NHS
The Shrewsbury and Telford Hospital
NHS Trust

Quality Account

01 April 2018 to 31st March 2019

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Quality Account 01 April 2018 – 31 March 2019

Section One: Introduction and Background

1.1 Chief Executive statement on Quality

I am pleased to introduce The Shrewsbury and Telford Hospital NHS Trust's (SaTH) Annual Quality Account. This report provides an overview of the quality of care delivered between April 2018 and March 2019 as well as our priorities of care going forward for 2019-20. There are relevant sections in the report detailing these priorities and highlighting a selection of the improvements made during the year as well as aspects of care we will continue to work hard to improve.

The Trust continues to build on the work it has been doing with the Virginia Mason Institute under the banner of our Transforming Care Production System improving care based on the insights of our patients and staff. We are developing engagement champions at all levels in the organisation, continue to invest in our freedom to speak up champions and are developing a cohort of coaches to further enable staff to be heard and supporting them to excel at their roles.

2018-2019 was an extremely challenging year for SaTH. Our CQC report, being placed into Special Measures and our staff survey results highlight how much work we have to do to regain people's confidence that our services are safe and of high quality. Our challenges relating to staffing (particularly in our Emergency Departments) and the age of our estate and IT infrastructure are well documented. Set against the backdrop of extremely high levels of emergency demand across both sites, it is clear the scale of challenge SaTH has to provide the quality of service that we aspire to, and that our patients, families and carers deserve. The Board and Senior Leadership teams at SaTH are totally committed to meeting these challenges in 2019-20.

This quality account outlines where we did well in 2018-19 in terms of quality, and where we must improve. Based around the feedback of the CQC we have developed a Quality Improvement Plan that focuses on really addressing the 'root causes' identified by our staff of the issues that the CQC highlighted.

We have therefore taken a different approach in this year's quality account. Our improvement priorities focus on key areas such as our Emergency Department, Maternity service, Staff Engagement, infection control and, linked to our Operational Plan for 2019/20, our ability to get our patients into the right bed at the right time when they need to be admitted.

We will report back on overall progress against our Quality Improvement Plan and the specific priorities we have chosen to highlight or any key areas of concern in our next Quality Account. We don't underestimate the scale of the challenges we face but I'm confident we have the talent and energy amongst our staff to make real improvements in 2019/20.

I commend this document to you as a reflection of an incredibly difficult year but a clear commitment to improve in 2019/20.

Bev Tabernacle, Deputy 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 2018-19 we saw contracted levels of activity as follows:

- 54,000 elective and day case spells
- 58,379 non-elective inpatient spells
- 422,000 outpatient attendances
- 137,197 accident and emergency attendances

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.

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)
- Midlands Partnership NHS Foundation Trust (specialist mental health and learning disabilities)
- West Midlands Ambulance Service NHS Foundation Trust (ambulance and patient transport)
- Welsh Ambulance Services NHS Trust (ambulance and patient transport)

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

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

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

In this section we aim to give detail about the progress we have made with the priorities for quality improvement that we identified in 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 October 2018.

2.1 Progress against priorities for improvement 2018-2019

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

What is important is that these priorities are not only for one year – they are usually based on existing work and will continue into the future. Therefore we have said what we are going to be doing for the year ahead even where we have fully achieved what we said we would do in 2018-2019.

Domain	What did we want to do better?	How did we say we were going to do that?	How will we know when we have?	How have we done?
Safety	**NHS Outcomes Framework:** Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm **SaTH Strategic Objective 2018-2019:** SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care			
	Learning faster and better - to improve the learning from incidents especially those considered to be near miss or low harm to reduce the number of moderate and severe harm incidents	Complete the review of all incidents that have not been reviewed over winter 2017-2018 and develop clarity of understanding of themes and trends Increase incident reporting across the Trust	Reduction of moderate and severe harm caused compared to 2017-2018 5% reduction in the number of reported: • High risk medication errors • Falls resulting in moderate or severe harm Hospital acquired pressure ulcers	Our number of high risk medication errors comparing 2017/18 and 2018/19 are outlined in the table below: • Our number of near miss no harm incidents have increased. We believe this is related to an improved reporting culture and staff flagging 'near misses' in order to raise issues and support learning to prevent further incidents; • The number of 'minimal harm' incidents have decreased by 19% • We have had one more moderate harm incident than in 17/18; • Overall we have seen a reduction in high risk medication errors by 2% but haven't achieved our target of 5%

Domain	What did we want to do better?	How did we say we were going to do that?	How will we know when we have?	How have we done?

	17/18	18/19	Total
Near miss/no harm	*440*	*463*	*903*
Minimal harm	*175*	*138*	*313*
Moderate Harm	*1*	*2*	*3*
Severe/Permanent or long term harm	*0*	*0*	*0*
Totals:	*616*	*604*	*1220*

We have had significant success relating to reduction in the overall number of falls. However we didn't succeed in reducing the number of falls resulting in moderate to severe harm. We had 22 in 2017/18 and 23 in 2018/19. However, average number of moderate harms or above measured per 1000 bed days in 2018/19 was 0.09/1000 bed days which is just under half that of the national benchmark.

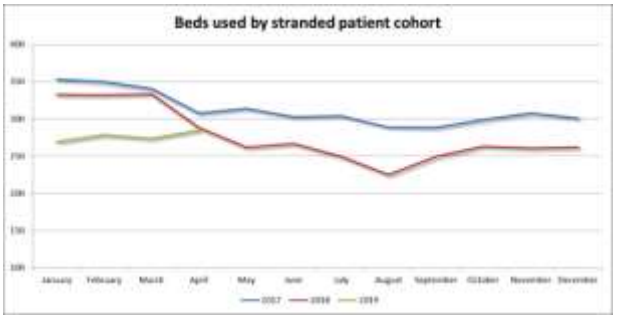
We acknowledge we set ourselves a difficult target when we are already sat below the national benchmark. However our Falls Group working with our clinical teams will continue to focus on reducing falls in 2019/20

In 2017/18 we had a total of 238 hospital acquired pressure ulcers (both those classified avoidable and unavoidable) across all three grades of pressure ulcer (2 to 4 with 4 being the most serious). In 2018/19 this number was 189 (21 of these were awaiting classification as this Quality Account was published).

The total number of hospital acquired pressure ulcers has reduced by 20% so we have reached our target. Within this however the number of grade 3 and 4 pressure ulcers increased from 31 in 2017/18 to 37 in 2018/19. We have seen an issue with pressure ulcers caused by devices such as nasal cannula's so we are reviewing our use of these devices.

Our maternity service has implemented the Saving Babies Lives Care Bundle version 2 (SBLCBv2) and will continue to work on the 5 key elements in 2019/20.

