



Quality Account

01 April 2017 - 31 March 2018

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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 going forward for 2018-2019. There are relevant sections in the report detailing these priorities and highlighting a selection of the many improvements made during the year as well as aspects of care we will continue to work hard to improve.

The Trust Board gains assurance on 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. The Quality and Safety Assurance Committee supports this assurance process as a critical component of our governance framework. This is chaired by a Non-Executive Director which is a formal committee of the board which scrutinises the internal monitoring of care and the progress made on 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 care that we provide and this year we have developed our Trust Quality Improvement Plan which has brought together a variety of high level actions to ensure that improvement is monitored, actioned and measured for sustainability in a coherent way.

We have also put in improvement actions from the Care Quality Commission inspection report from inspection of our services in December 2016. At the time of writing the 2016/17 report, we had not received the formal report which was received in August 2017.

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. 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 care for our patients when they really need it and to ensure that as they are kept safe and get home to their place of residence 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) (from 01 April 2018 Midlands Partnership NHS Foundation Trust)
- 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.

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. 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.	Patients will know what their expected date of discharge is so that they and their families have time to plan for them going home We will routinely use the principles of “Red to Green” (R2G) to ensure that we do not keep people waiting to go home unnecessarily. This is a way of seeing really quickly if we are doing all the things we need to do in a timely way to make sure people do not stay in hospital longer than they have	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 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 to ensure that everyone and

<p>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</p>	<p>to.</p> <p>We will make sure that everything they need is ready for them, including medication, information and equipment which is part of the R2G work.</p>	<p>their families know when they are due to go home.</p> <p>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 nine 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.</p> <p>We see fewer delays due to lack of medication or equipment that we are responsible for providing due, in part, to the work of the R2G Patient Journey Facilitators. The national inpatient survey tells us that we are “about the same” as other acute providers in this respect.</p>
<p>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</p>	<p>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</p>	<p>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.</p> <p>.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 and measure our progress through the results of the National inpatient survey, which in 2016 was 6.1/10 –</p>

<p>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</p>	<p>We will reduce the number of complaints that we get about discharge processes.</p> <p>Less people will come back into hospital because something went wrong with the discharge process</p> <p>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.</p> <p>We will measure our progress through our Datix incident reporting system which we use to monitor both incidents and complaints.</p> <p>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.</p> <p>We will measure how long people stay in with us and whether we could improve this for them by making sure we do everything we can to get them home safely at the right time. As part of this we will work closely with our colleagues in Shropshire Community Health NHS Trust and in the local authorities and CCGs.</p>	<p>worse than other Trusts.</p> <p>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).</p> <p>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.</p> <p>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.</p>
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<p>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</p>		
<p>Why is this a priority for us? We have used feedback in the form of patient stories for some</p>	<p>What will success look like? We will have a variety of methods to capture patient</p>	<p>How have we done? We are using video to capture stories, and are training staff to</p>

<p>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.</p> <p>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.</p> <p>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.</p>	<p>stories – for example by video, in person, in writing and through feedback to our partners.</p> <p>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</p> <p>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. The Board are able to follow up on the actions from feedback from the Care Groups, through visits to clinical areas and analysis of patient feedback.</p> <p>We will work with a variety of other groups such as Healthwatch or the Young Health Champions to make sure that people who sometimes do not get their voices heard are able to do so</p>	<p>do this using Trust equipment such as iPads.</p> <p>Patient representatives are part of the Transforming Care Partnership teams providing valuable patient perspectives to help us improve.</p> <p>Staff across the Trust have completed Story Telling training facilitated by patient leaders, and are actively encouraged to gather stories when appropriate.</p> <p>We are exploring different ways of closing the loop and ensuring that staff and public are aware of improvements made as a result of feedback.</p> <p>One way we do this is through the results of nationally and locally led surveys</p> <p>We are going out to seldom heard groups to gather feedback and will continue to strengthen links with local communities.</p>
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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?
<p>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.</p> <p>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.</p> <p>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.</p>	<p>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.</p> <p>We will see a reduction in complaints and PALs enquiries particularly in relation to communication, care and compassion.</p> <p>We will also help and support our staff to make changes where they need to.</p> <p>We will evidence that the requirements of the Duty of Candour will be met in 100% of incidents that require it to be met</p>	<p>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.</p> <p>We have not seen a reduction in complaints in relation to these areas – all have increased as have the number of complaints overall. We do welcome patient feedback in all its forms and use every opportunity to improve the care we provide.</p> <p>Duty of Candour in place for 100% of Serious Incidents and High Risk Case Reviews including incidents graded as moderate harm</p> <p>The national Maternity Survey published in January 2018 showed that:</p> <p>New mothers using our services felt that they were treated with respect and dignity, listened to and given the help they need.</p> <p>Women who raised concerns during their pregnancy or delivery had those concerns</p>

		<p>taken seriously and that they were spoken to in a way they could understand.</p> <p>We scored 8 out of 10 or higher in 42 out of the 51 categories relating to the care of mothers and babies.</p> <p>The Trust performed statistically better than most other trusts in 12 categories.</p> <p>Our Postnatal ward has just been awarded Diamond status in our Exemplar Programme – the first ward in the Trust to do so.</p> <p>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.</p> <p>National Maternity and Perinatal Report published March 2018 showed that:</p> <p>Caesarean section rate for the Trust is significantly lower than average</p> <p>Rates of haemorrhage and complicated tear are lower than average</p> <p>Women with a previous Caesarean section are as likely to achieve a successful vaginal birth compared to women in other units</p> <p>Lower episiotomy rate than national average</p> <p>Higher rate of spontaneous vaginal delivery</p>
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		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%
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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, all of which are linked to the CQC domains of quality:

- 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

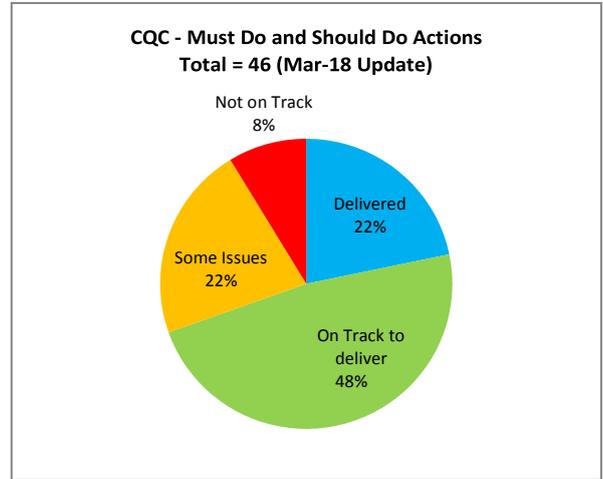
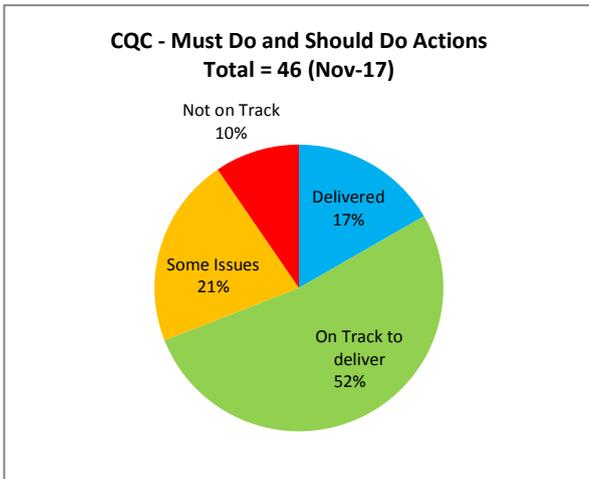
The “Safest and Kindest” Quality Strategy 2017-2018 identifies what Shrewsbury and Telford Hospital intends to achieve in terms of quality and safety. The ‘Safest and Kindest” Quality Improvement Plan’ denotes how this will be achieved and a Standard Operating Procedure (SOP) has been devised to provide 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.

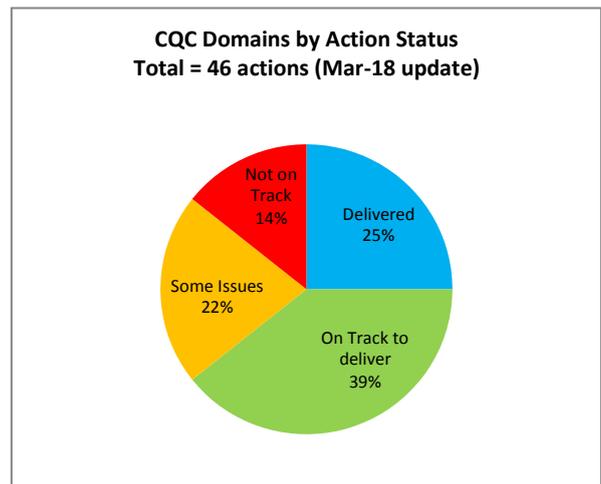
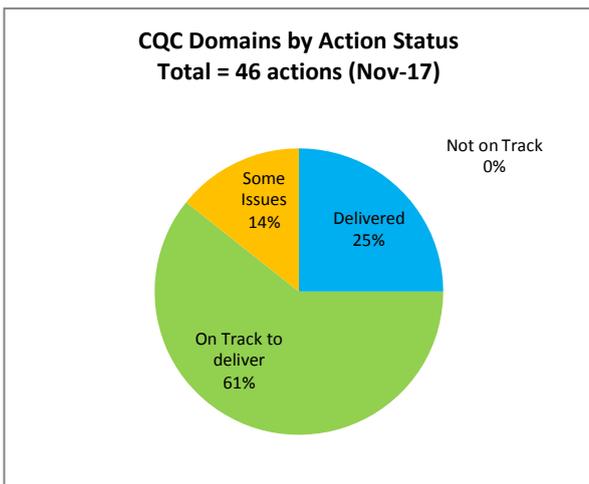
The Safest and Kindest Quality Improvement Plan incorporates the CQC domains which means that the Trust can identify and track how many actions relate to each domain and track progression in

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.

