulated	Closure target date	Closure Date	Status
NHS/PSA/Re/2017/001	NHS/PSA/Re/2017/001 - Resources to support safer care for full-term babies	Issued 23/02/2017 Circulated 28/02/2017	23/08/2017	24/08/2017	Closed
NHS/PSA/RE/2017/002	Resources to support the safety of girls and women who are being treated with valproate	Issued 06/04/2017 Circulated 06/04/2017	06/10/2017	05/10/2017	Closed
NHS/PSA/W/2017/003	Risk of death and severe harm from ingestion of superabsorbent polymer gel granules	Issued 05/07/2017 Circulated 11/07/2017	16/08/2017	14/08/2017	Closed
NHS/PSA/RE/2017/004	Resources to support safe transition from the Luer connector to NRFit™ for	Issued 11/08/2017 circulated 14/08/2017	11/12/2017	07/12/2017	Closed

Alert identifier	Alert Title	Date received - circulated	Closure target date	Closure Date	Status
	intrathecal and epidural procedures, and delivery of regional blocks				
NHS/PSA/W/2017/005	Risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies	Issued 27/09/2017 circulated 02/10/2017	08/11/2017	02/11/2017	Closed
NHS/PSA/D/2017/006	Confirming removal or flushing of lines and cannulae after procedures	Issued 09/11/2017 circulated 14/11/2017	09/08/2018		Open within timescales
NHS/PSA/W/2017/001	Risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders	Issued 09/01/2018 circulated 16/01/2018	20/02/2018	21/02/2018	Closed

NHS Safety Thermometer

This year we have continued to submit data as part of the NHS Safety Thermometer data set – a "snapshot" of all patients in the NHS on one day per month, measuring whether they have a pressure ulcer, have fallen in the previous 72 hours, have a catheter with an associated infection or a venous thromboembolism (blood clot) as these are the four most common harms that are measured in the NHS.

This year (2017-2018) our average percentage of patients recorded as being free from any of these harms was 91.72% and our average percentage of patients that we recorded as not having developed any of these harms in our care was 96.48%.

Venous Thromboembolism

Venous thromboembolism (VTE) is a condition in which a blood clot forms in a vein. It most commonly occurs in the deep veins of the leg which is called a deep vein thrombosis (DVT). The clot may dislodge from its site of origin to travel in the blood – called an embolism. This can travel to the lungs (pulmonary emboli) which can be extremely serious and at times, life threatening.

We screen patients for the risk factors for VTE on admission to hospital. This is the responsibility of the medical staff admitting the patient and is monitored closely on a monthly basis through the processes within the Trust. The Board is made aware of the compliance of the Trust against the national target of 95% through the Quality Performance Report.

Infection Prevention and Control (IPC)

The IPC service is provided through a structured annual programme of work which includes audit, teaching, policy development and review as well as advice and support to staff and patients. The main objective of the annual programme is to maintain the high standard already achieved and enhance or improve on other key areas. The programme addresses national and local priorities and

encompasses all aspects of healthcare provided across the Trust. The annual programme is agreed at the IPC committee and then reported to the Trust Board.

The Infection Prevention and Control (IPC) team continue to focus on the basic principles of good hand hygiene, environmental cleanliness, adequate decontamination of shared equipment, and ensuring that good practice in managing medical devices are complied with consistently. Our main challenges are the increasingly high patient flow and lack of capacity to isolate patients with infection effectively.

The Trust reports all cases of C Difficile (CDI) diagnosed in the hospital laboratory to Public Health England. However only cases where the sample was taken more than 72 hours after admission are considered attributable to the trust. Our target for C Difficile in 2017-2018 was to have not more than 25 Trust apportioned cases in patients over the age of two years. The number of C Difficile cases at the end of year is 32 so unfortunately we have not achieved our target.

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

Fifteen cases were apportioned to SaTH in first six months of the year (samples taken post 72 hours). This rose slightly to seventeen cases in the second six months. At the end of quarter three we had 26 cases of which the CCG review panel found that 19 were associated with a lapse in care, so this will be taken into account when determining financial penalties.

CDI lapse in care common themes included delay in sending samples, lack of evidence relating to antimicrobial stewardship.

At year end we have had zero cases of MRSA Bacteraemia (bacteria in the blood). It was now been 600 days since our last recorded case in the Trust.

Vancomycin resistant enterococcus (VRE) (post 48 hours) - we have had 32 cases (compared to 59 2016-17 and 117 2015-16). Fortunately most patients have been colonised rather than showing active infection.

MRSA new cases (not bacteraemia) – 18 cases so far this compares to 18 cases last year and 30 cases in 2015-16—we are reducing the ways that people can pick up the bacteria in the first place. We do this by screening all admissions apart from those in very low risk groups and if MRSA is detected we can then make sure we can offer a clearance regime with topical creams and sometimes milder antibiotics.

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

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

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

Quality Ward Walks

The IPC Nurses undertake a programme of monitoring within wards and departments. The Quality Ward Walk concentrates on four main areas; Cleanliness, Equipment, Isolation & Management of

Infected patients and Invasive Devices. The IPC nurses also record any other observations of IPC concern. The audit form is designed to give an overall percentage score so wards can be monitored over time for trends and also so the IPC nurses can identify challenges at both ward and Trust level.

At the time of Quality Ward Walk the IPC nurse verbally reports any areas of good practice and any concerns to the nurse in charge. A summary report including photos of areas of non-compliance is produced and emailed to the Ward manager, Matron, Head of Nursing, Associate Director Patient Safety and IPCT. The IPC link nurse, Domestic services' supervisor and Estates advisor are informed by exception based on findings.

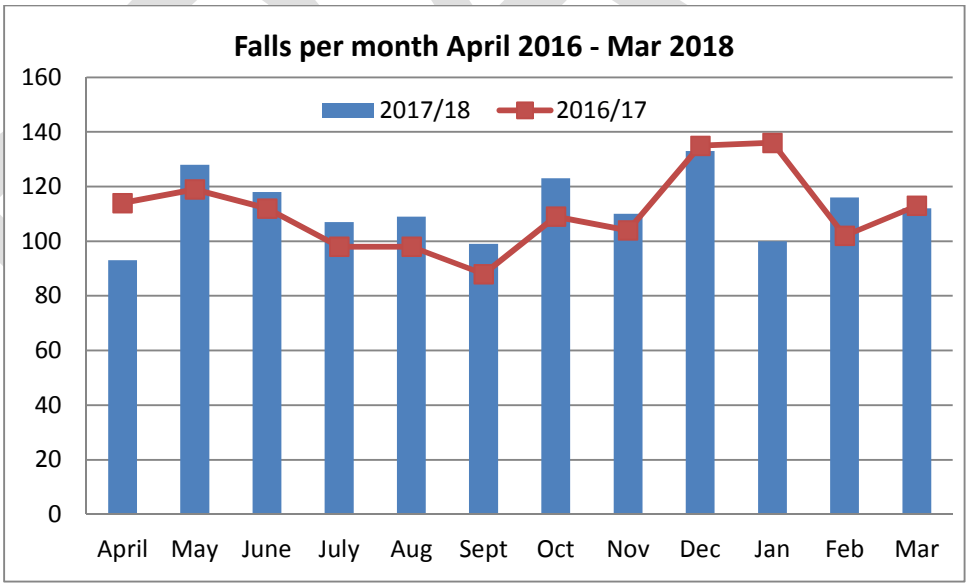
Detailed recommendations form part of the report and the IPC nurses request email feedback to be completed within two weeks. If the compliance score is significantly less than 80%, supported visits are undertaken by IPC team giving opportunity to observe the changes made to improve practice. In addition clinical areas that experience periods of increased infection, outbreaks or alert organism attribution will have spot checks undertaken in addition to the quarterly programme.