Domain	What did we want to do better?	How did we say we were going to do that?	How will we know when we have?	How have we done?
	All wards and clinical areas have safety huddles embedded as practice	Carry out baseline assessment of each ward and clinical areas practice of huddles to get a view of current state and to develop implementation plan Implement huddles in all clinical areas with agreed standard items for discussion	Reduction in incidents	Safety Huddles having been embedded across clinical areas – audit suggests 85% of our clinical areas. We will continue to fully embed huddles with a view to auditing and ensuring huddles are fully embedded across all our clinical areas by the end of 2019/20. Our total number of reported Serious Incidents reduced from 48 in 2017/18 to 40 in 2018/19 against a backdrop of a rise in demand for our services. We will continue to work to reduce this figure further in 2019/20. Our 'friends and family' scores remain strong as reflected in an overall in our 2019/19 results. The percentage of patients who responded to the survey and would recommend the Trust to family and friends were:
			Improved patient experience scores	Emergency Department: 97% Inpatients: 98% Inpatients: 97% Outpatients: 97%
			Staff report better feedback from incidents	We know we still need to improve on how staff receive feedback around incidents. We have outlined a plan to improve feedback which will include: • Better feedback and clarity around actions after a 'Datix' incident report has been submitted; • Continued use of safety huddles to brief staff on actions taken; • Development of 'Datix matters' which can be shared on safety boards, at team meetings and safety huddles showing what has happened after incidents have been raised; • Supporting work in our Scheduled Care Group to develop safety champions at department level who use 'Just Saying'' a structured safety conversation technique to talk to staff about safety issues and feedback about incidents and actions. We will then look to introduce this model across out hospitals; • Development of quarterly Trust wide learning forum to share learning from both negative (where something has gone wrong) and positive (where something has gone well) incidents; • Build on work in ITU, Emergency Departments and Anaesthetics to spread 'Learning from Excellence' a positive incident reporting and learning approach.
		Ensure learning from Value Stream #5 is rolled out in PDSA process		We have taken the learning from this work stream and this will form part of wider plan to disseminate safety learning as outlined above in 2019-20 that we will report back in our next quality account.

Domain	What did we want to do better?	How did we say we were going to do that?	How will we know when we have?	How have we done?
Effectiveness	**NHS Outcomes Framework:** Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm Domain 3: Helping people to recover from episodes of ill health or following injury **SaTH Strategic Objective 2018-2019:** **PATIENT AND FAMILY** Listening to and working with our patients and families to improve healthcare **SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care**			
	Eliminate the practice of additional patients being placed inappropriately	Timely, safe discharge before lunchtime so that beds are available for patients coming into the hospital		We have stopped the practice of patients being placed in areas inappropriate for delivering safe, high quality and dignified care. We have redefined our escalation ward areas (for use when we have very high emergency demand). We have also opened Clinical Decisions Units on both sites to ensure patients are cared for in the most appropriate place. We are working collaboratively with the Emergency Care Intensive Support Team to support new ways of working to improve streaming of patients to the most appropriate place so they get the right treatment and support as quickly as possible. We have been experiencing high levels of emergency demand and we know stopping this practice had created additional pressures in our Emergency Department which is reflected in our 2019/20 priorities. Our Operational Plan for 2019/20 is focussed on developing additional capacity to allow patients to access the right bed more quickly.
	We have less patients who are in hospital for more than 7 days (Reduction of stranded patients)	Discharge planning begins on admission with an estimated date of discharge agreed Links to collaborative working with the patient and their family		We have had considerable success in reducing the number of patients who are in our hospital for more than 7 days which helps to free bed capacity to treat new emergency admissions as illustrated in the graph below:  We will continue to work in 2019/20 to reduce the numbers of 'stranded' patients and this is a key priority as part of our Operational Plan and reflected in our 2019/20 Quality Priorities.

Domain	What did we Want to do better?	How did we say we were going to do that?	How will we know when we have?	How have we done?
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			
	Co-production 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 Terms of Reference agreed Areas of responsibility agreed Examples of outputs	The Patient and Carer Experience (PaCE) Panel has been established consisting of public and staff representatives who work together in a collaborative approach towards quality improvement and patient experience within the Trust. The Kaizen Promotion Office Team (our quality improvement support team) seeks to include a public representative within each Rapid Improvement Week and a member of the PaCE Panel has acted as a value stream sponsor. There are five maternity voices panels across the county who meet on a regular basis to ensure listening, learning and responsive action occurs. We also reviewed the feedback from the national maternity survey 2018 and have developed an improvement plan to address areas where the Trust has performed worse than other Trusts who took part in the survey.
	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.	The end of life care plan has been updated in 2018 and family members are involved in completing this in the end stages of life. Family members and carers are actively encouraged to be involved in providing care during the end stages of life if they choose to. Trust carers surveys were sent to people who care for someone with a learning disability; recent results identify an improvement in the proportion of carers who felt that if they had difficulties concerning the person they care for, they did have the opportunity to discuss them with staff.
	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	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	SaTH performed better in the 2017 National In-Patient Survey than the previous year in patients being asked their views, patients being involved as much as they wanted to be in decisions about their care and treatment and patients feeling they were involved in decisions about their discharge from hospital.

Domain	What did we Want to do better?	How did we say we were going to do that?	How will we know when we have?	How have we done?
	Improved experience of ED	Better flow through the department	Improved experience of ED	New patient safety checklists have been introduced within ED to support patient safety and improve patient experience. Flow in ED remains a significant challenge and is a key priority for improvement in 2019-20

2.2 Our Quality Improvement Action Plan

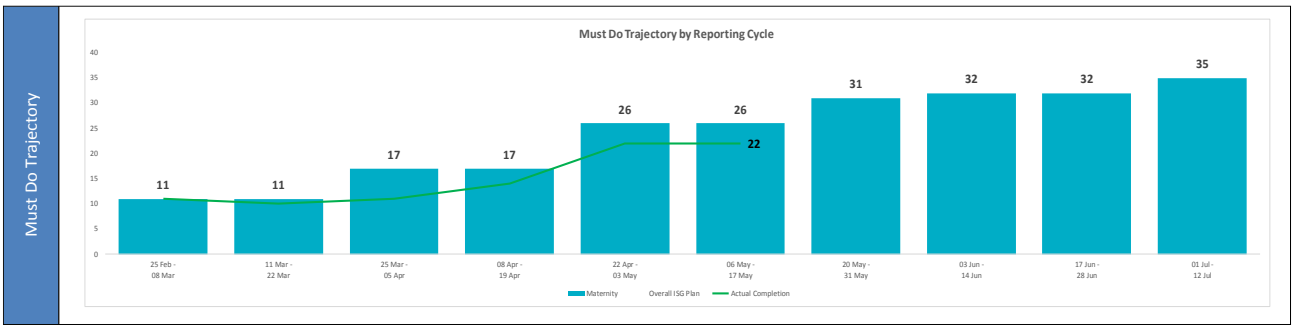
Following the CQC inspection of October 2018 we have developed a focussed CQC Trust Quality Improvement Plan (QIP) to respond to the 'Must do' and 'Should Do' actions identified by the CQC. We have approached this differently this year as we acknowledged previous actions plans hadn't been built from the 'ground up' but staff who deliver care and are closest to the issues which affect the quality of care our patients receive.