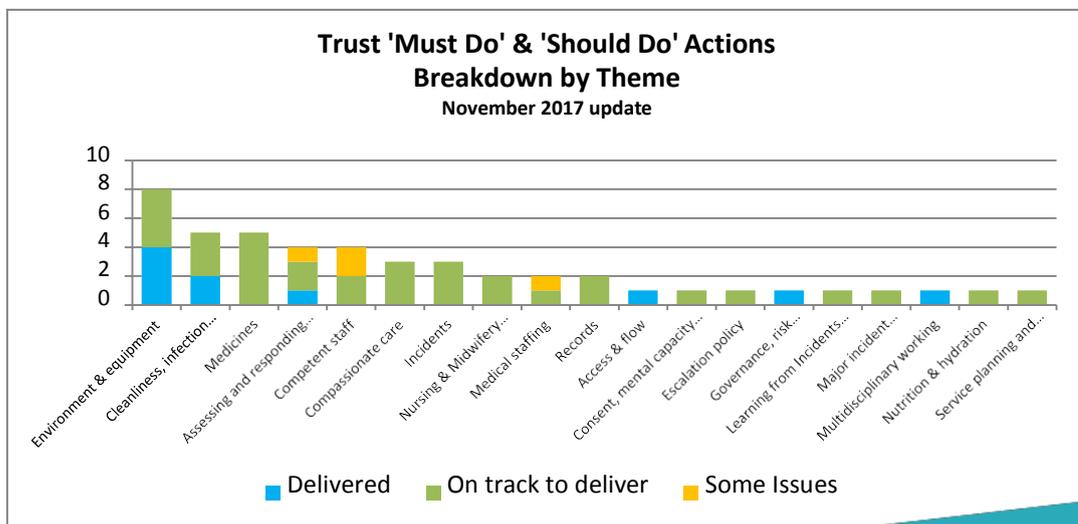
November 2017 v March 2018 comparison – CQC “Must do” and “Should do” actions by status

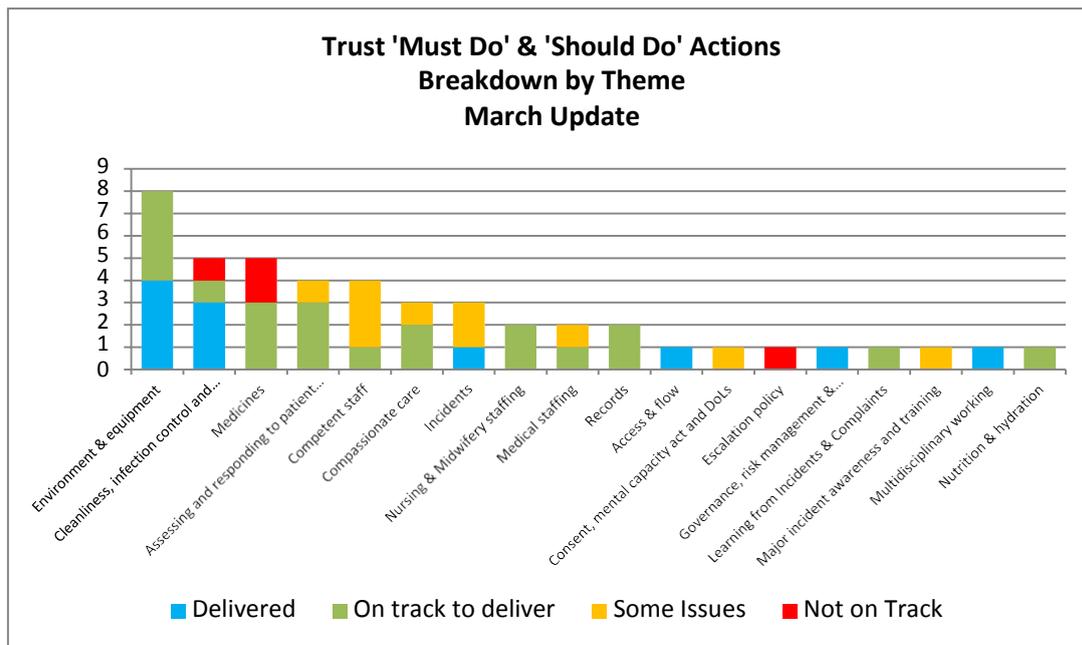


November v March comparison – CQC Domains by Actions status



“Must do” and “Should do” Actions by Theme (and Action Status)





Reasons for “Not on Track” in March 2018:

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.

Maternity Escalation Protocol:

Ensure accurate monitoring of maternity escalation protocol for all areas including Wrekin MLU:

Recommendations being incorporated into protocol (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. The plan is reported to the Quality and Safety Committee and the Trust Board on a quarterly basis.

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.

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	62	65	87	48	Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: this figure falls within the “as expected” 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	17.51	30.56	67.52	9.49	Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: we review all data regularly. Shrewsbury and Telford Hospital NHS Trust has taken the actions to improve this percentage and the so the quality of services by continuing to place utmost importance on high quality of care to palliative patients	21.27
The Trust’s reported outcome measure scores for:					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	
Groin hernia surgery	0.102	0.089	0.140	0.055		0.159
Varicose vein surgery	0	0.096	0.134	0.068		0.152
Hip replacement surgery	0.417	0.448	0.536	0.31		0.563
Knee replacement surgery	0.335	0.324	0.404	0.242		0.434
The percentage of patients aged:					Shrewsbury and Telford Hospital NHS Trust considers that these percentages are as described for the following reasons:	
0-15 and	10.86	8.17	16.14	0.10		9.90

Indicator	2017/18	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17
16 and over Readmitted to a hospital which forms part of the trust within 28 days of the being discharged from a hospital which forms part of the Trust	7.90	7.41	10.68	3.58	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 services: By individualised care pathway management to ensure that people go home at the right time with the right support in place	7.66
The Trust's responsiveness to the personal needs of its patients during the reporting period <i>(Most recent data available on the HSCIC website dated May 2018)</i>	68.2		86.2	54.4	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 Qtr 2 1st July - 30th September 2017-2018	62	80	100	43	Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: Our annual staff survey 2017 also highlighted a decreasing score for this specific advocacy question Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage and so the quality of its services, by: A full staff survey action plan has been approved by Trust Board and aims to focus an organisational wide response to address and improve specific key findings	80
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.58	95.00	99.90	93.47	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 routinely by the clinical teams. Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage and so the	95.68

Indicator	2017/18	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17
					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	11.74	12.46	87.60	1.30	Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: We monitor and report C Diff infection incidence 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 continued vigilance around infection prevention and control processes and mandatory training for staff	6.99
Number of patient safety incidents	5505	5,226	15228	1133	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	4398
Rate of patient safety incidents per 100 admissions	44.63	42.84	111.69	23.47		35.93
Percentage of patient safety incidents that resulted in severe harm or death	0.18	0.4	1.98	0.0		0.0
Friends and Family Test covering services for inpatients and patients discharged from A&E family or friends. AE: Percentage Recommended Trust	94	85	100	67	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.	96
Friends and Family Test covering services for inpatients and patients discharged from A&E family or friends. INPATIENTS: Percentage Recommended Trust	98	96	100	82	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.	99
Friends and Family Test covering services						

Indicator	2017/18	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17
for inpatients and patients discharged from A&E family or friends. OUTPATIENTS: Percentage Recommended Trust	95	94	100	75		96
Friends and Family Test covering services for inpatients and patients discharged from A&E family or friends. MATERNITY (Ante & Post): Percentage Recommended Trust	100	98	100	65		100

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 included information about how we aim to improve against these domains in our Quality Strategy “Safest and Kindest Every Day”.

Domain	What do we want to do better?	How are we going to do that?	How will we know when we have?
Safety	<p>NHS Outcomes Framework: Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm</p> <p>SaTH Strategic Objective 2018-2019: SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care</p>		

	<p>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</p>	<p>Complete the review of all incidents that have not been reviewed over winter 2017-2018 and develop clarity of understanding of themes and trends</p> <p>Increase incident reporting across the Trust</p> <p>Value Stream #5 will develop incident reporting by improving processes</p>	<p>Reduction of moderate and severe harm caused compared to 2017-2018</p> <p>5% reduction in the number of reported:</p> <ul style="list-style-type: none"> • High risk medication errors • Falls resulting in moderate or severe harm • Hospital acquired pressure ulcers
	<p>All wards and clinical areas have safety huddles embedded as practice</p>	<p>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</p> <p>Implement huddles in all clinical areas with agreed standard items for discussion</p> <p>Ensure learning from Value Stream #5 is rolled out in PDSA process</p>	<p>Reduction in incidents</p> <p>Improved patient experience scores</p> <p>Staff report better feedback from incidents</p>

Domain	What do we want to do better?	How are we going to do that?	How will we know when we have?
Effectiveness	<p>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</p> <p>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</p>		
	<p>Eliminate the practice of additional patients being placed inappropriately</p>	<p>Timely, safe discharge before lunchtime so that beds are available</p>	<p>Reduction in additional patients Improved satisfaction</p>

		for patients coming into the hospital	Reduced complaints
	We have fewer patients who are in hospital for six or more 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 walkabouts	The Patient Panel new group will be set up ToR agreed Areas of responsibility agreed Examples of outputs
	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
British Thoracic Society (BTS)	Urethroplasty Audit*	×	N/A	Not applicable
	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	✓	×	Data being collected locally for comparison
	Pain in Children*	✓	×	
	Procedural Sedation in Adults*	✓	×	
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*	✓	×	Ongoing data collection – data clerk being recruited
Congenital Heart Disease (CHD)		×	N/A	Not applicable
Dementia in General Hospitals*		✓	✓	100%
Elective surgery (National Proms Programme)*		✓	✓	100%

National Clinical Audit or Confidential Enquiry		Eligible	Participating	Submission rate (%) / Comment
Endocrine and Thyroid National Audit*		✓	✓	100%
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database*	✓	✗	
	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*		✓	✗	
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 project		✓	✗	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%
	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 Clinical Audit or Confidential Enquiry		Eligible	Participating	Submission rate (%) / Comment
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*	✓	×	Did not participate
	Inpatient Audit (NaDia) 2016*	✓	✓	100%
	Inpatient Audit (NaDia) 2017*	✓	✓	100%
	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-	Assessment of side effects of depot and LA	×	N/A	Not applicable

National Clinical Audit or Confidential Enquiry		Eligible	Participating	Submission rate (%) / Comment
UK)	antipsychotic medication*			
	Monitoring of patients prescribed lithium*	x	N/A	Not applicable
	Prescribing antipsychotics for people with dementia*	x	N/A	Not applicable
	Prescribing for bipolar disorder (use of sodium valproate)*	x	N/A	Not applicable
	Prescribing high-dose and combined antipsychotics on adult psychiatric wards*	x	N/A	Not applicable
	Prescribing Clozapine*	x	N/A	Not applicable
	Rapid tranquilisation*	x	N/A	Not applicable
	Use of depot/LA antipsychotics for relapse prevention*	x	N/A	Not applicable
Prostate Cancer Audit*	✓	✓	100%	
Pulmonary Hypertension	x	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	x	N/A	Not applicable	
UK Parkinson's Audit*	✓	✓	100%	
6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK	✓	x	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)	<ul style="list-style-type: none"> The outcomes of the audit were discussed at a cross site Consultant meeting and actions identified to ensure that medication is given appropriately and in a timely way.
	Consultant sign-off in the A&E Department	<ul style="list-style-type: none"> New Cas card completed which includes consultant sign-off. These are now in use.
	Severe sepsis and septic shock	<ul style="list-style-type: none"> 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 Transforming Care Institute have a Value Stream dedicated to improving the care of patients with sepsis
Dementia in General Hospitals*	<ul style="list-style-type: none"> A trial to introduce and promote the use of Butterfly boxes 	

Examples of actions taken following national audits	
Title	Action
	<p>(snack boxes) is currently taking place and is planned to be rolled out throughout the Trust.</p> <ul style="list-style-type: none"> • 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)*	<ul style="list-style-type: none"> • Increased training in Capacity Assessment and documentation. • Reported via Trust Mortality Group to Quality and Safety Committee
Major Trauma Audit (TARN)*	<ul style="list-style-type: none"> • 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)	<p>Perinatal Mortality Surveillance*</p> <p>A detailed action plan has been developed, and progress with this is updated on a quarterly basis. Some of the action points include:</p> <ul style="list-style-type: none"> • 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 • 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 mid trimester 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.