Since the IPC nurses have developed a feedback assurance process, areas that do not provide feedback in a timely manner are monitored closely and concerns escalated to the Heads of Nursing.

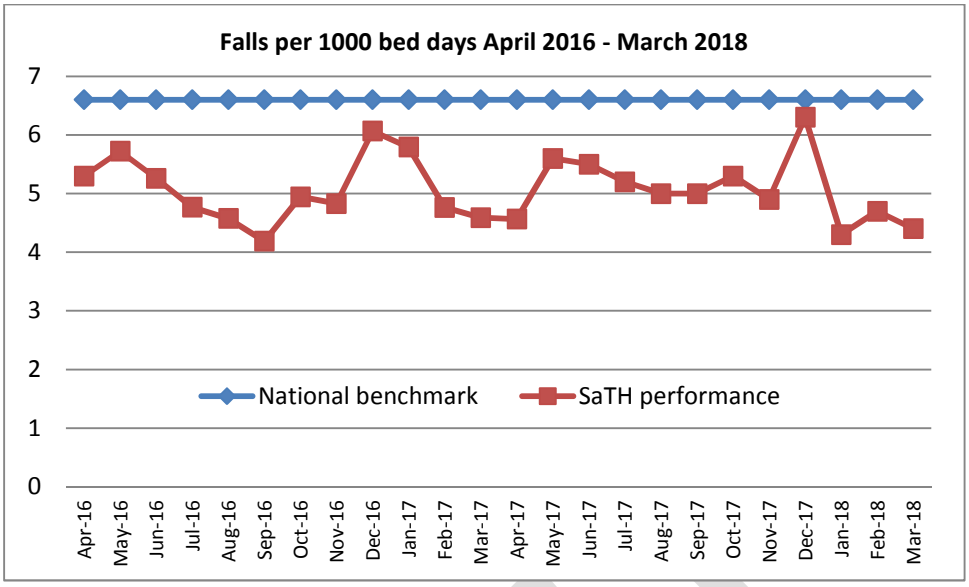
Falls Prevention

Falls remain an important focus for the Trust. We are fortunate to have a proactive Falls Prevention Lead in post who takes an active role in education, improving processes and identification of equipment. The Falls Prevention group is a sub group of the Clinical Governance Executive and monitors a work plan that covers all the work streams that are in place.

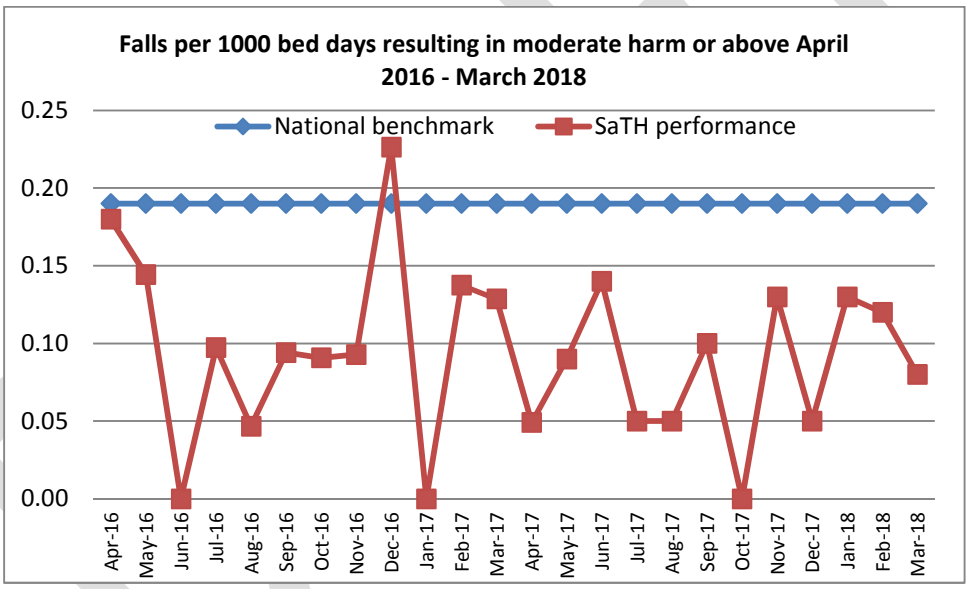
The chart below shows the number of falls recorded in 2017-2018 compared to the previous year:



There is a 0.1% increase in the number recorded but when calculated as per every 1000 bed days it suggests a decreasing trend:



The falls resulting in serious harm has reduced and as shown in the serious incident graph we reported three serious incidents compared to five in 2016-2017.