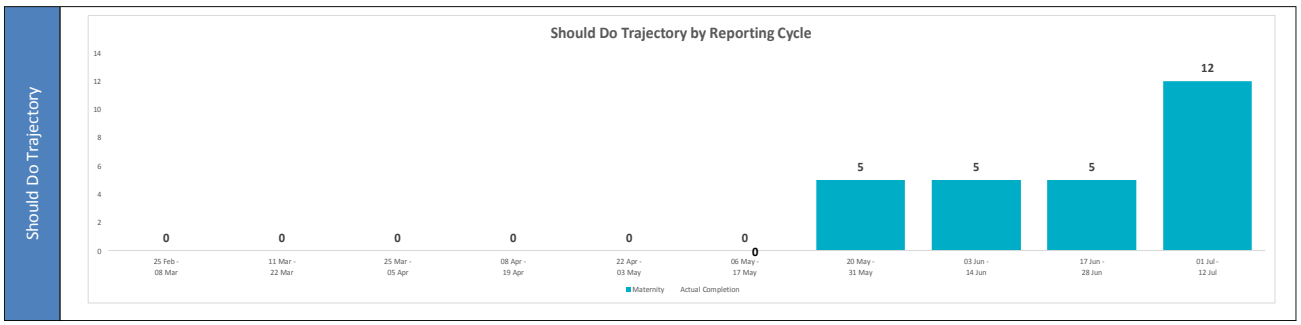
The improvement plan was brought together in a series of workshops held between January and April 2019 attended by staff from many different roles and clinical specialties in the Trust and based around five key areas linked to the CQC report:

- Unscheduled Care
- Scheduled Care
- Workforce
- Women's and Children's
- Well Led

Workshops focussed on understanding the 'root cause' of each CQC finding and developing plans to deliver sustainable improvement linked to clear measures of success. A Programme Management Office has been set up so we can properly track delivery of improvement actions and understand where we are making improvements and where further work is needed to make sure actions are on track. All five work streams of the QIP are now up and running and delivery of action plans is being monitored.

The graphs below outline our plan for when actions will be delivered that we will track via the Programme Management Office.





In our 2019-20 Quality Account we will update you on actions and report back specifically on any areas where we haven't delivered the improvements we planned.

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 2018-19.

Indicator	2018/19	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17	2017/18
The value and banding of the summary hospital level mortality indicator (SHMI) for the trust for the reporting period	52.6	61.96	79.57	45.94	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.	65.46	60.36
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	22.51	33.5	67.8	12.45	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	17.51

Indicator	2018/19	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17	2017/18
The Trust's reported outcome measure scores for: Groin hernia surgery Varicose vein surgery Hip replacement surgery Knee replacement surgery	 0 0 0.796 0.648335	 0.089 0.096 0.81 0.733	 0.140 0.134 1 or 0.883 0.969	 0.055 0.068 0.024 0.281	Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: Patient Reported Outcome Measures are an important way that we measure how well a patient feels the procedure went and how it has impacted on their life Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this indicator and so the quality of services by: encouraging patients to complete the questionnaires following the procedure and using the information to develop our services further	 0.159 0.152 0.563 0.434	 0.102 0 0.417 0.335
The percentage of patients aged: 0-15 and	 12.659	 9.65	 17.42	 0.3663	Shrewsbury and Telford Hospital NHS Trust considers that these percentages are as described for the following reasons:	 9.90	 10.86
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 April - February	8.872	8.103	11.275	3.859	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.	7.78	8.17
The Trust's responsiveness to the personal needs of its patients during the reporting period	67.1	68.6	85.0	60.5	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.	68.6	68.2

Indicator	2018/19	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17	2017/18
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	52.6	71.3	87.3	39.8	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	60
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.81	95.46	97.02	94.58	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 action relating to the quality of its services by: continuing with the monitoring of compliance and ensuring that clinical teams are aware of the requirement.	95.68	95.58
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	7.03	11.68	14.26	7.47	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	11.74

Indicator	2018/19	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17	2017/18
Number of patient safety incidents	6316	5,583	23,692	566	Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: The Trust continues to develop an improving reporting culture Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve the indicator and percentage and so the quality of its services by: incident reporting and investigating is discussed weekly at the Executive Rapid Review meetings and is also part of the TCI Value Stream #5 particularly in relation to sharing of outcomes and learning through safety huddles.	4398	5505
Rate of patient safety incidents per 100 admissions	54.8	44.52	107.4	13.1		35.93	44.63
Percentage of patient safety incidents that resulted in severe harm or death	0.16	0.3	1.16	0.0			
Friends and Family Test covering services for inpatients and patients discharged from A&E family or friends. AE: Percentage Recommended Trust	97	86	100	56	Shrewsbury and Telford Hospital NHS Trust considers this data is as described for the following reasons: the percentage of people responding to the Friends and Family Test is monitored by the Trust on a monthly basis. Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage (and so the quality of its services) by supporting our patients to feedback about the service. We will continue to develop different ways that people can complete this survey and therefore increase the response rate including using volunteers to advocate that patients and families complete the survey.	96	94
Friends and Family Test covering services for inpatients and patients discharged from A&E family or friends. INPATIENTS: Percentage Recommended Trust	98	96	100	77		99	98
Friends and Family Test covering services for inpatients and patients discharged from A&E family or friends. OUTPATIENTS: Percentage Recommended Trust	97	94	100	57		96	95
Friends and Family Test covering services for inpatients and patients discharged from A&E family or friends. MATERNITY (Ante & Post): Percentage Recommended Trust	-	98	100	69		100	100

2.4 Looking forward to our Priorities for Quality Improvement for 2019-2020

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.

We have made sure that the Quality Priorities reflect our CQC ratings, the enforcement actions we have been subject too from the CQC and linked to our CQC Quality Improvement Plan and Operational Plan. Also there is a key quality priority relating to our staff survey results as we know this is a priority area for improvement given the link between how staff feel about the organisation they work in and the quality of care which is delivered. We have focused down this year into a smaller number of areas and looked for a smaller number of measurable indicators that will really demonstrate if we have improved over the course of the next year:

Priority Area	Why have we chosen this?	What are we aiming to achieve?	How will we measure if we have improved?
Emergency Department (ED) care	Providing high quality ED services remains a significant challenge for the Trust Our patients need to know when they need emergency care they can access it quickly and get the best care possible Our emergency department was subject to a number of CQC 'must do' actions after CQC inspections in 2018 and 2019	We will focus on key measures to ensure we know patients in ED are being seen quickly. We will continue to look at the way we respond when patients are at risk of sepsis (a potentially life threatening condition) and our use of the 'Sepsis 6' bundle. We will demonstrate how we have learnt from incidents of missed diagnosis in ED and how we have used learning from incidents to improve We will demonstrate we are responding in a timely way when staff in ED submit 'Datix' incident reports so we know we are learning when staff raise concerns around safety.	Time to be seen for majors patients: we will reduce the average time to be seen for majors patients in 2019/20 Audit of compliance with the sepsis 6 bundle: We will continue to audit our compliance with the sepsis 6 bundle and update on how we did in our next quality account Numbers of serious incidents (SI's) related to missed diagnosis: we will publish learning from SI's related to missed diagnosis in 2019/20 and outline what improvements have been made Timely response to Datix incident reports: we will reduce the number of overdue Datix responses in our Emergency Department in 2019/20
Maternity	We need prioritise and ensure safe care for our mothers and babies	Savings Babies Lives Care Bundle Version 2 will continue to be implemented focusing on the five elements of care that are widely recognised as evidence-based and/or best practice: 1. Reducing smoking in pregnancy: 2. Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR) 3.Raising awareness of reduced fetal movement (RFM) 4. Effective fetal monitoring during labour 5. Reducing preterm birth	The second version of the care bundle includes a greater emphasis on continuous improvement with a reduced number of process and outcome measures. The implementation of each element will require a commitment to quality improvement with a focus on how processes and pathways can be developed and where improvements can be made. Specifically in relation to smoking we will: Work to reduce the number of women who smoke during pregnancy who use the Trust maternity service to 11% or below in 2019-20 (as part of a plan to reduce this to 6% by 2022).