<i>Examples of actions taken following national audits</i>		
<i>Title</i>		<i>Action</i>
National Diabetes Audit - Adult	Inpatient Audit (NaDia) 2016*	<ul style="list-style-type: none"> • 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)*		<p>A detailed action plan has been developed, which includes the following actions:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - 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)*		<ul style="list-style-type: none"> • Plan for improvement in admission temperature and 2 year follow-up rates. These domains have shown substantial improvement in 2017 compared to 2016. • 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		<ul style="list-style-type: none"> • 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 managers 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.

<i>Summary of examples of actions taken following local audits</i>	
<i>Audit Title</i>	<i>Recommendations / Actions</i>
CLINICAL SUPPORT - PATHOLOGY & RADIOLOGY	
Anatomical Marker, Jul-Dec 2017 (3982)	<ul style="list-style-type: none"> • 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

Summary of examples of actions taken following local audits

Audit Title	Recommendations / Actions
<p>Ankle Audit 2017 (3981)</p> <p>CT Doses re-audit (3791)</p> <p>CT KUB imaging (3939)</p> <p>Familial hypercholesterolaemia – NICE Quality Standard 41 (3828)</p> <p>Hand Imaging 2016 (3980)</p> <p>Reporting times for major trauma 2017 (3918)</p>	<ul style="list-style-type: none"> encourage the use of anatomical markers • A re-audit is planned to ensure improvements have been made • 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 • A Diagnostic Reference Level (DRL) for SaTH Low Dose Lung nodule CT will be included within 6 months • Poster showing accepted levels for the scan has been produced and displayed in the department • A re-audit has been undertaken • 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 • 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 • Significant improvement since last year. • Outsourced reporting has now commenced therefore a re-audit is planned for next year for comparison.
CLINICAL SUPPORT - PHARMACY	
<p>Are in-patients provided with enough information about their medicines? re-audit (3323)</p>	<ul style="list-style-type: none"> • 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	
<p>Dietitian Home Enteral Feeding (HEF) service for children (3439)</p> <p>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)</p>	<ul style="list-style-type: none"> • Referrals to clinic have been reviewed and prioritised • A re-audit is planned • 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	
<p>DCT and AND Audit – 2017 (3752)</p>	<ul style="list-style-type: none"> • 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

Summary of examples of actions taken following local audits

Audit Title	Recommendations / Actions
Deprivation of Liberty Safeguards – referrals (3957)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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.

SCHEDULED - HEAD, NECK AND OPHTHALMOLOGY

Dental abscess management (3697)	<ul style="list-style-type: none"> Further advanced airway management training is in place to support the anaesthetists
NHSLA Casenote & Stamp Max Fax 2016 (3692)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> A single page guideline for the management of hypotension based on NICE guidelines to guide junior doctors called to see

Summary of examples of actions taken following local audits

Audit Title	Recommendations / Actions
<p>Telephone follow up hip and knee arthroplasty (3967)</p> <p>Transfusion rate in hemiarthroplasty for hip fracture – NICE Clinical Guideline CG124 (3732)</p>	<p>patients with fractured neck of femur has been produced</p> <ul style="list-style-type: none"> • During winter additional physiotherapy will be available at weekends from November to April • Telephone follow up has proven safe and effective, and arrangements have been made for this service to continue • 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

<p>Bladder CBCTS – 109 (3891)</p>	<ul style="list-style-type: none"> • Bladder protocol and associated documentation have been reviewed • A re-audit is planned
<p>CT 7 3 2d1R – 95 (3797)</p>	<ul style="list-style-type: none"> • T quality system has been fully updated to conform to changes in BSI standard
<p>Endoscopy Unit Patient Satisfaction Questionnaire (10) - re-audit (3768)</p>	<ul style="list-style-type: none"> • 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
<p>Management of Suspected Neutropenic Sepsis against NICE Guidance and Trust Policy (3348)</p>	<ul style="list-style-type: none"> • The Acute Oncology Team are developing a risk assessment tool recommending when to change from IV to oral antibiotics in low risk patients
<p>NHSBSP guidelines and use of vacuum-assisted excision (VAE) for B3 pathology - a 5 year audit (3715)</p>	<ul style="list-style-type: none"> • This audit demonstrates that this saves money and reduces the steps in the patient’s pathway. Therefore full implementation is planned
<p>Surgical Casenote Audit 2017 (3723)</p>	<ul style="list-style-type: none"> • 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
<p>Use of bisphosphonates in patients with newly diagnosed multiple myeloma - re-audit (3807)</p>	<ul style="list-style-type: none"> • Document reasons for choice of bisphosphonate in letters/notes if NOT using zoledronic acid • Documenting creatinine clearance and dose adjustments in notes is on-going
<p>Weekend Handover of Surgical Inpatients (3765)</p>	<ul style="list-style-type: none"> • 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

<p>Assess completion of diabetic foot examinations within 24 hours of admission (3501)</p>	<ul style="list-style-type: none"> • 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
<p>Headaches – NICE Clinical Guideline CG150 (3829)</p>	<ul style="list-style-type: none"> • Creation of a Headache letter template • A re-audit is planned as per Trust NICE 5 year rolling

Summary of examples of actions taken following local audits

Audit Title	Recommendations / Actions
	programme
HPA Urine Compliance - 2016 PRH (3607)	<ul style="list-style-type: none"> • ED Cas Cards have been updated to include a section for urine dip stick testing
Mental Health in Emergency Department (3859)	<ul style="list-style-type: none"> • ED Cas Cards have been updated to include a Mental Health section
Think Glucose - patient experience survey 2014 - re-audit (3052)	<ul style="list-style-type: none"> • On-going ward nurse training is reinforced by study days, general training and opportunistic ward teaching
VTE Assessments on AMU: A Snapshot Audit (3822)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • To identify likely difficult patients (using TCI form) – 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)	<ul style="list-style-type: none"> • Maternity are in the process of streamlining neonatal alerts for Hep C in 'high risk' women • Education for neonatal team for persistent pulmonary hypertension (PPHN) & inotrope use is to be scheduled in teaching programme
Inotrope treatment episodes NNU Time to treat & choice of treatment (3837)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • Play therapy leaflet for parents to be designed • Support for innovative Play concepts has been implemented

Summary of examples of actions taken following local audits	
Audit Title	Recommendations / Actions
Unplanned extubation in the Newborn (3786)	<ul style="list-style-type: none"> • This project has been accepted for the MRPS meeting in Birmingham Children’s Hospital for a poster presentation • A re-audit has been planned • 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:

Priority	Number	Scheme	Have we achieved the CQUIN?
National	1a	Improvement of Health and Wellbeing of NHS staff	Not Achieved
National	1b	Healthy food for NHS staff, visitors and patients	Pending confirmation. Trust view is this is achieved.
National	1c	Improving the uptake of flu vaccinations for front line clinical staff	Achieved
National	2a	Timely identification of sepsis in emergency departments and acute inpatient settings	Partial achievement
National	2b	Timely treatment of sepsis in emergency departments and acute inpatient settings	Partial achievement
National	2c	Antibiotic Review	Partial achievement
National	2d	Reduction in antibiotic consumption per 1000 admissions	Pending confirmation
National	4	Improving services for people with mental health needs who present to A&E	Achieved with partial award in Q2.
National	6	Offering advice and guidance – improve access for GPs to consultant advice prior to referring patients in to secondary care	Achieved
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	Achieved
Specialised Services	WC4a PICU	Paediatric Networked Care – non PICU centres	Pending confirmation – trust view is this is achieved.
Specialised Services	GE3	Hospital Medicines Optimisation	Pending confirmation
Specialised Services	DESP 2016	Diabetic Eye Screening Programme	Pending confirmation. Trust view is this is achieved.