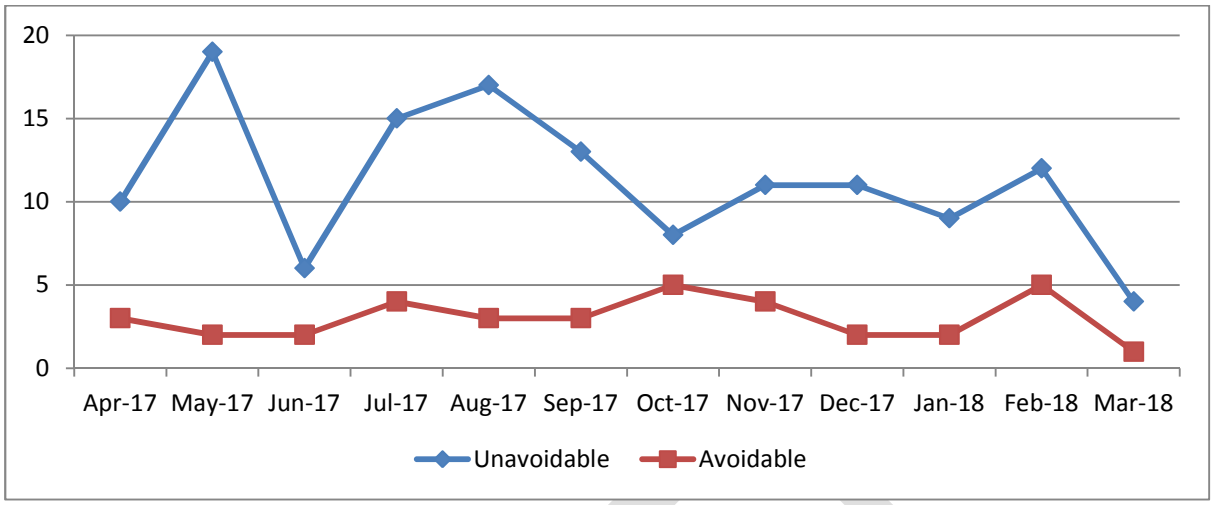


Pressure Ulcers

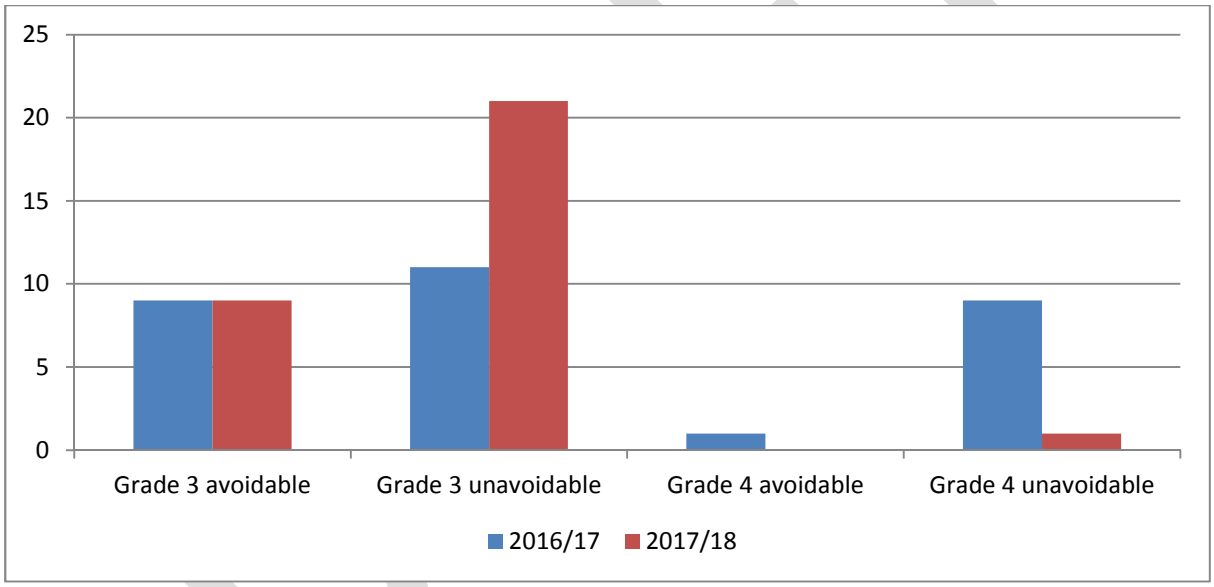
A pressure ulcer - also known as a 'bed sore' or 'pressure sore' - is an ulcerated area of skin caused by irritation and continuous pressure on part of your body. Pressure ulcers are more common over places where your bones are close to your skin such as your heels, the lower part of your back and your bottom. There are various things that can increase your risk of developing a pressure ulcer. In particular, risk increases if your mobility is reduced for some reason and you are spending long periods lying in bed or sitting in a chair such as when you are in hospital.

When patients are in our care we take every opportunity to prevent pressure ulcers occurring. However, despite our best efforts this still can happen for a variety of reasons (we call these "unavoidable") and occasionally we do not do all that we should to protect our patients from this harm (we call these "avoidable"). There are three grades of pressure ulcer ranging from 2 – 4, four being the most serious. In 2017 we reported the following:

Grade two pressure ulcers (note: at the time of writing there are still a number of incidents that are awaiting review for avoidability)



Grade three and four pressure ulcers:



Avoidable grade three and four pressure ulcers are considered to be serious incidents and are reported as such. Unavoidable are reviewed locally within the Care Groups. Going forward, our strengthened processes around learning and reviewing clusters of incidents will enable us to better understand the themes and trends around pressure ulcer development and how to improve this so that no patients experience these painful skin conditions.

Safeguarding Vulnerable Adults

In the Trust we have two nurses who are specialists in the area of Safeguarding Vulnerable Adults. Embedding the six key principles of the Care Act 2014 has been a priority for SaTH in 2016-2017. The principles are:

- **Empowerment** People being supported and encouraged to make their decisions and informed consent.
- **Prevention** It is better to take action before harm occurs.

- **Proportionality** The least intrusive response appropriate to the risk presented.
- **Protection** Support and representation for those in greatest need.
- **Partnership** Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability** Accountability and transparency in safeguarding practice.

This has been introduced throughout the Trust by the Safeguarding Team by safeguarding adult awareness training sessions and reinforcing the importance of making safeguarding personal.

Safeguarding training also helps staff identify abuse and actions that need to be taken.
Asking the individual for their wishes or outcomes of the safeguarding process is emphasised.
For the individual who does not have capacity when a concern is raised is to ensure that the person has an appropriate advocate acting in their best interests.

SaTH remains committed in the protection of an individual who may be unable to protect themselves from harm, liaising with external agencies reinforces the practice that "safeguarding is everyone's business"

SaTH records and reports all Deprivation of Liberty Safeguards referrals/outcomes and liaises with relevant supervisory bodies.

SaTH has a robust reporting process for all safeguarding concerns ensuring that there is accountability and transparency throughout all of our practice.

Safeguarding investigations are completed by the Safeguarding Team at SaTH which are shared with the relevant individual/ agency including the CQC and both Shropshire and Telford and Wrekin CCG's. Actions or any learning points are then disseminated throughout the Trust.

The Trust is represented on the Adult Safeguarding Boards of both the local authorities in Shropshire and the team supports many of the sub groups of the Boards in their work.

Safeguarding Children and Young People
The Trust is committed to improving child safeguarding processes across the organisation and aims to safeguard all children who may be at risk of harm. Processes are developed to empower staff to be child centred, preventative and holistic. The safeguarding team continues to deliver the safeguarding agenda encompassing a multi-agency and partnership approach.

The governance arrangements for children's safeguarding remain in place to allow for effective monitoring and assessment of compliance against locally agreed policies and guidelines.

The Trust has contributed to both the Safeguarding Children's Boards of the local authorities in Shropshire and has continued to be an active partner agency in sub groups addressing the priorities.

The Trust has continued to increase the number of Domestic Abuse referrals through the MARAC process and works closely with the MARAC co-ordinators across Telford and Wrekin and Shropshire. Domestic Abuse training continues to be part of the Statutory training for all clinical staff across the Trust.

Implementation of an IT system across Shropshire and Telford has improved information sharing.

Prevent

Prevent is part of the Government counter-terrorism strategy CONTEST and aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism.

Prevent focuses on all forms of terrorism and operates in a 'pre-criminal' space'. The Prevent strategy is focused on providing support and re-direction to individuals at risk of, or in the process of being groomed /radicalised into terrorist activity before any crime is committed. Radicalisation is comparable to other forms of exploitation; it is a safeguarding issue that staff working in the health sector must be aware of.

The Prevent Duty 2015 requires all specified authorities including NHS Trusts and Foundation Trusts to ensure that there are mechanisms in place for understanding the risk of radicalisation. Furthermore, they must ensure that health staff understand the risk of radicalisation and how to seek appropriate advice and support. Healthcare staff will meet, and treat people who may be vulnerable to being drawn into terrorism. The health sector needs to ensure that healthcare workers are able to identify early signs of an individual being drawn into radicalisation.

Staff must be able to recognise key signs of radicalisation and be confident in referring individuals to their organisational safeguarding lead or the police thus enabling them to receive the support and intervention they require.

There are two levels of training:

- Basic Awareness Training – we provide this to all staff on Corporate Induction and then through Safeguarding Updates.
- Workshop to Raise Awareness of Prevent (WRAP) – required by specific staff and provided through face to face training by facilitators who have been provided with a Home Office reference number (currently four in the Trust). NHS England have stated that all Trusts must have achieved a compliance rate of 85% of applicable staff trained through WRAP by March 2018.