Priority Area	Why have we chosen this?	What are we aiming to achieve?	How will we measure if we have improved?
Maternity	To continue to deliver high quality care in line with the five year forward view	Our maternity unit to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access support that is centred around their individual needs and circumstances.	To deliver improvements in line with the national recommendations and proposed times frames working with our local health partners as part of the transformation programme. This will be monitored through our maternity oversight group.
Staff Survey	Our staff survey results were in the lowest quartile across the country. We know there is a strong link between how staff feel and the quality of care we deliver Recruitment and staff shortages are an on-going challenge and we need to be able to retain our staff.	We will aim to improve our staff survey response to the question 'care of patients is my organisations top priority' as a key staff survey measure	We will improve from a positive response rate of 62.3% to a minimum of 68.0% by next staff survey in 2019 with an aim to use this as a basis to be at national average or above by the 2020/21 staff survey.
Patient access to the right bed at the right time in an emergency	Getting patients from the emergency department and to the right bed when they need admitting remains a challenge Patients forced to wait in the emergency department (particularly on corridors) have a poor experience which compromises their dignity and cause them distress An overcrowded emergency department makes it more difficult for staff to provide safe care and causes staff significant stress	Linked to our operational plan we are aiming to ensure patients who are admitted via our Emergency Department who need admitting get into an appropriate bed as quickly as possible. Creating the right capacity and 'flow' of patients in emergency will reduce waits in our Emergency Department and allow staff to provide high quality and safe care.	A 10% improvement on the 4hr target to admit or discharge patients seen in the emergency department Further reduction in 'stranded' patients (patients medically fit for discharge who are waiting to leave hospital): No more than 220 patients over 7 days during 2019/20
Infection Prevention and Control	Our patients need to know they are being treated in an environment where the chance of acquiring an infection during their stay is as low as possible	During 2018/19 our infection prevention and control processes were reviewed by NHS Improvement. We are currently rated 'Red' in terms of progress against the NHSI infection control action plan. To comply with all areas highlighted as part of the NHSI assessment.	We will be rated as 'green' (fully compliant) against the NHSI action plan by quarter three in 2019/20.

We will work on these priorities in 2019-20 and report back how we do in our next quality account.

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 2018-19 Shrewsbury and Telford Hospital NHS Trust provided and/or subcontracted the full range of services for which it is registered.

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 comply 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 organisations review and ensure that they contribute to those audits that are relevant to their services.

During 2018-19 there were 75 / 105 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 57 / 68 national clinical audits and 6 / 7 national confidential enquiries in which it was eligible to participate.

The reports of 35 national clinical audits and 3 national confidential enquiries were reviewed by the provider in 2018-2019 and Shrewsbury and Telford NHS Trust intends to take the following actions to improve the quality of healthcare provided

***Audits on HQIP List 2018/19**

Title		Eligible	Participating	Submission rate (%) / Comment
Anxiety and Depression*		×	×	Not applicable
British Association of Urological Surgeons	Cystectomy*	✓	✓	42%
	Nephrectomy audit*	✓	✓	68%
	Percutaneous Nephrolithotomy (PCNL)*	✓	×	Not applicable
	Radical Prostatectomy Audit*	✓	✓	100%
	Female Stress Urinary Incontinence Audit*	×	×	Not applicable
British Thoracic Society (BTS)	Community Acquired Pneumonia*	✓	✓	Currently in progress
	Bronchiectasis (adult)	✓	✓	100%

Title		Eligible	Participating	Submission rate (%) / Comment
	Bronchoscopy	✓	✓	89% PRH & 97% RSH
	Non-invasive ventilation adults*	✓	✓	Currently in progress
Care in Emergency Departments (CEM)	Feverish Child*	✓	✓	207 cases submitted
	Vital signs- adults*	✓	✓	258 cases submitted
	VTE*	✓	✓	86 cases submitted
Case Mix Programme (CMP)* - ICNARC		✓	✓	Currently in progress
Child Health Clinical Outcome Review Programme (NCEPOD)	Cancer in Children, Teens and Young Adults*	✓	✓	There were no eligible cases during the submission period
	Long-Term ventilation*	✓	×	Unable to identify patients in a timely manner
	Young People's Mental Health*	✓	✓	83%
National Asthma & COPD Audit Programme (NACAP)	Primary Care*	×	×	Not applicable
	Pulmonary rehabilitation*	×	×	Not applicable
	Adult Asthma Secondary Care*	✓	×	Not applicable
	Paediatric Asthma*	✓	×	Due to commence data collection Jun-19
Dementia in General Hospitals*		✓	✓	Awaiting report
Elective surgery (National Proms Programme)*		✓	✓	71.9% response rate
Endocrine and Thyroid National Audit		✓	✓	100%
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database*	✓	×	Not applicable
	Inpatient Falls*	✓	✓	Currently in progress
	National Hip Fracture Database (NHFD)*	✓	✓	On-going
Head & Neck cancer (Saving Faces)		✓	✓	On-going
Inflammatory bowel disease (IBD) Registry, Biological Therapies Audit*		✓	×	Issues around capacity
Learning Disability Mortality Review Programme (LeDeR)*		✓	✓	100%
Major Trauma Audit (TARN)*		✓	✓	PRH – 100%/RSH- 88.8%
Mandatory Surveillance of bloodstream infections and clostridium difficile infection*		✓	✓	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Maternal mortality surveillance and mortality confidential enquiries*	✓	✓	Not applicable
	Perinatal Mortality Surveillance*	✓	✓	36 cases reported for 2018
	Maternal morbidity confidential enquiries*	✓	✓	Not applicable
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Acute Bowel Obstruction*	✓	✓	Currently in progress
	Acute Heart Failure*	✓	✓	100%
	Perioperative diabetes*	✓	✓	9/10 clinical & 10/10 anaesthetic
	Pulmonary Embolism*	✓	✓	11/12 returned
Mental Health Clinical Outcome Review Programme	Safer Care for Patients with Personality Disorder (NCISH)*	×	×	Not applicable
	Suicide in children and young people (CYP) (NCISH)*	×	×	Not applicable