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 Shrewsbury and Telford Hospital NHS Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	Good	Requires improvement	Requires improvement	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

Our ratings for Bridgnorth Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (community services)	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for Ludlow Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (community services)	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Our ratings for Oswestry Maternity Unit

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity (community services)	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Data Quality Report 2017

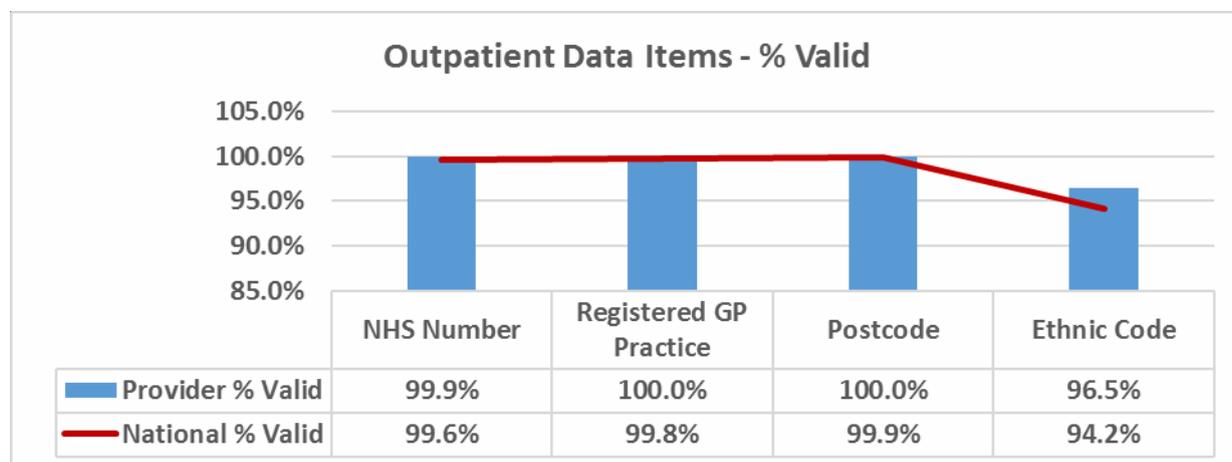
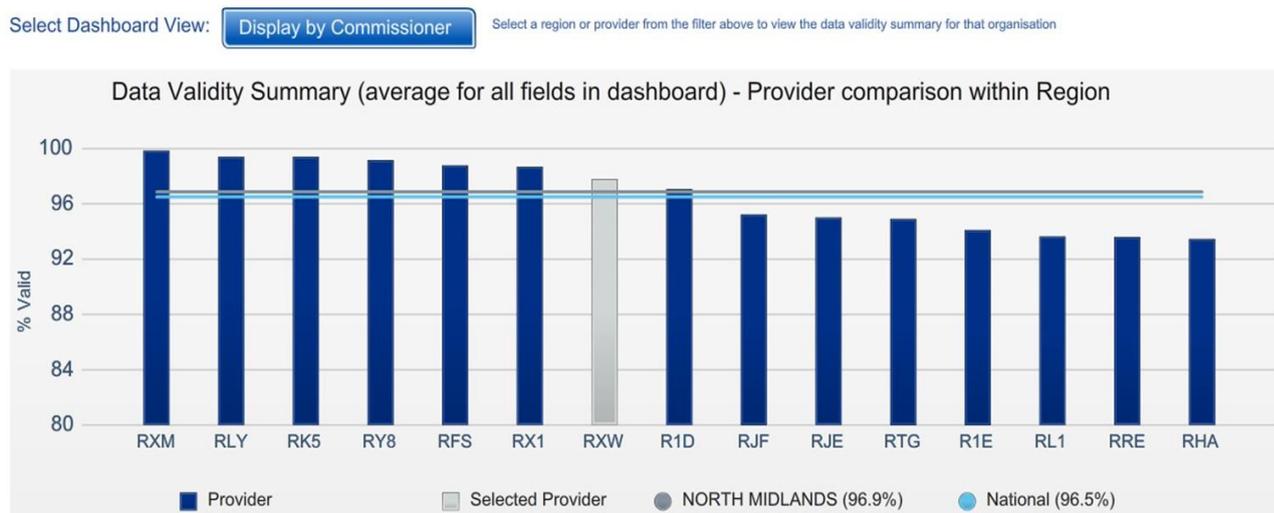
Shrewsbury and Telford Hospital NHS Trust recognises the central importance of having reliable and timely information, both internally to support the delivery of care, operational and strategic management and overall governance, and externally for accountability, commissioning and strategic planning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

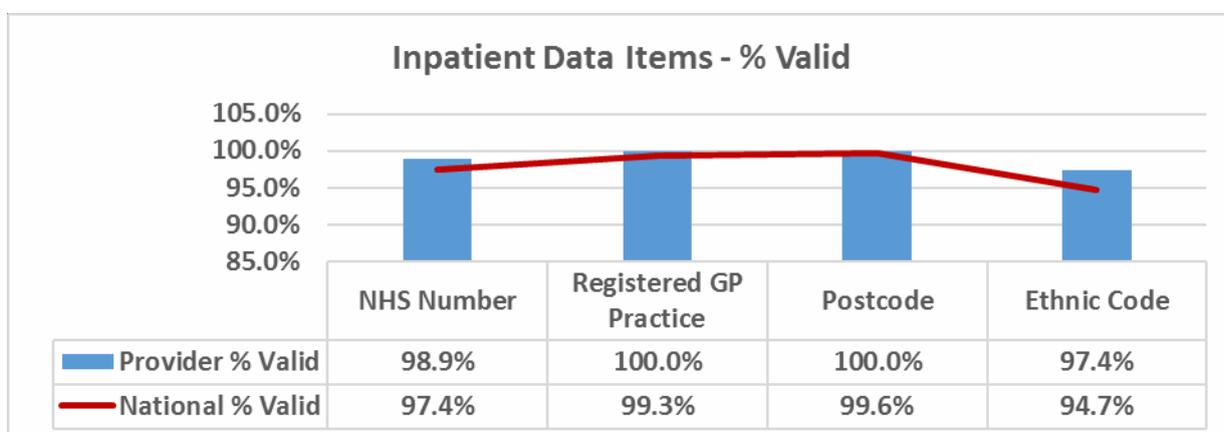
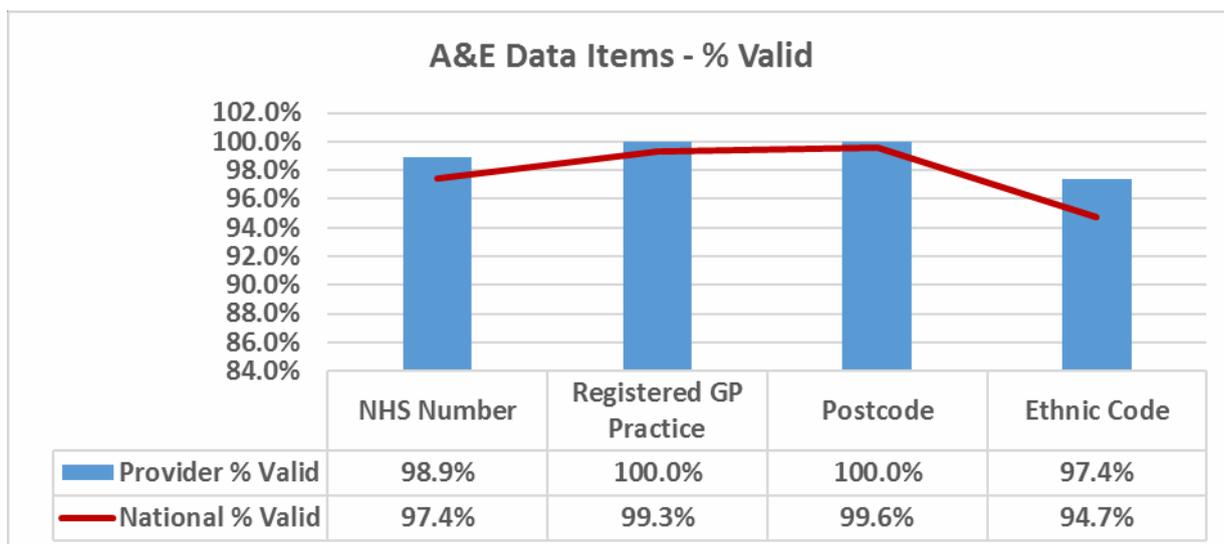
High quality and meaningful information enables people at all levels in the Trust (including external stakeholders) from frontline staff to Board level Directors to:

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

The Information Governance Toolkit Requirement 506 states that organisations must have documented procedures and a regular audit cycle in place to check the accuracy of service user data. The above audit covers key data items identified in NHS Digital guidance for Acute Trust Data Sets. The Data Quality Team follows good practice and has a regular audit cycle in line with the new Data Security Protection Toolkit Assertions (DSPT) formally IG Toolkit Requirements. Duplicate registration incidents are reported monthly to respective areas with any recommendations for further PAS training included.

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





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

Data Item: April 2017-March 2018	Total records completed / populated
Identification of duplicate patient registrations recorded on PAS – merged both electronically and physically	2512
Demographic Corrections - NHS Spine for validation	2633
Missing NHS Numbers against patient records – fields populated	1354
Rejected Discharge Summaries from GPs corrected and sent to valid GP	2772
Open referrals recorded on the system in error – corrected and closed	1479

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.

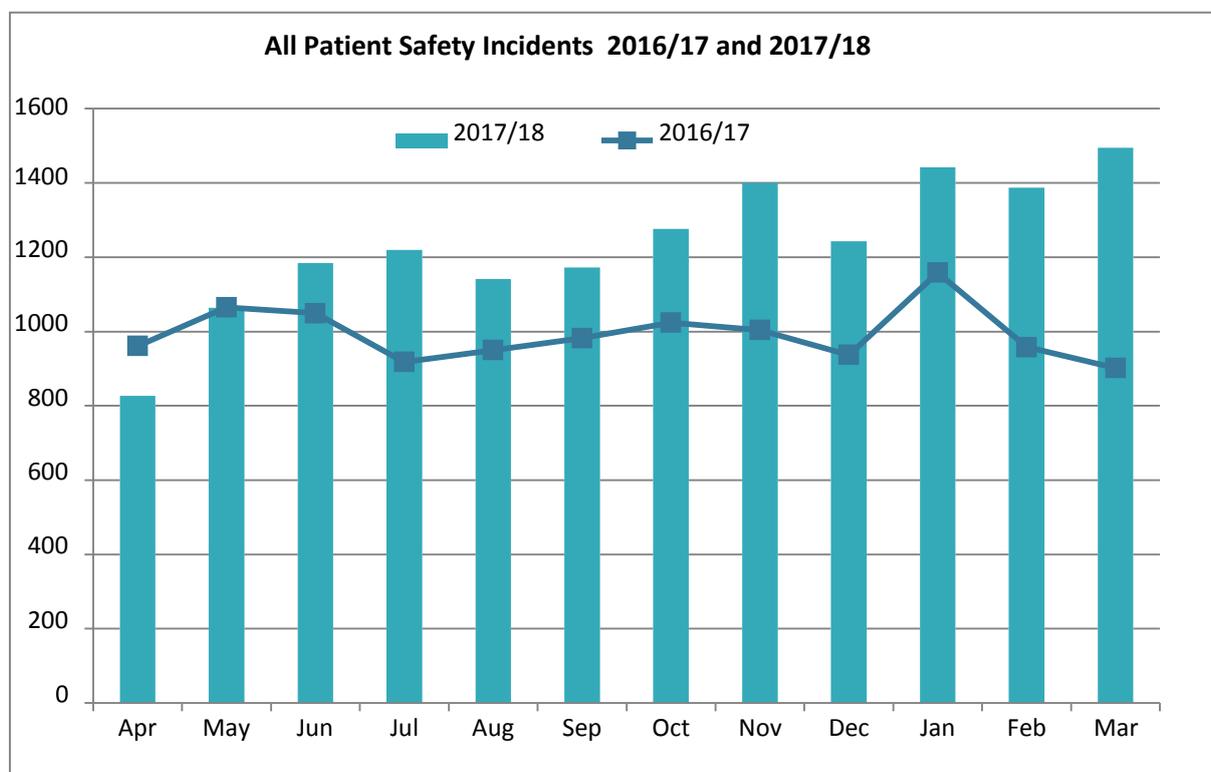
One of these is the Executive Rapid Review – a meeting that is held weekly and which looks at all moderate and severe harm incidents from the previous seven days along with all complaints from the same time period. This ensures that we are identifying trends early, that the right processes are in place,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