During Qtr four 2017-2018 the Trust continued to train members of staff through WRAP sessions and our total of trained staff is now 41.7% against the target of 85%. Whilst this is an improvement against our baseline, we have not achieved the required compliance rate of 85% by the end of March. We have identified further opportunities when we can train staff to achieve as high a compliance rate as possible and are working with commissioners to provide assurance to them that we are doing all we can to train staff.

Staff Survey Infographic to go in

The NHS Staff Survey is just one of the ways that we measure whether the Trust has an open culture where staff feel able to raise concerns. The results this year show a mixed picture for the organisation. While we strive to improve our score for staff confidence and security in reporting concerns, we have consistently been in the bottom 20% when compared to other Trusts like SaTH across the NHS.

We have created an overview of the Key Findings from the Staff Survey into the diagram below. In addition, we are specifically required to report on the following indicators:

For more information on our NHS Staff Survey results go to: https://www.sath.nhs.uk/about-us/staff-survey/

3.2 Clinical Effectiveness

Seven Day Services – awaiting update from Mark Cheetham
A Seven Day Services Working Group was established in **November 2016** which is chaired by a Consultant Surgeon on behalf of the Medical Director with representation from each Care Group.

The purpose of this working group is to plan, identify workforce gaps, financial implications and develop business plans for each area to enable implementation of these four key standards by March 2018. The working group is also keeping sight of the additional six standards and working up plans to identify the gaps in resources and workforce to enable implementation.

National progress on the 4 standards was provided.

Clinical Standard 2 – Time to first Consultant Review
Performance improvements since September 2016 in 62% of Trusts. Majority of Trusts meeting this standard for over 70% of patients. This is recognised as the most challenging standard nationally.
SaTH performance at last audit 71%

Clinical Standard 5 – Access to Diagnostics
Overall good performance. CT and microbiology available 7 days at all trusts. Vast majority compliant with Upper GI, Endoscopy and Ultrasound.
Issues noted with weekend echocardiography and MRI provision. MRI being tackled through network approach and National Echo working group looking at echocardiography.

Clinical Standard 6 – Access to Interventions
Further improvements and majority of Trusts meeting this standard overall. Almost all Trusts delivering 6 of 9 interventions on a 7 day basis.
Issues with weekday and weekend interventional radiology in some areas. Formal network arrangements for some interventions are required.
SaTH position – current informal arrangement for interventional radiology at weekend.

Clinical Standard 8 – Ongoing Consultant-directed Review
Further improvements since September 2016 in 34% of Trusts. Almost half of all Trusts meeting this standard on a 7 day basis. Issues around once daily weekend review being low compared to both weekdays and with twice daily reviews. Further work to build capacity.
SaTH performance once daily review 83%, twice daily review 87%

Monitoring inpatient care

Every month the quality dashboards are discussed with the Care Groups. As part of this, ward performance is reviewed covering specific metrics relating to safety, effectiveness and experience. This includes:

MRSA bacteraemia
C Diff
MRSA screening rates
Number of pressure ulcers
Number of falls
Medication errors
Staffing information

Appraisal rates
Sickness absence rates
Training attendance
Safeguarding referrals
Mixed sex accommodation breaches
Number of complaints

Monitoring mortality

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These add new mandatory disclosure requirements relating to "Learning from Deaths" to Quality Accounts from 2017 – 2018 onwards. As a result we are including the following information as required by the regulations:
Requires approval and advice from Medical Director re section 27.5 and 27.6

	Prescribed Information	Statement
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure	During 2017-2018, 1917 patients of Shrewsbury and Telford Hospital NHS Trust died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 419 in the first quarter 433 in the second quarter 506 in the third quarter 556 in the fourth quarter
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 09 May 2018, 1206 case record reviews and investigations have been carried out in relation to 100% of the deaths included in item 27.1 In 14 cases* a death was subjected to both a case record review and an investigation. *(This number reflects the number of Serious incident investigations. The Trust is currently developing a process for collating the number of high risk case reviews and less formal investigations performed by, and discussed within the Care Groups) The number of deaths in each quarter for which a case record review was carried out was: 289 in the first quarter 291 in the second quarter 349 in the third quarter 277 in the fourth quarter
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown) with an explanation of the methods used to assess this	2 deaths, representing 0.11% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These were reported as Serious incidents and a Root cause analysis report undertaken. In relation to each quarter, this consisted of:

	Prescribed Information	Statement
		1 death representing 0.24% for the first quarter 1 death representing 0.23% for the second quarter 0 representing 0% for the third quarter 0 representing 0% for the fourth quarter The Trust uses the CESDI (Confidential Enquiry into Stillbirths and Deaths in Infants) definitions for scoring the outcomes of reviews: Grade 0 - No sub-optimal care Grade 1 - Sub-optimal care but different management would have made no difference to outcome Grade 2 - Sub-optimal care – different care MIGHT have made a difference to outcome (possible avoidable death) Grade 3 - Sub-optimal care. WOULD REASONABLY BE EXPECTED to have made a difference to outcome (probable avoidable death) The outcomes for the year, by number of deaths and percentages of total reviewed are: CESDI 0 1081 90.38% CESDI 1 97 8.11% CESDI 2 16 1.33% CESDI 3 2 0.16%
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation the deaths identified in item 27.3	Case 1. Delayed diagnosis of a silent perforated duodenal ulcer. The patient did not present with specific recognisable sign and symptoms but a chest x ray taken overnight clearly showed a pneumoperitoneum. It is the opinion of the review that had it been acted on at this point or on the later ward round, then the outcome for the patient would have been consideration for surgery intervention which would most likely have been successful. Learning: For the Urology Team to view radiological images that have been taken over night unless they have been formally reported by the Radiologist. Advice is sought through the appropriate speciality escalation process. Recognition of Pneumoperitoneum on x ray To remind Clinicians of the process for the allocation of Consultants for patients being admitted to the Surgical Assessment Ward Case 2 Delayed diagnosis of an Intracerebral haemorrhage and administration of Coagulation Factor IX in a patient with haemophilia B. Learning: A warning against confirmatory bias and the need to develop a

	Prescribed Information	Statement
		pathway for Haemophiliac patients, when admitted to the Emergency Department, providing a process for contacting the on-call haematologist regardless of reason for attendance.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period	A report is currently being compiled of the main themes from 'Learning from Deaths' 2017-18. Individual actions undertaken as a result of Serious Incident Investigations and deep dive thematic reviews are what
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Narrative
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period	Trust wide data collection commenced in April 2017. There is no 'relevant document' for the previous reporting period 2016-17. Thematic retrospective 'Deep Dive' reviews conducted during 2017-18: 39 patients identified from the National Hip Fracture database, who died within 30 days of admission during the calendar year 2015. 61 patient deaths reported to the Trauma Audit and Research Network (TARN) from April 2015-2017
27.8	An estimate of the number of deaths included in 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this	Trust wide data collection commenced in April 2017. There is no 'relevant document' for the previous reporting period 2016-17 Fractured neck of femur review 2015 1 patient died following an in-patient fall. All appropriate cases had been discussed with, or investigated by the Coroner. 1 patient, representing 1.63% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. TARN review 2015-17 No avoidable deaths were identified. 5 cases had already been subject to investigation for sub optimal care. All appropriate cases had been discussed with, or investigated by the Coroner.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8	N/A. Trust wide data collection commenced in April 2017. There is no 'relevant document' for the previous reporting period 2016-17.

Exemplar Programme

The **Exemplar Programme** is a method of assessment that enables clinical areas to be measured against specific standards to achieve one of three levels of award. Not only is this a way of learning from excellence but it enables leaders to celebrate with their staff.