Title		Eligible	Participating	Submission rate (%) / Comment
	Suicide, Homicide & Sudden Unexplained Death (NCISH)*	×	×	Not applicable
	The Assessment of Risk and Safety in Mental Health Services (NCISH)*	×	×	Not applicable
National Audit of Breast Cancer in Older People (NABCOP)*		✓	✓	1150 diagnosed
National Audit of Cardiac Rehabilitation*		✓	✓	Currently in progress
National Audit of Care at the End of Life (NACEL)*		✓	✓	50 case notes PRH. 0 quality surveys returned 71 case notes RSH. 4 quality surveys returned
National Audit of Intermediate Care (NAIC)*		×	×	Not applicable
National audit of meningitis management- a NITCAR audit (NAMM)		✓	✓	Currently in progress
National Bariatric Surgery Registry (NBSR)*		✓	✓	Not applicable
National Cardiac Audit Programme (NCAP) - NICOR	Adult Surgery audit*	×	×	Not applicable
	Angioplasty Audit (Percutaneous Coronary Interventions (PCI)*	×	×	Not applicable
	Arrhythmia Audit (Cardiac Rhythm Management Audit)*	✓	✓	100%
	Congenital Heart Disease (CHD)*	×	×	Not applicable
	Heart Attack Audit (Acute Myocardial Infarction – MINAP)*	✓	✓	PRH - 300 RSH - 271
	Heart Failure Audit*	✓	✓	529 cases
National Cardiac Arrest Audit (NCAA)*		✓	✓	PRH – 62 RSH – 52
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)*		×	×	Not applicable
National Clinical Audit of Psychosis	core audit*	×	×	Not applicable
	EIP spotlight audit*	×	×	Not applicable
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)*		×	×	Not applicable
National Comparative Audit of Blood Transfusion programme	Audit of Transfusion Associated Circulatory Overload (TACO)*	✓	✓	36 cases (100%)
	Audit of Patient Blood Management in Scheduled Surgery*	✓	✓	16 cases (100%)
	Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients*	✓	✓	36 cases (100%)

Title		Eligible	Participating	Submission rate (%) / Comment
	National Comparative Audit of Blood Transfusion programme - Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children*	✓	×	Seldom transfuse FFP or cryo to children
	National Comparative Audit of Blood Transfusion programme - Management of massive haemorrhage*	✓	✓	2 cases (100% of expected sample)
	Care Processes & Treatment Target*	✓	✓	1915 submitted
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 2018		✓	✓	153 responses (46.2% response rate)
National Mortality Case Record Review Programme*		✓	×	Not applicable
National Paediatric Diabetes Audit (NPDA)*		✓	✓	289 cases for 16/17
National Vascular Registry*		✓	✓	100%
Neonatal intensive and special care (NNAP)*		✓	✓	Currently in progress
Neurosurgical National Audit Programme*		×	×	Not applicable
National Gastrointestinal Cancer Programme	Oesophageal gastric Cancer (NAOGC)*	✓	✓	100%
	National Bowel Cancer (NBOCA)*	✓	✓	86%
Ophthalmology Audit (cataract)*		✓	✓	1932 procedures
Paediatric intensive care (PICaNet)*		×	×	Not applicable
Perioperative Quality Improvement Programme		×	×	Not applicable
Prescribing Observatory for Mental Health (POMH-UK)	Assessment of side effects of depot and LA antipsychotic medication*	×	×	Not applicable
	Monitoring of patients prescribed lithium*	×	×	Not applicable
	Prescribing antipsychotics for people with dementia*	×	×	Not applicable
	Prescribing for bipolar disorder (use of sodium valproate)*	×	×	Not applicable
	Prescribing high-dose and combined antipsychotics on adult psychiatric wards*	×	×	Not applicable
	Prescribing Clozapine*	×	×	Not applicable
	Rapid tranquilisation*	×	×	Not applicable

Title		Eligible	Participating	Submission rate (%) / Comment
	Prescribing antidepressants for depression in adults*	×	×	Not applicable
Prostate Cancer Audit*		✓	✓	100%
Pulmonary Hypertension*		×	×	Not applicable
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*		✓	✓	All applicable patients
Seizures and Epilepsies in Children and Young People (Epilepsy12)*		✓	✓	Currently in progress
Sentinel Stroke National Audit Programme (SSNAP)*		✓	✓	100%
Serious Hazards of Transfusion (SHOT): UK National haemo-vigilance scheme*		✓	✓	100%
Seven Day Hospital Services*		✓	✓	100%
Surgical Site Infection Surveillance Service*		✓	✓	Not applicable
UK Cystic Fibrosis Registry*		×	×	Not applicable
UK Parkinson's Audit		✓	✓	100%

Reviewing reports of local clinical audits

The reports of 65 local clinical audits were reviewed by the provider in 2018-19 and Shrewsbury and Telford Hospital NHS Trust intends to take actions to improve the quality of healthcare provided. Some examples of local clinical audits and actions taken to improve quality are outlined below:

Some examples of local clinical audits are shown below:

No.	Audit Title	Key actions/improvements following audit
CLINICAL SUPPORT - PATHOLOGY & RADIOLOGY AND THERAPIES		
1	Dietician Home Enteral Feeding (HEF) service for children (re-audit) (4227)	• A data base has been set up to record activity and clinical portal records Dietician activity
2	Factors contributing to interval cancers in the NHS Breast Screening Service (4210)	• Presentation to the team reiterating the importance of positioning and the NHSBSP standards
3	Malignant breast disease (4195)	• The symptomatic breast imaging service is following RCR (Royal College of Radiologists) standards • Results are discussed in radiology and breast multi-disciplinary meetings
4	Nurse led HSG service 2016 (4158)	• The audit shows a good, effective, safe service
5	Percutaneous Biopsy Procedures (4169)	• Compliance with standards demonstrated
6	PROMPTs trial Bilsky score reporting with central review of images (4170)	• Audit demonstrates reporting within national targets
7	Shropshire Breast Screening Programme Client Satisfaction Survey 2017 (3823)	• Overall, the results are very positive and suggest an efficient service that is well-run and well-received • In order to improve the number of responses for the next survey, more questionnaires will be handed out and women encouraged to return them.
8	Ultrasound screening of soft tissue lumps referred from primary care (4249)	• No change in practice at this time - appropriate use of ultrasound resources for GP access is demonstrated • There will be continued appropriate vetting of requests and assessment of the ultrasound results