The other, mentioned 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

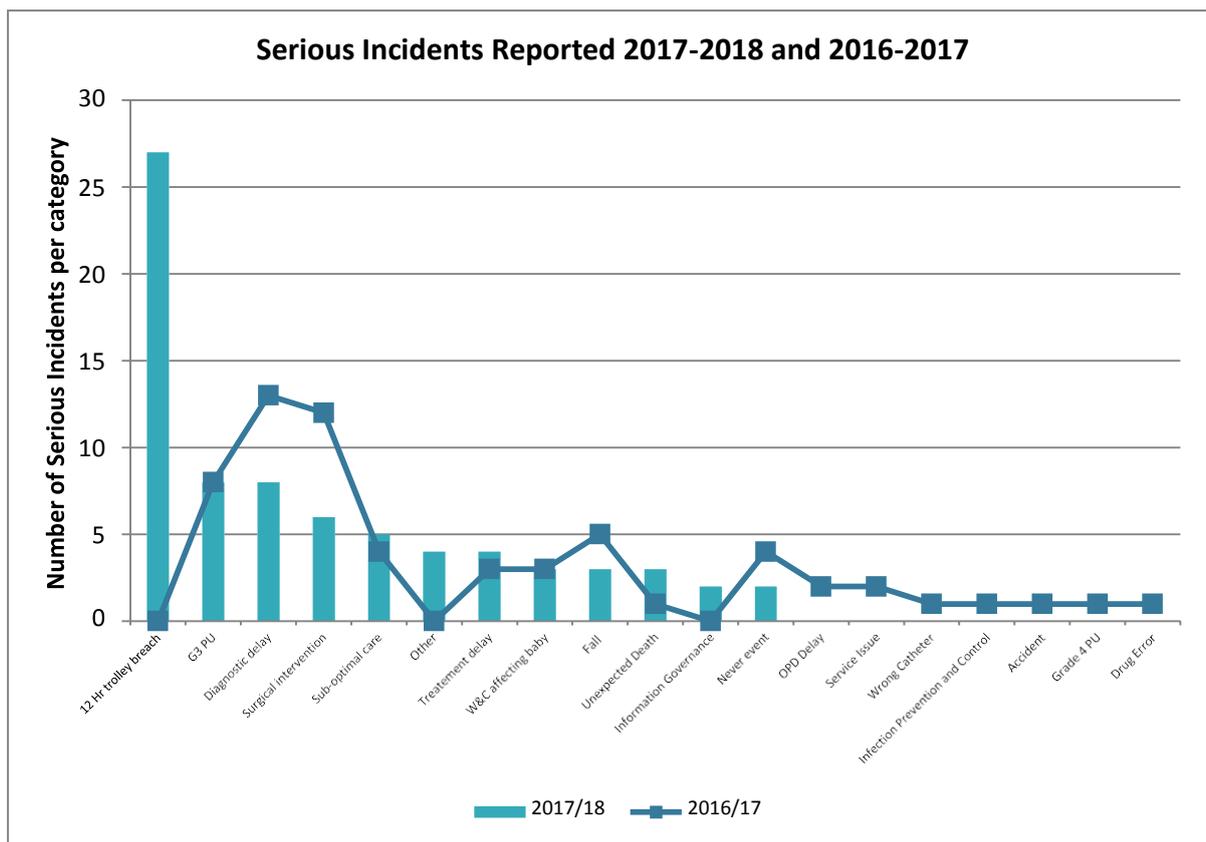
and tested methodology learned from the work with the Virginia Mason Institute to explore in depth specific areas of patient safety – for example, reporting and learning from incidents. This will be rolled out further in 2018-2019 and we look forward to reporting our progress with this work. The Trust 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 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 intrathecal and epidural procedures,	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
	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.

At the end of Qtr 4 2017-2018 we had reported 32 cases of CDI with 24 of them being found due to lapses in care. 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.

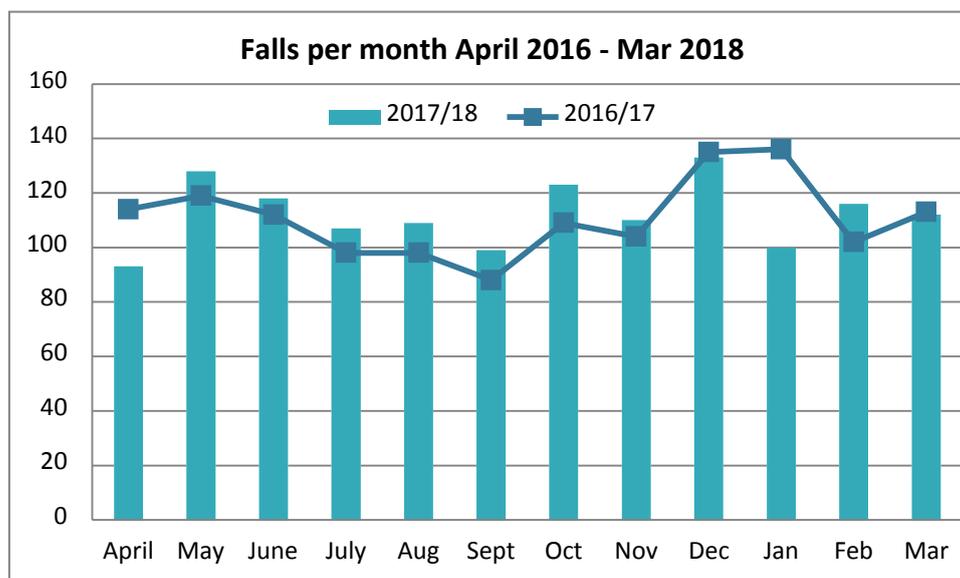
Detailed recommendations form part of the report and the IPC nurses request email feedback to be completed within two weeks. If the compliance score is significantly less than 80%, supported visits are undertaken by IPC team giving opportunity to observe the changes made to improve practice. In addition 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.

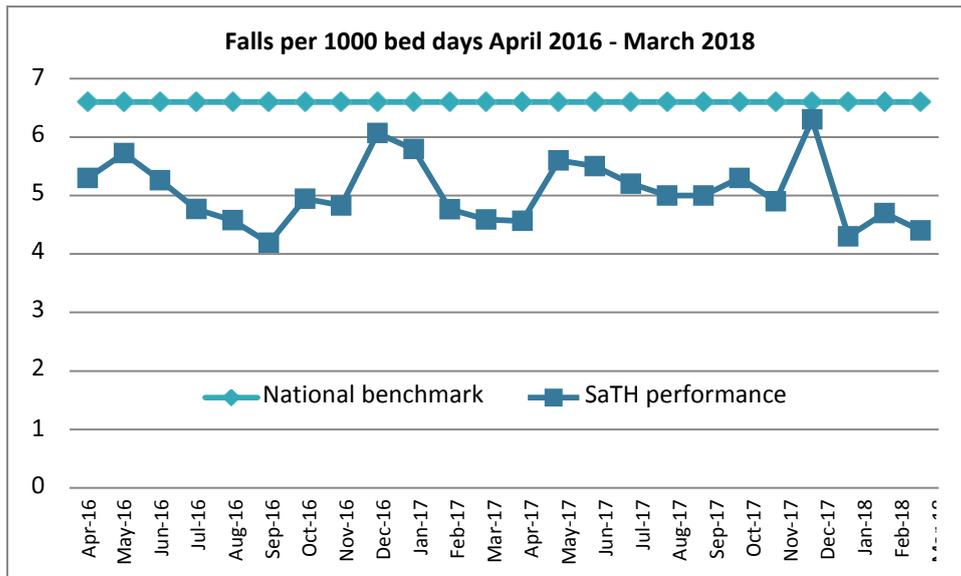
Falls Prevention

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.

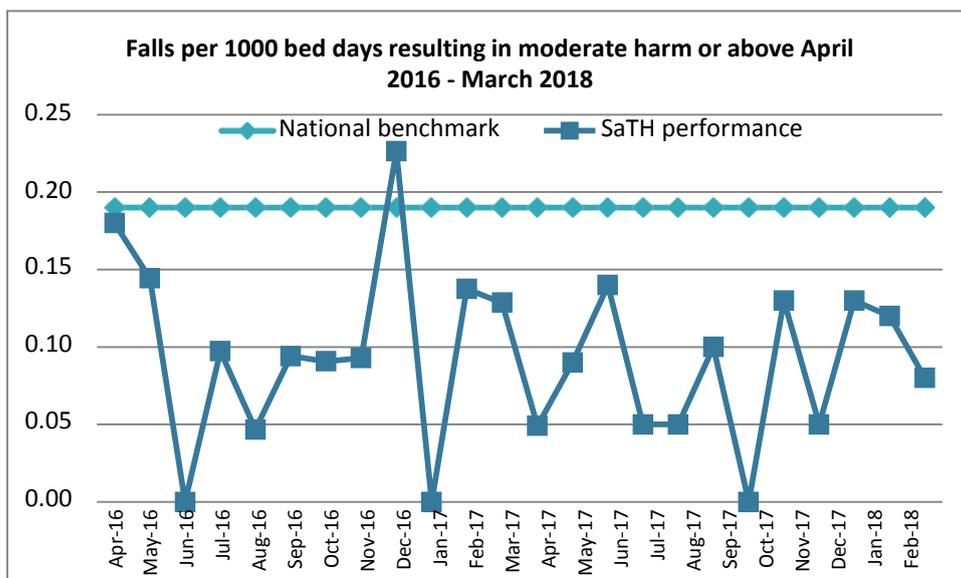
The chart below shows the number of falls recorded in 2017-2018 compared to the previous year:



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.