The programme represents our vision and aspirations for the Trust. The core standards within the programme build upon our previous achievements and ambitions for Nursing and Midwifery. The standards, which are based on a positive patient experience, are:

- Environment
- Infection Prevention and Control
- Documentation
- Tissue Viability
- Falls Prevention
- Nutrition and Hydration
- Leadership
- Professional Standards
- Communication
- Care and Compassion
- Medicines Management

Following successful attainment of the first pilot ward (Ward 16 Stroke/Rehab) to achieve' gold' Heads of Nursing have identified 18 further areas to be assessed over an 18 month period (Jan-18 to Jun-19). The postnatal ward are the first ward to achieve 'diamond' status and we are current working with Neonates and Critical Care on their assessments.

Feb-18	Mar-18	Apr-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Postnatal	Neonates	PRH ITU	RSH ITU	22 Ante-natal	Gynae	Chemo Day Unit	4 T&O	RSH DSU	11 Gastro	19 Paeds	23OC	RSH Endo	24 Lab	17 T&O	10 Frail Complex
								TDSU				PRH Endo			

Women & Children's - 5 areas
Scheduled Care - 10 areas
Unscheduled Care - 2 areas

Exemplar Improvement in Quality Indicators

The impact of the Exemplar Programme has been significant involving many stakeholders, as the table below shows. In order to prepare and be ready the Exemplar team aims to initiate engagement with an area five months prior to formal assessment date. Each area will undertake a minimum of four Genba walks and a mock assessment in order to fully prepare, raise awareness and prioritise accordingly.

Training compliance *Statutory safety update* *Medical devices* *Oral medications*	**Appraisal compliance**	**Food safety**	**Cleanliness**	**Health & Safety**

Pharmacy audits	**Legionella compliance**	**Nurse call bells/ PAT testing**	**Resus trolley checking**	**Infection control audits**
Friends & Family scores and response rates	**Protected mealtime compliance**	**Documentation**	**Uniform policy**	**Staff knowledge**

It is evident that as each ward progresses through the Exemplar journey, improvements in quality indicators may be seen. The team has integrated VMI methodology in into the programme and each area completes a progress sheet to demonstrate the journey and highlight any areas that may have slipped below the specific requirements and will need further attention to retain exemplar status.

NHS The Shrewsbury and Telford Hospital NHS Trust

Exemplar WARD PROGRAMME

Exemplar Progress Report

Department: A ward	**Date:** Mock – 19th November 2017 Assessment 1 – 22nd January 2018 = Redeemable Reassessment of 4 standards – 26th February 18 = Gold 30 day check = maintaining 60 day check = issue identified 90 day check = maintaining
Award status: Gold	**Team Leader:** A Manager

Metric (units of measurement) Highest score put forward for each standard Silver = 10; Gold = 5; Diamond 0; Anything else is 15+ and requires additional notes below	Mock 19/11/17	Target	Formal 22/01/18	Reassess 26/02/18	30 days 26/03/18 Self-Assess	60 days 26/04/18 Matron	90 days 26/05/18 Corporate	Comments
Environment Estates (legionella/PAT testing/nurse call bells) Food Safety (kitchen award) Facilities (Credits for cleaning > 92% Silver, 95% Gold, 98% Diamond) H&S Audit (55% Silver, 70% Gold, 85% Diamond) Resus Checks (90% Silver, 95% Gold, 100% Diamond) On-site inspection/RaTE (90% target)	10	10	5	N/A	0	15	0	April 18 – Drop in Resus checklist compliance. Addressed immediately and improvement demonstrated. Now included on VMI production board as additional check
IPC Quality Ward Walk (16-18 Silver, 19 Gold, 20 Diamond Hand hygiene (95% for 3 mths Silver, 4 mths Gold, 5 mths Diamond) On-site inspection/RaTE (90% target)	15	10	15	10	10	5	5	
Documentation On-site inspection/RaTE (90% target)	15	10	15	0	0	0	0	
Tissue Viability On-site inspection/RaTE (90% target)	0	10	0	N/A	0	0	0	
Falls On-site inspection/RaTE (>90% target)	N/A	10	N/A	N/A	N/A	N/A	N/A	
Nutrition & Hydration On-site inspection/RaTE (>90% target)	0	10	0	N/A	0	0	0	
Leadership SSU/Appraisals (90% Silver, 95% Gold, 100% Diamond) Medical Device Training (50% Silver, 75% Gold, 100% Diamond) Oral medications/IV assessment (85% Silver, 95% Gold; 100% Diamond) On-site inspection/RaTE (>90% target)	20	10	15	5	5	5	5	

Outcomes

- Increased awareness of ward managers, teams and staff in Exemplar quality standards and stakeholder requirements
- Better multi-disciplinary working – Exemplar brings together stakeholders into one main assessment; previously they were all stand-alone assessments/audits. In order to achieve 'Silver' an area needs to achieve the minimum standards across all the areas and not just be good in one.
- CQC assurance – any area that has been through Exemplar has demonstrated compliance with the minimum standards and also meets CQC inspection.
- Documentation compliance – raised the importance of good record keeping in-line with NMC and Trust standards.
- Positive stakeholder engagement which has helped stakeholders to raise awareness, support wards and will drive up performance/compliance:
  - Facilities – Cleanliness
  - Education targets – achieving SSU, Medical Devices, Oral Medications compliance/completion targets
  - Appraisal targets – Increased and attainment of compliance

- Complaints – Increased compliance with adherence to response times
- Health & Safety – Increased compliance and course attendance
- Pharmacy – Increased awareness and compliance with pharmacy standards and improvement in performance on controlled drugs and rolling audits
- Estates – Increase awareness of how to raise and action estates work, increased legionella compliance
- Resus – Increase in Resus trolley check performance
- Protected Mealtimes & Food Safety – Exemplar has raised the profile of protected mealtimes and food safety which is helping to improve overall outcomes and improvements in practices.
- Infection, Prevention and Control – Increased performance in audits and communication between the teams in raising issues and asking for support.
- Patient Experience – FFT response rates increase

Challenge – Exemplar has enabled staff to explore and challenge and improve existing processes, some examples include:

Challenge	Action
Patient information books out of date and not always available	Update and refresh of patient information books in progress
RSH – white pharmacy delivery boxes had a broken locks	Profile raised and successful trial of iBins commenced. 5 iBins in situ on each site with more on order.
SSU compliance spreadsheet is not always easy to understand	Profile of education team has been raised and wards have successfully challenged incorrect data and more likely to request help and support from the education team who work with the ward manager to proactively plan and give advice on how to maintain SSU going forwards.
Visibility of pharmacy rolling audit results had stopped	Review of process to ensure pharmacy audit results are received and emailed out regularly
Pharmacy staff did not always check the RN who ordered a CD (controlled drug) was the same RN who received a CD	Reminder to pharmacy staff to always check which introduces and additional safety check
Controlled Drug audit compliance was poor with wards failing on similar issues regularly	Pharmacy attends NMF to provide training and updates. Exemplar encourages ward managers to work with pharmacist to improve results and address issues.
IPC Quality Ward Walk (QWW) audits use the same questions across all care groups which can result in a much lower number of applicable questions.	IPC are reviewing their QWW to see if they can tailor the audit to specific areas.
Toilet brushes not always dated which wasn't compliant with policy	Facilities reviewed process and introduced an additional check before released to reduce defect
Insufficient or cancelled H&S courses	Review of courses and additional ones added to the programme
Access to Safersharps assessment inconsistent	H&S team able to address and improve access

	for staff
Wards highlighted problems with agency nurses who had worked on different wards 'not knowing how we work here'	Corporate nursing are working on introducing agency flash cards to improve process
Online oral medications module contains out of date information.	Awareness of issue raised and being explored
Food safety awards were different to Exemplar	Awards changed to demonstrate consistent approach and make it easier to understand