No.	Audit Title	Key actions/improvements following audit
9	X-ray request form compliance (4084)	• Changes have now been made to the request card to ensure a more robust service • Training issues have been highlighted including how to complete the request card and what content should be included. These have been discussed with A&E
CORPORATE – TRUST WIDE		
10	Analysis of the quality of recent discharge summaries from the Trust (3942)	• Learning points from this audit will be incorporated into the junior doctors' education programme during the coming year to make sure that each is addressed. • Results disseminated to Trust's Deputy and Care Group Medical Directors, members of the NHS Standards working group and to the GPs who completed the audit, for their information and awareness • The audit has been rolled out to 5 further practices to produce a larger sample, and we are awaiting the results.
11	Care after death (4111)	• A community policy for care after death is being developed • The End Of Life Care team will facilitate additional training sessions • Ward managers to distribute the care after death policy, and nurses will sign to confirm this has been read. • A re-audit is planned
12	Carer's Survey – Learning disabilities (4068)	• Liaise with the Pre-op Assessment Teams to ensure that they are advising carers and relatives to bring the Patient Passport into hospital for planned admissions • Increased staff awareness regarding the Patient Passport and engagement of carers in the admission process enabling any concerns to be identified
13	Compliance relating to completion of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) form (4048)	• The main learning is the need to provide more specific detail with regard to the rationale behind the findings of the capacity assessment using Mental Capacity Act Form 1. This has been amended accordingly • Additional guidance on the 5 principles of the MCA, Consent, Capacity and Best Interest have been uploaded to the Trust internal website • Audit findings to be used in future training sessions.
14	Defined Ceiling of Treatment (DCT) and Allow Natural Death (AND) Audit - Feb 2018 (4046)	• Following dissemination of the results, the Trust is now planning to adopt the nationally recognised ReSPECT form • Continue to increase awareness amongst doctors and nurse and remind them of the legalities of the form
15	Dementia carer's survey - March 2017 (4076)	• Information on the Butterfly scheme is now included in the information pack provided by the Dementia Support Service • Increased staff awareness regarding 'this is me' document • Guidance for carers is included in the information pack provided by the Dementia Support Service
16	Fluid Balance Chart Audit 2018 (4051)	• Improvement in the recording of oral and IV Intake demonstrated • Further training and education to ward staff will be on-going
17	Local A&E Survey - March 2018 (4074)	• Accurate waiting times were provided to 75% of patients • Staff were reminded to provide information regarding potential side effects of medication • To ensure patients receive pain relief as required, the department is introducing a mandatory pain score
18	Local Children and Young Person's Survey - March 2018 (4073)	• The survey highlighted that parents and carers did not have access to hot drinks on the ward. Hot drinks are now allowed on the ward as long as they have a lid on. There are cups and lids are now available in the parent's room • New mattresses have been ordered for fold up beds to allow overnight stay for parents/guardians
19	Mouth care audit 2017 (3735)	• A mouth care policy has been introduced

No.	Audit Title	Key actions/improvements following audit
		• A re-audit is in progress
20	Nursing Documentation March 2018 (Dec-17 notes) (4075)	• The audit demonstrated improved completion of Inter ward transfer documentation • Further reinforcement of the importance of the Butterfly scheme and patient passport is included in Dementia awareness sessions
21	The Deteriorating Patient (Jan to Jun 2018) (4138)	• To increase awareness, the audit was shared throughout the Trust • Deteriorating patients training session is now included on Preceptorship programme and Fundamentals of care programme • NEWS2 has been introduced and training has been provided • Safety huddles take place on the wards, where patients at risk, including the deteriorating patient are discussed and documented
22	The Deteriorating Patient (Jul to Dec 2017) (3995)	• Introduction of NEWS 2 training throughout the Trust with emphasis on documentation
23	Urinary Catheter Point Prevalence Survey (4108)	• Discharge letter now includes reasons for catheterisation and dates
SCHEDULED - ANAESTHETICS, THEATRES & CRITICAL CARE		
24	Anaesthetic involvement in the management of the sick child in RSH Emergency Department (4135)	• To address the gaps in the skills and knowledge of anaesthetic and theatre staff, a competency package has been created and implemented • Training sessions to support package are planned
25	Inadvertent Hypothermia in ICU (PRH) - NICE CG65 (4090)	• Teaching has been provided as part of nurses professional development by the PD nurse to increase use and knowledge of active heating
26	Peri-operative fasting (3951)	• Audit confirmed current practice is safe and satisfactory
27	Peri-operative temperature monitoring (4022)	• Warming cabinets have now been installed in 3 extra theatres • A poster has been placed in the seating area to increase awareness
28	Post-Operative Nausea & Vomiting (PONV) Prophylaxis Prescribing (4117)	• A guideline is being developed to aid prescribing in PONV
SCHEDULED - HEAD, NECK AND OPHTHALMOLOGY		
29	Endoscopic Dacryocystorhinsostomey re-audit - NICE IPG113 (4155)	• Surgical outcomes were comparable to the available current standards. There were no areas of concern
30	ENT VTE Audit (4213)	• Handover sheet now has area for VTE assessment • Twice daily ward round are in operation and juniors reminded when seeing new patients for first time to ensure VTE assessment done
31	Holistic Needs Assessment (3770)	• The service has been beneficial and therefore will continue
32	Steroid and PPI prescribing audit (4019)	• To improve compliance, the guidelines have been amended
33	Temporal Artery Biopsy audit (4105)	• No recommendations necessary, high quality service
34	Thyroid Cancer Support Group Audit (3909)	• The audit showed that there is a need for a local Thyroid Cancer Support group. This is currently in development
35	Post-op blood transfusion in hip fractures (4091)	• Overall practice is good. National guidelines are being adhered to
36	Re-evaluation of XR reporting in orthopaedics (3990)	• Significant improvement in documenting x-ray reporting in both trauma and elective patients.
37	Consent – 138 (4125)	• 100% compliance with the Quality Assurance Procedure relating to Consent processes
38	Denosumab - compliance with protocol & dental pathway (3771)	• A Standard Operating Procedure (SOP) for patients on Densoumab including dental reviews has been developed
39	Eribulin for treating locally advanced or metastatic breast cancer after 2 or more chemotherapy regimens – NICE TAG423 (4165)	• The audit highlighted 100% compliance with NICE guidance

No.	Audit Title	Key actions/improvements following audit
40	Follow up ID audit 2018 – 155 (4205)	• A newsletter has been disseminated to staff reminding them of the importance of correct labelling of patient belongings/equipment
41	IGRT May 2018 – 133 (4064)	• The audit shows that there is a dramatic improvement in compliance when following the IGRT process • A new treatment sheet has been introduced which should help to improve minor non- compliances
42	Lubiprostone for treating chronic idiopathic constipation – NICE TAG318 (3963)	• No evidence of inappropriate use
43	Lung cancer (non-small cell, EGFR mutation positive) - afatinib - TAG310 (4164)	• 100% compliant
44	Metastatic Spinal Cord Compression (MSCC) in Adults NICE QS56 (3714)	• Acute Oncology Clinical Nurse Specialist team have reviewed and updated the information provided to patients and relatives • There has been additional training on all admission portals by Acute Oncology Lead consultant and Acute Oncology CNS team to raise awareness of MSCC management with admitting clinical teams
45	Urinary tract infections in adults – NICE QS90 (4163)	• Adherence to NICE guideline demonstrated
46	VTE Prophylaxis after emergency gastrointestinal surgery (3863)	• NICE recommendations were used to update local guidelines
UNSCHEDULED – EMERGENCY ASSESSMENT & MEDICINE		
47	Anaphylaxis – NICE QS119 (3842)	• Cascade pathway developed with standard letter to the Emergency Department and Acute Medical Unit consultants
48	Cinacalcet use in SaTH NICE TAG117 (4057)	• NICE guidance is reinforced in Renal Forum meetings • Monthly Multi-Disciplinary Teams are now used to discuss the patients receiving Cinacalcet
49	Consultant sign-off for high risk patients (4181)	• Implementation of Consultant in Charge standard operating procedure (SOP) will mean that all patients are discussed with a consultant whilst they are on duty – this will lead to improved compliance with guidelines
50	C-Spine imaging (4099)	• Implementation of the Consultant In Charge standard operating procedure (SOP) resulting in direct feedback on every case whilst there is a consultant in the department
51	Documentation of consideration of Non Accidental Injury in paediatric injuries re-audit (3526)	• A safe guarding checklist has been incorporated into the Emergency Department casualty card
52	End of life patients - case note review NHSI (3958)	• Audit highlighted need for refurbishments required to Chaplaincy, ED Relatives Room and bereavement services. ED relative's room refurbishments are now complete
53	Headaches – NICE CG150 re-audit (4160)	• Fundoscopy workshops have taken place • Audit findings were widely shared aiming to address the concerns raised.
54	Implantable cardioverter defibrillators and cardiac resynchronisation therapy for arrhythmias and heart failure (review) – NICE TAG314 (3222)	• Monthly device MDT now in place to discuss cases that are not adherent to NICE guidelines
55	Medical Case note 2018 (3989)	• The unscheduled care group are exploring the possibility of auditing a sample of notes on a monthly basis • Funding has been requested to ensure each doctor (of all grades) has a 'GMC stamp' which is connected to an elasticated device allowing easy access and thus use
56	Transient loss of consciousness in adults and young people – NICE CG109 (PRH) (4159)	• A protocol for this group of patients is in development