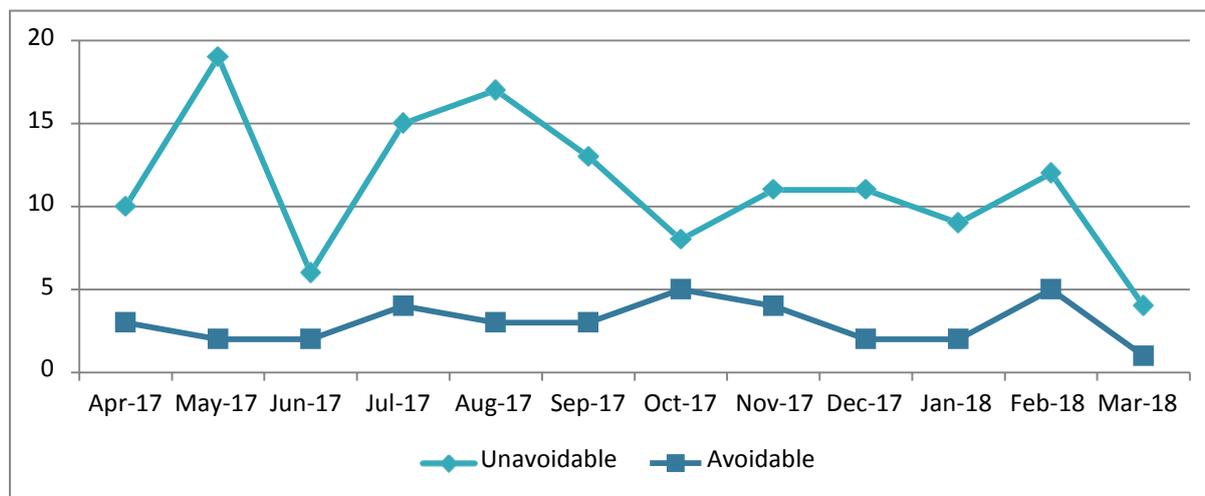


Pressure Ulcers

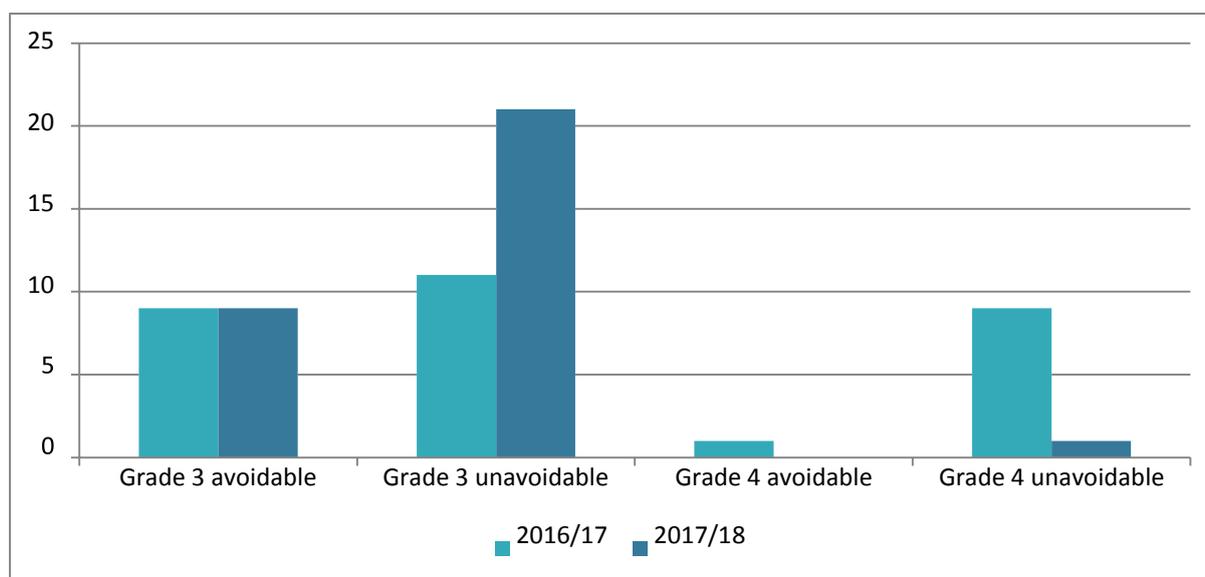
A pressure ulcer - also known as a 'bed sore' or 'pressure sore' - is an ulcerated area of skin caused by irritation and continuous pressure on part of your body. Pressure ulcers are more common over places where your bones are close to your skin such as your heels, the lower part of your back and your 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, 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

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/>

WHAT YOU THINK ABOUT WORKING

Our Organisation

Staff agreeing "care of patients is an organisation top priority"

67%
TRUST SCORE 2017

76%
NATIONAL 2017 AVERAGE

68%
TRUST SCORE 2016

Top Ranking Scores

SaTH Score 2017
9%

National 2017 Average
12%

SaTH Score 2016
9%

% of staff experiencing discrimination at work in the last 12 months

2%

2%

3%

% of staff experiencing physical violence from staff

11%

14%

17%

% of staff experiencing physical violence from patients, relatives or the public

24%

27%

26%

% of staff experiencing harassment, bullying or abuse from patients, relatives or the public

86%

85%

88%

% of staff believing that the organisation provides equal opportunities for career progression or promotion

Overall Staff Engagement

3.73 TRUST SCORE 2017

3.75 TRUST SCORE 2016

3.79 NATIONAL 2017 AVERAGE

1 POORLY ENGAGED STAFF

2

3

4

5 HIGHLY ENGAGED STAFF

63%
TRUST SCORE 2017

73%
NATIONAL 2017 AVERAGE

65%
TRUST SCORE 2016

Staff agreeing that the organisation acts on concerns raised by patients

Violence, harassment & bullying

56%
TRUST SCORE 2017

67%
NATIONAL AVERAGE 2017

67%
TRUST SCORE 2016

Staff reporting most recent experience of violence

44%
TRUST SCORE 2017

45%
NATIONAL AVERAGE 2017

43%
TRUST SCORE 2016

Staff reporting most recent experience of harassment or bullying

25%
TRUST SCORE 2017

25%
NATIONAL AVERAGE 2017

22%
TRUST SCORE 2016

Staff experiencing harassment or bullying from staff

56%
TRUST SCORE 2017

67%
NATIONAL AVERAGE 2017

67%
TRUST SCORE 2016

Staff experiencing harassment or bullying from patients

Working patterns

51%
TRUST SCORE 2017

51%
NATIONAL AVERAGE 2017

48%
TRUST SCORE 2016

% of staff satisfied with the opportunities for flexible working patterns

70%
TRUST SCORE 2017

71%
NATIONAL AVERAGE 2017

69%
TRUST SCORE 2016

% of staff working extra hours



The scores from 1-5 reflect the average score when 1 = Strongly Disagree and 5 = Strongly Agree



Staff feel able to contribute towards improvements at work:



Job Satisfaction

Staff recommending the organisation as a place to work or receive treatment



Staff motivation at work



Staff satisfaction with level of responsibility and involvement



Effective team working



Staff satisfaction with resourcing and support



Managers

Recognition and value of staff by managers and the organisation



3.41 /5
TRUST SCORE 2017

3.44 /5
NATIONAL 2017 AVERAGE

3.44 /5
TRUST SCORE 2016

Staff reporting good communication between management and staff



29%
TRUST SCORE 2017

33%
NATIONAL 2017 AVERAGE

31%
TRUST SCORE 2016

Support for immediate managers



3.74 /5
TRUST SCORE 2017

3.74 /5
NATIONAL 2017 AVERAGE

3.73 /5
TRUST SCORE 2016

Appraisals & Support for development

	TRUST SCORE 2017	NATIONAL AVERAGE 2017	TRUST SCORE 2016
Quality of appraisals	3.02 /5	3.10 /5	3.05 /5
Quality of training	4.03 /5	4.05 /5	4.05 /5
% appraised in last 12 months	87%	86%	86%

Patient care & experience

	TRUST SCORE 2017	NATIONAL AVERAGE 2017	TRUST SCORE 2016
Staff satisfaction with the quality of work and care they are able to deliver	3.80 /5	3.92 /5	3.85 /5
Effective use of patient feedback	3.52 /5	3.71 /5	3.56 /5
Staff agreeing that their role makes a difference to patients	88%	90%	90%

Health and Wellbeing



Staff feeling unwell due to work related stress



Staff feeling pressure to attend work when unwell

3.58 /5
TRUST SCORE 2017

3.62 /5
NATIONAL AVERAGE 2017

3.63 /5
TRUST SCORE 2016

Organisations interest in Health and Wellbeing

Fairness and effectiveness of procedures for reporting errors

3.59 /5
TRUST SCORE 2017

3.73 /5
NATIONAL AVERAGE 2017

3.63 /5
TRUST SCORE 2016

% REPORTING ERRORS, NEAR MISSES OR INCIDENTS IN LAST MONTH

90%
TRUST SCORE 2017

90%
NATIONAL AVERAGE 2017

91%
TRUST SCORE 2016

Errors and Incidents

32%
TRUST SCORE 2017

30%
NATIONAL AVERAGE 2017

31%
TRUST SCORE 2016

STAFF WITNESSING POTENTIALLY HARMFUL ERRORS

Staff Confidence in reporting unsafe clinical practice

3.51 /5
TRUST SCORE 2017

3.65 /5
NATIONAL AVERAGE 2017

3.56 /5
TRUST SCORE 2016



3.3 Clinical Effectiveness

On 27/7/2015 we received a letter from the Medical Directors of NHS England, TDA and Monitor with regard to the NHS 7 Day Service Forum (NHS England Publications Gateway 03837). This was with regard to the developed ten clinical standards describing the minimum level of service that hospital patients admitted through urgent and emergency routes should expect to receive on every day of the week.

SaTH was identified by NHSI as having the capabilities to meet the four clinical standards, 2, 5, 6 and 8 by March 2018.

A 7 Day Services Working Group was established in November 2016 which is chaired by the Care Group Medical Director for Scheduled Care, on behalf of the Medical Director with representation from each care group.

The purpose of this working group is to plan for the introduction of 7 day working in all areas, identify workforce gaps, financial implications and develop business plans for each area to enable implementation of these four key standards.

The working group is also keeping sight of the additional 6 standards and working up plans to identify the gaps in resources and workforce to enable implementation. The Trust Board has received a presentation of this work in February 2018.