Workload

To date four areas have completed the full Exemplar process and workload in achieving success is detailed below:

Type	Detail	Time
Planning	Arrange schedule of visits, prepare documentation and confirm mock/formal assessment dates	0.5 hour
Genba*	Initial genba to meet the ward manger and matron, raise awareness of the Exemplar programme and requirements to achieve minimum standard (Silver) and a basic self-assessment of current performance.	1 hour
Genba*	Second genba to discuss current performance, explore any barriers in achieving exemplar and offer support and advice	1 hour
Pre-Intelligence	15 stakeholders are contacted to provide Exemplar scores based on an agreed matrix. Stakeholder scores plus other key information is used to populate a pre-intelligence report which gives an indication of achievement in each of the standards and highlights areas of focus for the Mock assessment.	22.5 hours
Assessment	Mock assessment – 2 members of corporate nursing complete the full assessment which is a 'fresh eyes' approach and aims to highlight any potential issues.	4 hours
Report	Stakeholder scores and results of mock report are typed up and a mock assessment report created	7.5 hours
Genba*	Third genba to feedback results of mock assessment and formulate a plan to address	1 hour
Planning	Assessment team confirmed (8 members) and facilities booked.	2 hours
Genba*	Fourth genba prior to formal assessment to check progress and address any concerns	1 hour
Pre-Intelligence	15 stakeholders are contacted to provide updated Exemplar scores based on an agreed matrix. Stakeholder scores plus other key information is used to populate a pre-intelligence report which gives an indication of achievement in each of the standards and highlights areas of focus for the Mock assessment. Document preparation for formal assessment.	26 hours
Assessment	Pre-formal assessment, the assessment team meet up to go through the process, expectations of the team, explore intelligence data and allocation of standards and teams	1 hour
Assessment	Formal assessment day - 8 people x 7.5 hours.	7.5 hours
Report	Stakeholder scores and results of mock report are typed up and an assessment report created, ratified by assessment team and emailed out to Ward Manager and Matron.	7.5 hours
Report	Receipt of and explore and provide response to any factual accuracy challenge to the report.	3.5 hours

Report	Report finalised and emailed to Ward Manager, Matron and Care Group Leads.	0.5 hours
Assessment	30 day Ward Manager progress assessment	3 hours
Assessment	60 day Matron progress assessment including preparation	6 hours
Assessment	90 day Corporate nursing progress assessment	7.5 hours
Other	If an area doesn't receive Silver, Gold or Diamond further visits/assessments will be required to support	As required
Total Time		103 hours (2.74 weeks)

*Depending on progress areas may need additional genba visits to support

Exemplar Team Objectives (18 months, Jan-18 to Jun-19)

Exemplar Team Objectives					
Action	**Target**		**Progress**	**Status**	**Detail**
Genba Walks (Corporate Nursing)	1 ward per week	78	37	On track	
Executive Genba Walks	1 ward every other month	6	0	Not on track	Process refined and 1st Executive genba scheduled for June
Mock Assessment	1 ward per month	18	6	On track	
*2017/18 Assessments completed	10% (38 areas identified)	4	3	Some Issues	Promotion of ward manager to matron; Back on track for 2018/19
*2018/19 Assessments completed	20% (38 areas identified)	8	0	On track	

*Financial year

3.3 Patient Experience

Responsiveness to national targets around waiting times

Formally reported patient experience indicators per month include a range of waiting times, lengths of hospital stay, complaints and other feedback received and results from the national programme of the Friends and Family Test. The Trust Annual Report gives detail against national targets around various activity and performance.

Complaints Service and Patient Advice and Liaison Service (PALS)

In 2017-2018, the Trust received 600 formal complaints; this equates to less than one in every 1000 patients making a complaint (0.69 complaints per 1000 patients). During 2017-2018, the Trust has continued to strengthen learning from complaints made by patients and their families. Learning from complaints is shared across the Trust through a variety of meetings and training to ensure that as a Trust we learn from poor patient experience. Response rates have increased from 30% at the end of 2016-2017 to 74% at the end of 2017-2018, with further improvements planned to increase response rates further.

The PALS team continues to support patients and their families with on the spot resolution and in 2017-2018 assisted 1491 patients and families with their concerns. In addition, the PALS team provides the Trust Bereavement Service, issuing families with the Medical Certificate of Cause of

Death and providing them with support in the next steps, as well as facilitating bereavement meetings where families request these. At the end of 2016-2017, an onsite registrar service at the Royal Shrewsbury Hospital was introduced. This has been developed and increased in 2017-2018 and regularly receives positive feedback from bereaved families.

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

- Signage to be put up in A&E advising members of the public that they cannot film there
- Booking staff to advise patients that they may be seen sooner that estimated waiting times
- 24 hour ECG results to be sent out daily.
- Staff to ensure they provide up to date waiting times
- Staff to ensure they document all communication with relatives
- Single use tape measures to be ordered for A&E
- Housekeeper numbers to be increased in A&E
- Regular audit of hand hygiene in Ophthalmology
- All consent forms to be available in each clinic room
- Weekly checks to be carried out by bookings team to review all patients not yet on lists
- Mouth care policy for end of life patients implemented
- Medication safety update delivered to wards on security of patients' own medications, self-administration policy and use of dosette boxes
- Review and strengthening of SOP for dispensing trays
- Introduction of 'plan for the day' sheets to be given to patients following ward rounds
- New head and neck assessment for vulnerable patients with NIV / oxygen therapy / NG tubes.
- Flow chart of actions to be taken when a pressure sore develops produced for ward staff
- Refresher training on admission planning and scheduling
- Nursing staff to ensure that all consent forms, including paediatric forms, are available in each clinic room
- Checks in place to ensure that staff declutter and wipe clean lockers and tables at least twice a day
- Letter to be sent to staff about smoking in non-smoking areas
- Update of endoscopy patient information leaflets to include the role of nurse or operating department practitioner
- Communication skills training for admin staff/secretaries
- Staff members attending training to deal with communication and difficult situations that may occur on the ward
- Revise guidance on the review of babies after birth whose mothers are suspected of sepsis
- Improve multi-disciplinary working to ensure patients and family members are involved in decision-making processes re discharge
- Ensure mother's birth wishes are properly communicated to midwives attending birth
- Nursing staff to check omitted medicine in daily huddle and ensure that reasons for omission are clearly documented
- Develop link worker role for hearing aids/devices.
- Review in place for flow through Paediatric Assessment Unit
- Booking team to contact patients by phone when dating patients with less than two weeks' notice
- New nursing documentation has a section within it that outlines discharge plans for patients and should be followed.
- ED dementia link nurse role to be introduced
- Update wording on website to clarify when partners can stay with women in labour

- Hysteroscopy leaflet updated with more information on pain

Individual staff are asked to reflect on complaints that they have been involved on, and learning from complaints is also discussed at ward and departmental meetings. In 2018-2019, the PALS team will be capturing learning from PALS contacts and will share this learning across the Trust, to ensure that all learning from patient feedback is captured and cascaded to all areas.