No.	Audit Title	Key actions/improvements following audit
57	Use of D-dimer and CTPA in diagnosing Pulmonary Embolism (PE) (3987)	• Single page decision making tool added to the patient's notes which will help in correct referral for CTPA and D-dimer tests. This also ensures uniformity of practice and complies with NICE guidelines
WOMEN & CHILDREN'S		
58	Decision to treat to time of administration of antibiotics in the neonatal service (3572)	• **The importance** of administering antibiotics within 1 hour of the decision time to treat was highlighted at induction • The 'Blood culture sticker has been modified • Earlier Senior intervention encouraged where there are difficulties in obtaining access
59	Diabetic ketoacidosis - paediatric regional audit (3950)	• Guideline has been modified and feedback given to junior doctors and nursing staff
60	Documentation of breastfeeding discussion (3947)	• A tick box has been introduced about breast feeding discussion on the admission booklet
61	Inpatient Hypoglycaemia management for paediatric patient with type 1 diabetes mellitus (3779)	• To raise awareness of hypoglycaemia management, cue cards have been distributed to medical and nursing staff
62	Intravenous fluid therapy in children and young people in hospital – NICE NG29 & QS131 (3938)	• IV Fluid prescriptions page is being updated • IV Fluids in Children guideline has been updated
63	Management of Febrile Neutropenic Patients (3940)	• a new clerking proforma for Febrile Neutropenic Patients has been implemented • Clarification of points raised by the audit were discussed and agree at MDT • A laminated poster of updated Trust guideline on Febrile neutropenia has been placed near the Nursing station on the unit
64	Transfer Letters in Paediatrics (4173)	• The audit highlighted the need for a standardised format of transfer letter, this has been implemented
65	Urinary incontinence in women – NICE QS77 (3913)	• A Systemic follow up after Botox treatment is now in place.

The table below outlines actions taken to improve quality of care following national clinical audit:

Examples of actions taken following national audits	
Title	**Action**
A&E Survey	• To improve ambulance handover and patient privacy and dignity a pit stop at RSH is awaiting executive approval
Endocrine and Thyroid National Audit	• Day case para-thyroidectomy is now becoming accepted into mainstream practice. SaTH has supported this for some time. This has been made possible by adequate preparation of the patient when they are undergoing total para-thyroidectomy, and by giving appropriate discharge medication in the case of primary parathyroid disease
Inpatient Falls 2017	• Falls information booklets now printed and available to patients and wards
Learning Disability Mortality Review Programme (LeDeR)*	• Additional support to the patients and families of LD patients provided by the SaTH Dementia team, including the provision of blank passports where not available. Scoping exercise to provide an additional LD support worker / nurse to this team funded by SaTH • All patients flagged with a Learning Disability will be sent an appointment for face to face explanations

Examples of actions taken following national audits	
Title	**Action**
	regarding endoscopic procedures. Staff will ensure the patient understands, or has support to help take the Bowel prep prior to attending their appointment • SaTH will participate in the expected roll out of RESPECT in autumn 2019
National Audit of Breast Cancer in Older People (NABCOP)	• Increased documentation of patient WHO status. • Review of chest wall radiotherapy rates after mastectomy: current guidelines followed
National Bowel Cancer (NBOCA)*	• To improve data completeness and quality of information, the data is now being reviewed by the consultant before submission.
Sentinel Stroke National Audit Programme	• A business case has been developed for a fifth stroke consultant to create a sustainable stroke rota • Therapies to deliver Business Case to Commissioners for the expansion of Early Supported Discharge (ESD) to support all stroke patients • On target with on-going development of stroke specific training programme for new staff/on-going for existing staff

Research and Development

The number of patients receiving relevant health services provided or subcontracted by Shrewsbury and Telford Hospital NHS Trust in 2018-2019 that were recruited during this period to participate in research approved by a research ethics committee was 2081 against a target of 1900. 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, and lower mortality rates. 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.

For the year 2018 -2019 the Trust was top 10 in the West Midlands region, and 80th in the NIHR League table for the total number of participants recruited into clinical trials and 61st place for the number of trials open to patients to participate in. The department were successful in securing two of the regional Clinical Trial Scholar posts which are intended to develop the Chief Investigators of the future, generating and developing more research in their chosen area. The Trust lead Research Nurse was also successful in securing a place in the NHS '70 for 70' programme aimed at developing and enhancing the number of nurses and midwives involved in clinical research.

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

A proportion of our income in 2018-19 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 2018-19:

Priority	Number	Scheme	Have we achieved the CQUIN?
National	1a	Improvement of Health and Wellbeing of NHS staff	Not achieved – CQUIN submission requiring 2016 data as part of return.
National	1b	Healthy food for NHS staff, visitors and patients	Partially achieved: At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.4: 66% achieved
National	1c	Improving the uptake of flu vaccinations for front line clinical staff	Fully achieved
National	2a	Timely identification of sepsis in emergency departments and acute inpatient settings	Partially achieved - Target 90% Emergency Depts. = 78.0% Acute inpatients = 100% *For CQUINs 2a and 2b a Sepsis improvement plan is in place which is monitored via Clinical Governance Executive and Quality and Safety Committee.* *A Sepsis Nurse is being employed to support areas requiring improvement*
National	2b	Timely treatment of sepsis in emergency departments and acute inpatient settings Received IV antibiotics with 1 hour	Partially achieved - Acute Inpatients was 61.5% received IV antibiotics within 1 hour against a target of 90%
National	2c	Antibiotic Review. Percentage of antibiotic prescriptions documented and reviewed by a competent clinician within 72 hours following three criteria	Not achieved - 11/50 = 22% (Target 90%) *Data is regularly reported to Care Group Boards and reviewed at Clinical Governance Executive. Care Groups are working to improve compliance with the measures relating to this CQUIN*
National	2d	Reduction in antibiotic consumption per 1000 admissions	***Awaiting confirmation pending national data release***
National	4	Improving services for people with mental health needs who present to A&E	Fully achieved
National	6	Offering advice and guidance – improve access for GPs to consultant advice prior to referring patients in to secondary care	Fully achieved
Specialised Services	WC4a PICU	Paediatric Networked Care – non PICU centres	Not achieved – Incomplete data submission to SUS Q3/Q4
Specialised Services	GE3	Hospital Medicines Optimisation	Fully achieved
Specialised Services	DESP 2016	Diabetic Eye Screening Programme	Fully achieved