Current Position - National 7 Day Service Audits

Clinical Standard 2

Proportion of patients reviewed by a Consultant within 14 hours at admission

Survey		
September 2016	March 2017	September 2017
85%	71%	70%

NB: Methodology changes between September 2016 and March 2017 mean that data may not be 100% comparable between the two surveys. The changes relate to the validation of data entered – the 2017 survey requires each entry that has a validation error to be corrected before it is possible to submit the record

Clinical Standard 6

Do inpatients have 24 hour access to consultant directed interventions 7 days a week?

- either on site or via formal network arrangements?

Service	Weekday			Weekend		
	March 2016 Survey	September 2016 Survey	March 2017 Survey	March 2016 Survey	September 2016 Survey	March 2017 Survey
Critical Care	Yes	Yes	Yes	Yes	Yes	Yes
Primary Percutaneous Coronary Intervention	Yes	Yes	Yes	Yes	Yes	Yes
Cardiac Pacing	Yes	Yes	Yes	Yes	Yes	Yes
Thrombolysis for Stroke	Yes	Yes	Yes	Yes	Yes	Yes
Emergency General Surgery	Yes	Yes	Yes	Yes	Yes	Yes
Interventional Endoscopy	Yes	Yes	Yes	Yes	Yes	Yes
Interventional Radiology	Yes	Yes	Yes	Yes	Yes	No
Renal Replacement	Yes	Yes	Yes	Yes	Yes	Yes
Urgent Radiotherapy	Yes	Yes	Yes	Yes	Yes	Yes

Clinical Standard 8

Proportion of patients receiving once or twice daily reviews – survey comparison

Survey	
September 2016	March 2017
78%	87%
91%	83%

NB: Methodology changes between September 2016 and March 2017 mean that data may not be 100% comparable between the two surveys. The changes relate to the validation of data entered – the 2017 survey requires each entry that has a validation error to be corrected before it is possible to submit the record.

Progress so Far

- Improved job planning over the past 4 years which has a structured approach prioritising emergency care within job plans
- Outsourcing of overnight radiology to make best use of Consultant Radiologist reporting time
- Establishing a separate Consultant on-call rota for Critical Care for RSH
- Funding of weekend therapy service for fractured neck of femur/joint replacements
- Emergency general surgery and
- Funding 7-day trauma operating lists at RSH
- Paediatrics meeting the 7 day service standards in standards 2 and 8.
- Obstetrics and Gynaecology meeting the 7 day service standards in standards 2 and 8.
- Recruitment of 9 substantive consultants since April 2018 (compared with 10 consultants in 2017/2018)

Next steps

- Financial approval for business cases for Support Services to provide therapists and pharmacists 7 days per week over the next 2 years
- Establishing a Consultant of the week in ENT following successful expansion of the consultant workforce
- Developing a single-site inpatient gastroenterology service in order to improve the care of patients with GI bleeding or inflammatory bowel disease
- Invest in Consultants to see patients in the acute admitted areas, EDs, AMUs and SAUs
- Identify and prioritise investments that would improve flow and 4 hour performance
- Join up the current work to improve flow
- Identification of services to deliver with next 2 years
- Identification of services which cannot deliver until Future Fit has completed

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:

	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	<p>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:</p> <p>419 in the first quarter 433 in the second quarter 506 in the third quarter 556 in the fourth quarter</p>
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.	<p>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</p> <p>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)</p> <p>The number of deaths in each quarter for which a case record review was carried out was:</p> <p>289 in the first quarter 291 in the second quarter 349 in the third quarter 277 in the fourth quarter</p>
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	<p>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.</p> <p>In relation to each quarter, this consisted of:</p> <p>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</p> <p>The Trust uses the CESDI (Confidential Enquiry</p>

	Prescribed Information	Statement												
		<p>into Stillbirths and Deaths in Infants) definitions for scoring the outcomes of reviews:</p> <p>Grade 0 - No sub-optimal care</p> <p>Grade 1 - Sub-optimal care but different management would have made no difference to outcome</p> <p>Grade 2 - Sub-optimal care – different care MIGHT have made a difference to outcome (possible avoidable death)</p> <p>Grade 3 - Sub-optimal care. WOULD REASONABLY BE EXPECTED to have made a difference to outcome (probable avoidable death)</p> <p>The outcomes for the year, by number of deaths and percentages of total reviewed are:</p> <table border="1" data-bbox="901 757 1316 907"> <tr> <td>CESDI 0</td> <td>1081</td> <td>90.38%</td> </tr> <tr> <td>CESDI 1</td> <td>97</td> <td>8.11%</td> </tr> <tr> <td>CESDI 2</td> <td>16</td> <td>1.33%</td> </tr> <tr> <td>CESDI 3</td> <td>2</td> <td>0.16%</td> </tr> </table>	CESDI 0	1081	90.38%	CESDI 1	97	8.11%	CESDI 2	16	1.33%	CESDI 3	2	0.16%
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	<p>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 overnight 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</p> <p>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 pathway for Haemophiliac patients, when admitted to the Emergency Department, providing a process for contacting the on-call haematologist regardless of reason for attendance.</p>												
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	A report is currently being compiled of the main themes from 'Learning from Deaths' 2017-18.												

	Prescribed Information	Statement
	<p>what the provider has learnt during the reporting period</p>	<p>Individual actions undertaken as a result of Serious Incident Investigations and deep dive thematic reviews include:</p> <p>Fractured neck of femur: To introduce a single page guideline for the management of hypotension based on NICE guidelines for junior doctors called to see patients with a fractured neck of femur (complete) Extend recovery resource for monitoring post-operatively (complete) Additional physiotherapy support during the winter period (complete)</p> <p>Other examples: Guidance has been issued for the process of administering anti-epileptic drugs (AEDs) in patients who are unable to take orally.</p> <p>Fluids and Electrolytes Concern was raised about an increase in December 2015, March and April 2016 which may reflect patients being readmitted with fluid and electrolyte disorders at times of high activity. Most patients were admitted with dehydration secondary to sepsis, UTI or pneumonia. Readmission rate within 28 days overall was below peer average. The figures in November 2016 showed variation between observed and expected mortality as stable and within expected control limits. Recommendations following the review were:</p> <p>Continue to monitor this group for a further six months to assess any changes Identify administrative personnel to address the administrative errors. SaTH Medical Director to speak with Shropshire Community Health NHS Trust Medical Director to share conclusions and consider how to reduce number of unnecessary transfers (complete)</p>
27.6	<p>An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.</p>	<p>The actions described above are reviewed at the Mortality Group meetings within the Trust – audits are carried out as planned by each area. The Fluids and Electrolyte review was repeated in July 2017 and co-operative working between Trusts continues.</p>
27.7	<p>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</p>	<p>Trust wide data collection commenced in April 2017. There is no 'relevant document' for the previous reporting period 2016-17.</p> <p>Thematic retrospective 'Deep Dive' reviews conducted during 2017-18:</p>

	Prescribed Information	Statement
		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.

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.



Exemplar Progress Report

Department: A ward	Date: Mock – 19 th November 2017 Assessment 1 – 22 nd January 2018 = Redeemable Reassessment of 4 standards – 26 th 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 months Silver, 4 months Gold, 5 months 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.
- 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	Reminder to pharmacy staff to always check

who ordered a CD (controlled drug) was the same RN who received a CD	which introduces an 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 Safer sharps 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)

3.4 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 2017/18, 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 within agreed timescales 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. Timescales are agreed with the complainant, but are usually 30 working days, extended to 45 and 60 for complaints that are more complex, for example involve other organisations.

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.

The Trust is committed to becoming the safest and kindest Trust and as part of that, it is important that each complaint is seen as an opportunity to reflect, learn and make improvements in the areas that matter most to our patients and their carers and families. To assist with this, all staff asked to comment on a complaint, are asked to consider what learning has arisen from the complaint and what actions are needed to implement that learning. Some examples of learning and changes in practice that have arisen from complaints are set out below:

Changes in Practice

- Signage to be put up in A&E advising members of the public that they cannot film there
- Staff to ensure they document all communication with relatives
- Regular audit of hand hygiene in Ophthalmology
- Weekly checks to be carried out by bookings team to review all patients not yet on lists
- Review and strengthening of SOP for dispensing trays
- 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
- 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
- Housekeeper numbers to be increased in A&E
- 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
- Review in place for flow through Paediatric Assessment Unit

Training

- Medication safety update delivered to wards on security of patients' own medications, self-administration policy and use of dosette boxes
- Flow chart of actions to be taken when a pressure sore develops produced for ward staff
- Refresher training on admission planning and scheduling
- Communication skills training for admin staff/secretaries
- Staff members attending training to deal with communication and difficult situations that may occur on the ward

New Policies and Processes

- 24 hour ECG results to be sent out daily.
- Single use tape measures to be ordered for A&E
- Mouth care policy for end of life patients implemented
- 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.
- Develop link worker role for hearing aids/devices.

- 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

Information for Patients

- Booking staff to advise patients that they may be seen sooner than estimated waiting times
- Staff to ensure they provide up to date waiting times
- Update of endoscopy patient information leaflets to include the role of nurse or operating department practitioner
- Booking team to contact patients by phone when dating patients with less than two weeks' notice
- 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 Care Board meetings, and 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