Friends and Family Test

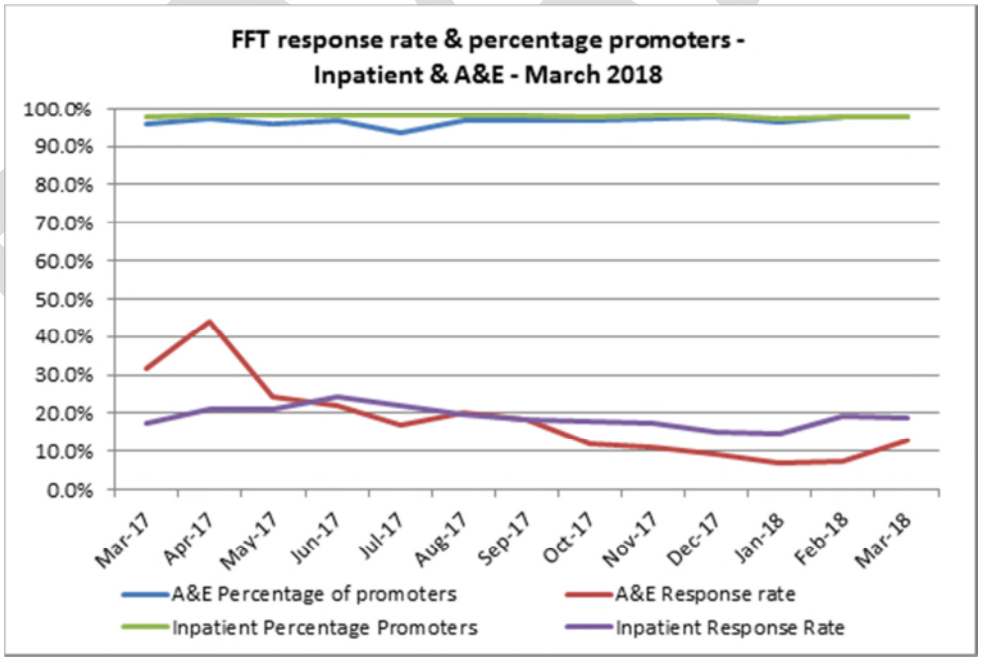
We have taken several approaches to understand and therefore improve the experience that people have of our care at SaTH. One of the approaches that has been used is the Friends and Family Test – a one question measure used across the organisation asking respondents **"Would you recommend the service to friends and family if they were to have similar treatment or procedure"?**

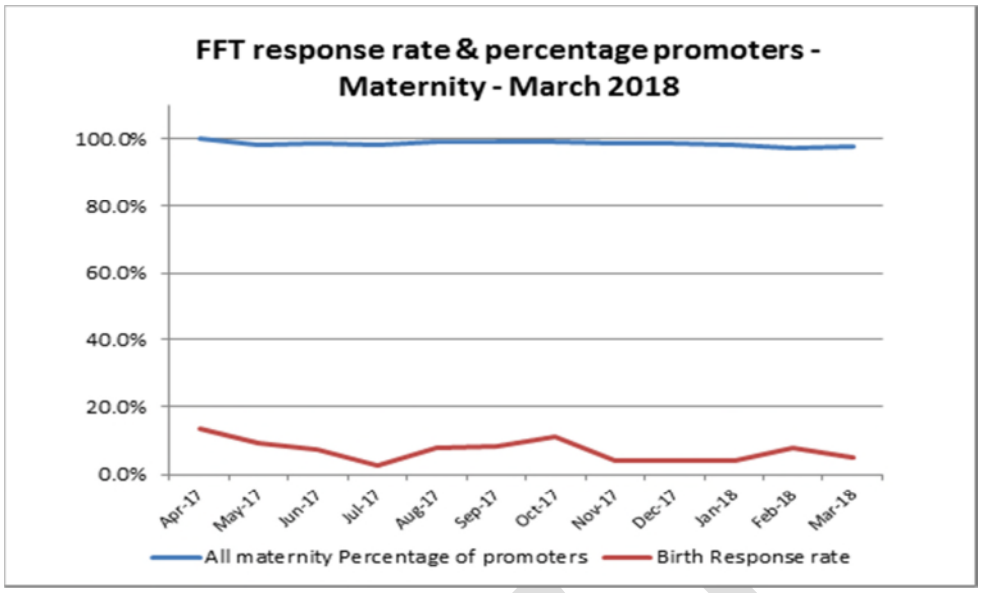
We report monthly to the Quality and Safety Committee the responses made to the survey at a Trust level and also the response rate (the percentage of people that have received treatment) that responded to the question. We believe that there are ways that we can improve this response rate therefore giving us more information about what people think of the services.

We ask the question in many of our areas but are mandated to report on the following:

In Patient responses
Emergency Department responses
Maternity responses.

Our performance against this metric in 2017 – 2018 is as shown below:





Patient Stories

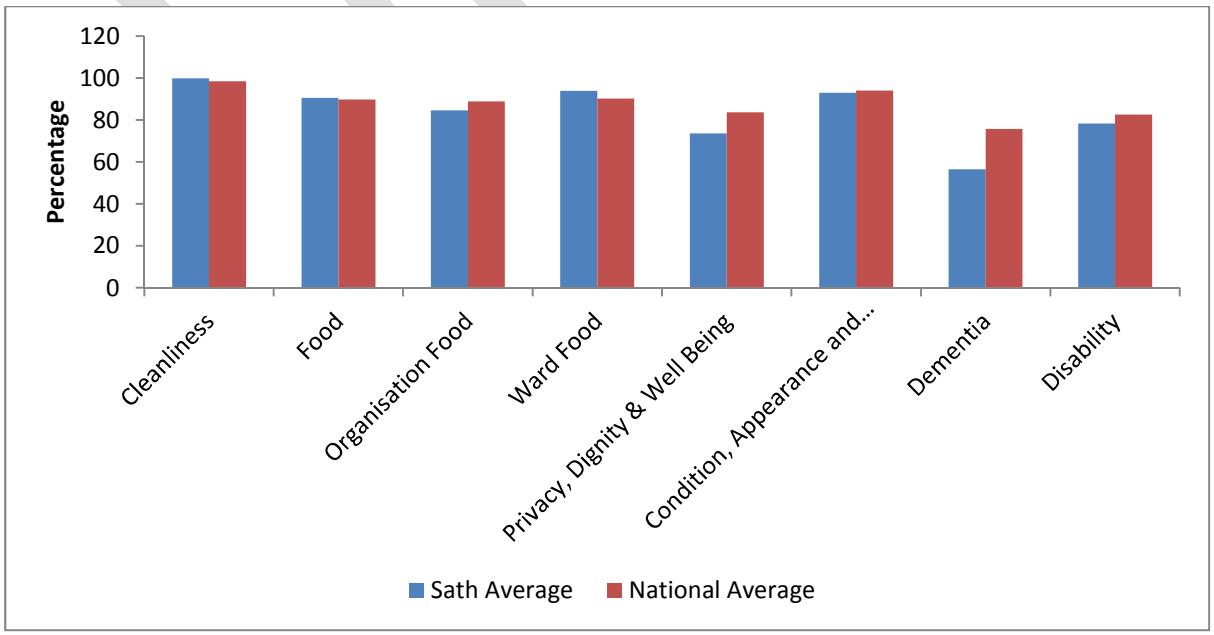
Each month a patient story is delivered to the Board. This powerful feedback tool allows patients and their families to discuss the impact of their experience of our services on their journey of care.