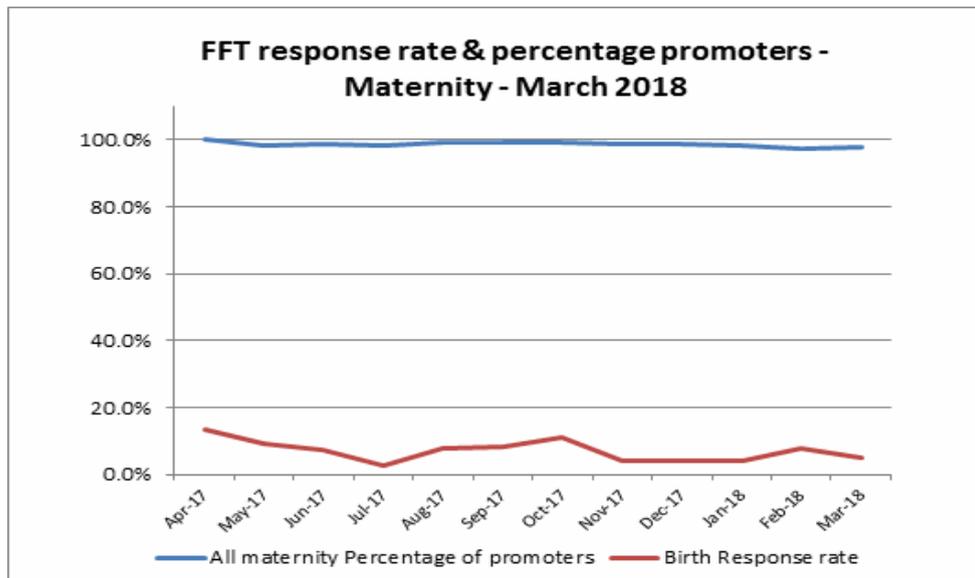
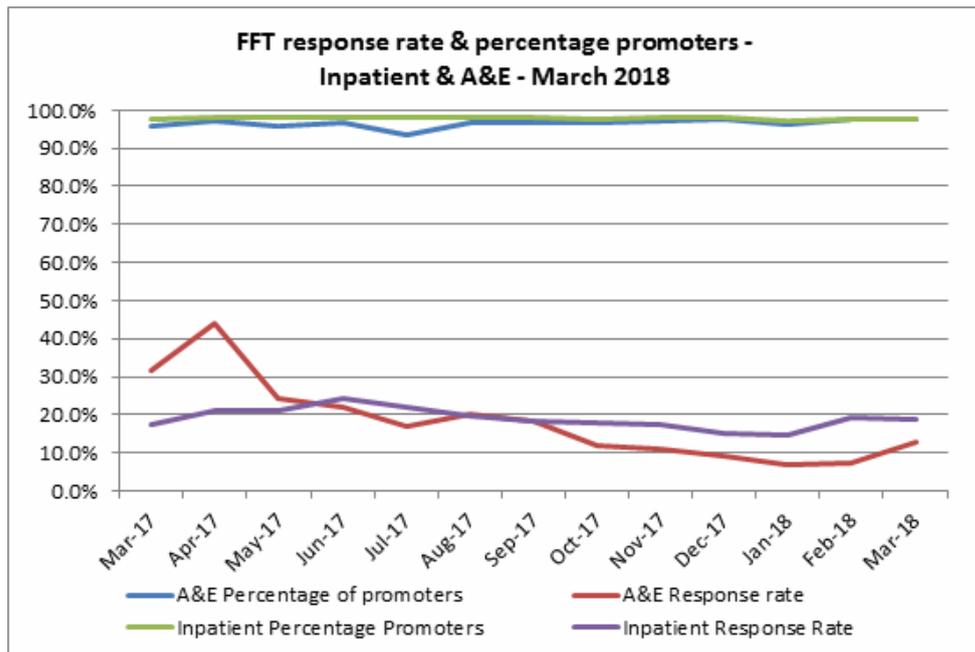
We have taken several approaches to understand and therefore improve the experience that people have of our care at SaTH. One of the approaches that has been used is the Friends and Family Test – a one question measure used across the organisation asking respondents **“Would you recommend the service 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 and this increase is a high priority for us.

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 Experience and Involvement Panel (PEIP)

During 2017-2018 it was agreed that PEIP would change to allow the Trust to better engage with patient representatives and to allow the panel to reflect the community demographic we serve.

The new model will have at its heart the concept of collaborative working. The proposed new representative group will combine patient representatives and staff members who will co-design and co-produce a model of working to deliver improvements to the overall patient experience, which truly reflects what matters to our patients.

People’s Academy

The Shrewsbury and Telford Hospital NHS Trust is committed to working with communities across Shropshire, Telford and Wrekin and Powys to ensure that we deliver the best care possible. We have appointed a Community Engagement Facilitator, to develop this commitment into action.

Our Trust is the first in the country to develop a People’s Academy which is open to anyone living in the localities that we serve. The SaTH People’s Academy comprises a series of four sessions held over four weeks which give information about the NHS, the Trust, our population and how people can influence. Sessions include presentations from different teams and behind-the-scenes tours.

The People’s Academy syllabus was co-produced with public representatives, and after a successful pilot in January 2018 a full programme of courses has been rolled out across both hospital sites.

All future patient/public representatives working with the Trust will be asked to complete an Academy course within six months of starting with us.

In addition to the Academy, we are attending community events and meetings across Shropshire, Telford and Wrekin and Powys and, as a direct result of feedback gathered, have already added email addresses to outpatient appointment letters.

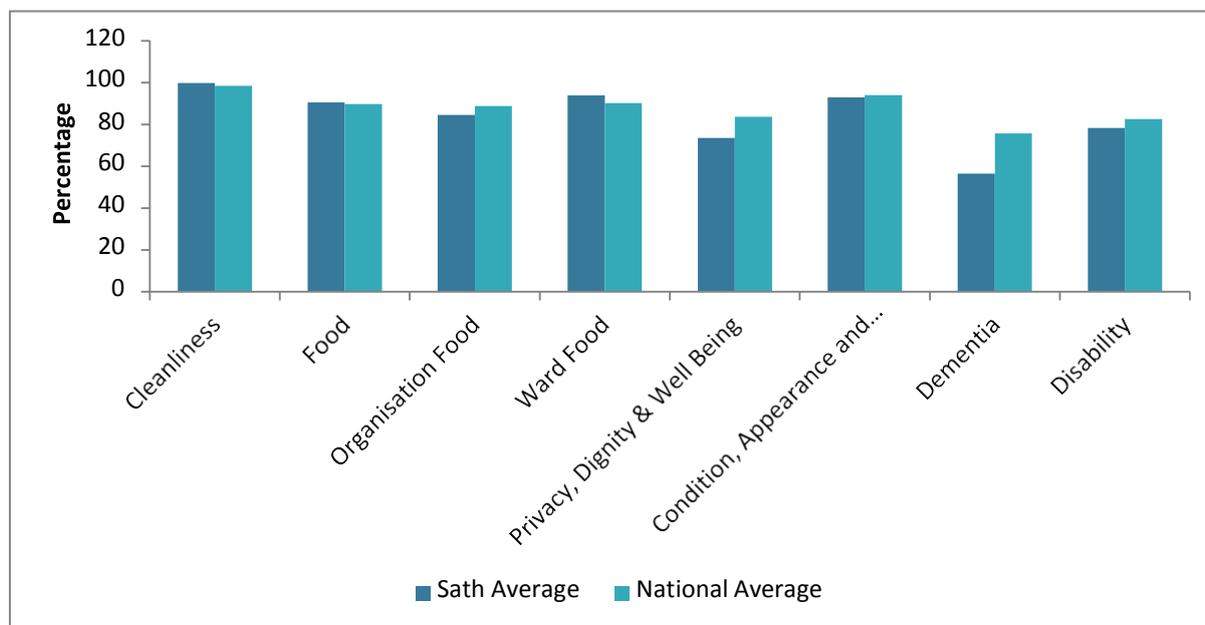
Patient Stories

Each month a patient story is delivered to the Trust 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.

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.



PLACE scores by site:

Site	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity & Well Being	Condition, Appearance and Maintenance	Dementia	Disability
RSH	99.54	93.62	75.81	95.71	54.35	88.74	55.36	62.23
PRH	99.28	83.43	74.25	96.09	66.26	93.94	57.54	67.35
Oswestry MLU	100.00	90.57	96.44	83.55	86.03	91.61	-	89.13
Bridgnorth MLU	100.00	94.24	90.06	97.55	80.43	97.41	-	91.08
Ludlow MLU	99.79	90.48	86.29	95.95	81.03	92.80	-	81.97
Sath Average	99.72	90.47	84.57	93.77	73.62	92.90	56.45	78.35
National Average	98.40	89.70	88.80	90.20	83.70	94.00	75.70	82.60
Sath 2016 Average	99.4	90.5	81.71	93.61	68.99	91.14	58.14	74.1

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
- Shropshire Council

4.2 Changes made to the Quality Account following receipt of statements

Page	Change Made	Date
4	Amendment to reflect the name of SSSFT to MPFT	14 June 2018
8	Additional detail on how the Board receive updates on progress of actions from patient stories	14 June 2018
12/13/18/21/57/59	Minor formatting to text	14 June 2018
33	Additional tables included as requested - CQC	14 June 2018
51	Further detail added re Seven Day Services (not requested)	14 June 2018
54	Additional information added 27.6 and 27.7 (not requested)	14 June 2018
63	Additional table added - PLACE	
43	Amendment made to statement re CDI following CCG feedback	26 June 2018

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 by Directors:

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.

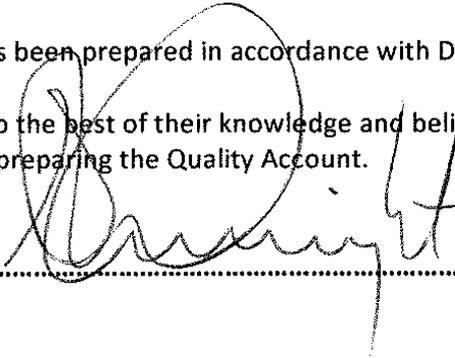
There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice.

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

27 June 2018
.....

Appendices:

Appendix one: Statement from our Auditors

Appendix two: Glossary

Statement from our Auditors:



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

We are required to perform an independent assurance engagement in respect of The Shrewsbury and Telford Hospital NHS Trust's Quality Account for the year ended 31 March 2018 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations") and the National Health Service (Quality Account) Amendment Regulations 2017 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following indicators:

- Rate of clostridium difficile infections; and
- Friends and family test patient element score.

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

Respective responsibilities of the Directors and the auditor

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

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

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

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

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

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

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

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

- board minutes for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 19/06/2018;
- feedback from local Health watch organisations, dated 20/06/2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/05/2018;
- the [latest] national patient survey, dated 13/06/2018;
- the [latest] national staff survey, dated December 2017;
- Care Quality Commission inspection, dated 16/08/2017; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated May 2018.

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

This report, including the conclusion, is made solely to the Board of Directors of The Shrewsbury and Telford Hospital NHS Trust.

We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and The Shrewsbury and Telford Hospital NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

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

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

Limitations

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

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

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

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

Basis for disclaimer of conclusion on the Friends and Family Indicator (FFT)

In testing a sample of 25 records included within the FFT indicator, we were unable to select any samples from April 2017 to December 2017 inclusive due to the Trust not retaining these records. As a result of being unable to review a sample for the whole period, we are unable to give limited assurance on the FFT indicator.

Conclusion

Based on the results of our procedures, except for the effects of the matter raised in the "Basis for disclaimer of conclusion on the Friends and Family Indicator (FFT)" section above nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Account subject to limited assurance (Rate of clostridium difficile infections) has not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
1 Park Row
Nottingham
NG1 6FQ

28 June 2018

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	<p>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.</p> <p>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.</p> <p>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.</p>
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 <u>Equality and Diversity Council</u> 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.