As well as the patient, a member of staff will then tell the Board of the changes and improvements that have been made or are planned as a result of the feedback.

Kate Ballinger's input

Patient Led Assessment of the Care Environment (PLACE)

The assessments involve local people (known as Patient Assessors) going into hospitals as part of teams to assess how the environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia. From 2016 the assessment has also looked at aspects of the environment in relation to those with disabilities.



The annual PLACE inspection in 2017 took place in the following areas

- Royal Shrewsbury Hospital
- Princess Royal Hospital
- Oswestry Midwife Led Unit
- Ludlow Midwife Led Unit
- Bridgnorth Midwife Led Unit

As the chart above shows we scored above the national average in some of the areas including cleanliness, food and ward food. We scored lower than the national average for organisational food, privacy, dignity and wellbeing, condition, appearance and maintenance, dementia and disability.

The reasons for this are around the buildings – for example, the lack of treatment rooms on most wards, no day rooms on the wards, the lack of patient TV at RSH, and no rooms for private conversations on most wards.

Part four: Statements from external organisations

4.1 Statements from our Partners

- Shropshire Clinical Commissioning Group
- Telford and Wrekin Clinical Commissioning Group
- Healthwatch Shropshire
- Healthwatch Telford and Wrekin
- Shropshire Council

4.2 Changes made to the Quality Account following receipt of statements

Page	Change Made	Date

4.3 Thank you

We would like to thank you for taking the time to read our Quality Account and hope that you found it informative, interesting and that most importantly it has enabled you to better understand the work of the Trust, of our goals for quality and our commitment to the delivery of safe, effective and high quality care.

How to give us feedback about this Quality Account

Copies of this document are available from our website (www.sath.nhs.uk), by email from consultation@sath.nhs.uk or in writing from:
Chief Executives Office, The Shrewsbury and Telford Hospital NHS Trust, Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XQ.

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

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

We welcome your feedback on our Quality Account.

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

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

Statement of Directors responsibilities in respect of the Quality Account

Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

The Quality Account presents a balanced picture of the Trust's performance over the period covered
The performance information reported in the Quality Account is reliable and accurate

There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice

The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions and is subject to appropriate scrutiny and review

The Quality Account has been prepared in accordance with Department of Health guidance

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

Signature ……..

Date ……..

Appendices:
Appendix one: Statement from our Auditors
Appendix two: Glossary

Statement from our Auditors:

To follow

Glossary of Terms used in this Quality Account

Care Quality Commission (CQC)	The Care Quality Commission is the independent regulator of health and social care in England. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisations. See www.cqc.org.uk
Clinical Audit	Clinical Audit is a way to find out if healthcare is being provided in line with standards and allows care providers and patients know where a service is doing well and where there could be improvement. The aim is to make those improvements to improve outcomes for patients.
Clinical Research	Clinical research is a branch of healthcare science that determines the safety and effectiveness of medications, devices, diagnostic products and treatment regimens intended for human use. These may be used for prevention, treatment, diagnosis or for relieving symptoms of a disease. Clinical research is different from clinical practice. In clinical practice established treatments are used, while in clinical research evidence is collected to establish a treatment.
Clostridium Difficile (C Diff)	Clostridium Difficile, also known as C. Difficile or C. Diff, is a bacterium that can infect the bowel and cause diarrhoea. The infection most commonly affects people who have recently been treated with antibiotics but can spread easily to others. C. Difficile infections are unpleasant and can sometimes cause serious bowel problems, but they can usually be treated with another course of antibiotics
Commissioners	Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Clinical Commissioning Groups (CCG) in England and Local Health Boards (LHBs) in Wales are the key organisations responsible for commissioning healthcare services for their area. Shropshire CCG, Telford and Wrekin CCG and Powys Teaching Health Board purchase acute hospital services from The Shrewsbury and Telford Hospital NHS Trust for the population of Shropshire, Telford & Wrekin and mid Wales. See www.shropshire.nhs.uk , www.telford.nhs.uk and www.powysthb.wales.nhs.uk
Commissioning for Quality and Innovation (CQUIN)	A payment framework introduced in the NHS in 2009/10 which means that a proportion of the income of providers of NHS services is conditional on meeting agreed targets for improving quality and innovation. See www.institute.nhs.uk/cquin
Equality and Delivery System Two (EDS2)	EDS2 is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

Exemplar Ward Programme	The Exemplar Programme represents our vision and aspirations for our Trusts. The core standards build upon our previous achievements and ambitions for Nursing and Midwifery to be the best in the NHS. The patient experience will be at the centre of Exemplar.
Health Research Authority (HRA)	The HRA protects and promotes the interests of patients and the public in health and social care research.
Health and Social Care Information Centre (HSCIC)	HSCIC (now called NHS Digital) provides national information, data and IT systems for health and care services.
Healthcare Quality Improvement Partnership (HQIP)	HQIP is an independent organisation lead by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices. It was established in April 2008 to promote quality in healthcare and in particular to increase the impact that clinical audit has on healthcare quality improvement.
Learning Disability Mortality Review (LeDeR)	LeDeR was set up as a result of one of the key recommendations of the Confidential Inquiry into premature deaths of people with a Learning Disability (CIPOLD). It aims to make improvements in the quality of health and social care for people with learning disability and to reduce premature deaths in this population.
Learning from Deaths	Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and their families, and identify where they could do more. A CQC review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England opens in a new window found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.
Methicillin-resistant Staphylococcus Aureus (MRSA)	MRSA is a bacterium responsible for several difficult-to-treat infections.
National Clinical Audit and Patient Outcomes Programme (NCEPOP)	This programme consists of more than 30 national audits related to some of the most commonly occurring conditions. These collect and analyse data supplied by local clinicians to provide a national picture of care standards for that specific condition. On a local level, the audits provide trusts with individual benchmarked reports on their compliance and performance, feeding back

	comparative findings to help participants identify necessary improvement for patients.
National Institute for Health and Care Excellence (NICE)	NICE provides national guidance and advice to improve health and social care.
National Institute for Health Research (NIHR)	NIHR is funded by the Department of Health to improve the health and wealth of the nation through research.
National Mortality Case Record Review (NMCRR)	NMCRR aims to improve understanding and learning about problems and processes in healthcare associated with mortality and also to share best practice.
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS Outcomes Framework	The NHS Outcomes Framework sets out the indicators that will be used to hold NHS England to account for improvements in health outcomes
Nurse Associate Role	The Nursing Associate role is a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. Following huge interest some 2,000 people are now in training with providers across England. (https://hee.nhs.uk/our-work/developing-our-workforce/nursing/nursing-associate-new-support-role-nursing)
Pressure Ulcers	Pressure ulcers are also known as pressure sores, or bed sores. They occur when the skin and underlying tissue becomes damaged. In very serious cases, the underlying muscle and bone can also be damaged. See www.nhs.uk/conditions/pressure-ulcers
Red to Green (R2G)	The R2G approach is a visual management system to assist in the identification of wasted time in a patient's journey. It can be used in wards in both acute and community settings as part of the Safer Care Bundle (https://improvement.nhs.uk/resources/safer-patient-flow-bundle/)
Workforce Race Equality Scheme	Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.