Statements from the Care Quality Commission

Shrewsbury and Telford Hospital NHS Trust is registered with the CQC. The current registration status is "inadequate" our inspection ratings based on the five CQC domains are outlined below:

The CQC took the following enforcement action against the Trust in 2018-19:

Regulated activity	Reason	Area
Regulation 31 Section 31 of the Health and Social Care Act 2008. Treatment of disease and injury	Deteriorating patient and Sepsis Environment Paediatric patients, Triage and streaming and staff competencies Medical review for women regarding : CTG, MEOWs, Reduced Fetal movement , triage and delivery ward hand over / board round	ED Maternity
Section 29- 17/10/2018 (Regulation 17 and 18) Tissue viability, Nutrition and Hydration assessment and risk assessments Staffing level is in ED, Critical Care and EOLC and training requirements	Risk assessments not being Documented Staffing levels not meeting national requirements	Ward 10 and 15 ED , Critical Care and EOL Team
Requirements notices		
Regulation 5 HSCA (RA) Fit and proper person: Directors		RSH
Regulation 9 HSCA (RA)	Person centred care-	RSH
Regulation 10 HSCA (RA) Dignity and Respect		RSH and RSH
Regulation 11 HSCA (RA) Regulations 2014 Need for consent	When a person who used services lacked capacity to make an informed decision, staff did not always act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice	PRH and RSH
Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment	Staff did not always assess the risks of people in good time and in response to people's changing needs.	PRH and RSH

	Learning from incidents was not always shared and promoted within and between service specialties and across the trust to Minimise the likelihood of reoccurrence.	
Requirements notices		
Regulation 13 HSCA (RA) Safeguarding service users from abuse and improper treatment	MCA and DoLS training and assessments	RSH and RSH
Regulation 15 HSCA Safety and Suitability of Premises	People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because of inadequate maintenance.	PRH and RSH
Regulation 17 HSCA (RA) Regulations 2014 Good governance	Learning from incidents and complaints	PRH and RSH
Regulation 18 HSCA Staffing	Not sufficient numbers of suitable staff deployed to meet the care and treatment of Patients	PRH and RSH

Our commitment to Data Quality

Information Governance Toolkit Attainment Levels

The Data Security and Protection Toolkit (DSPT) has now replaced the Information Governance toolkit as the standard for cyber and data security for healthcare organisations.

The Data Security and Protection Toolkit is an online self-assessment tool that allows organisations to measure their performance against the National Data Guardian's 10 data security standards. 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).

All organisations that have access to NHS patient data and system must use this toolkit to provide assurance that they are practising good data security and that personal information is handled correctly.

The Trusts overall score for the March 2019 submission was standards not fully met (plan agreed) with four of the standards out of ten not fully met. We are working alongside NHS Digital to improve our standards for the March 2020 submission.

Data Quality Report 2019

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.

The Trust submitted records during 2018/19 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

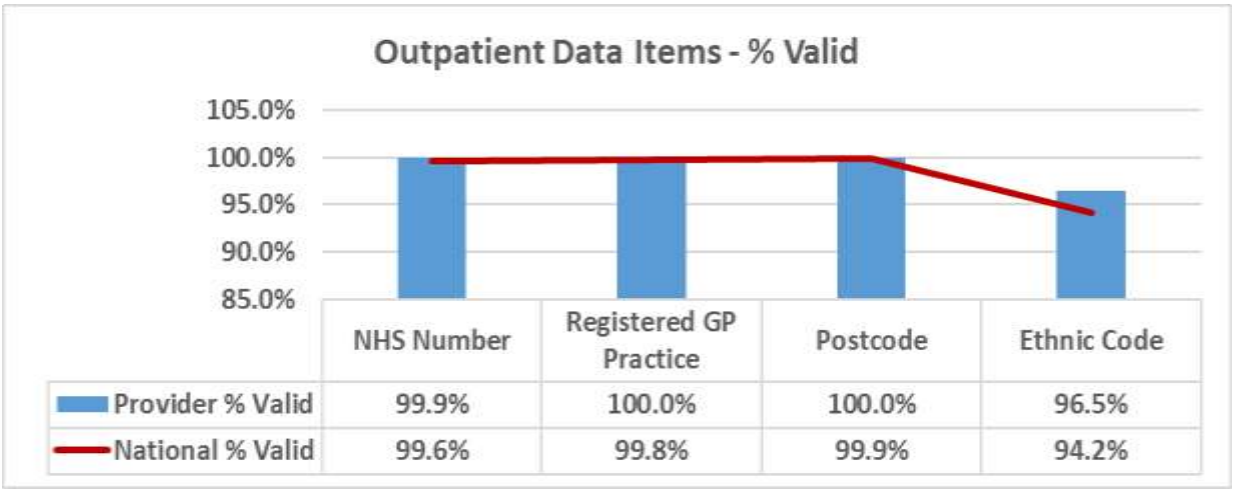
The percentage of records in the published data which included the patient's valid NHS number was:

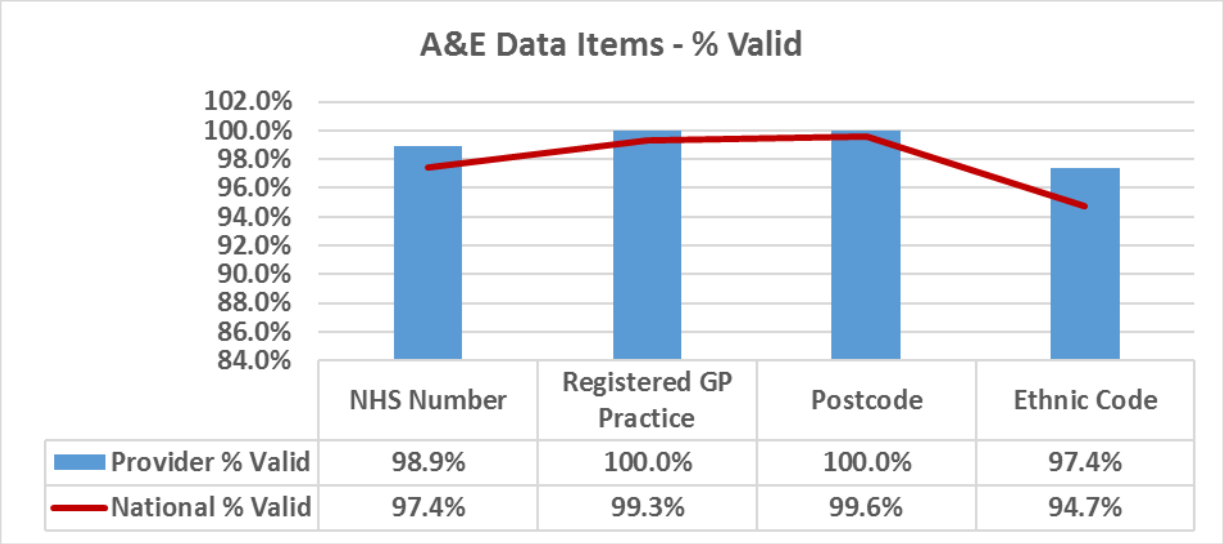
98.9% for admitted patient care, 99% for outpatient care and 98.9% for accident and emergency care.

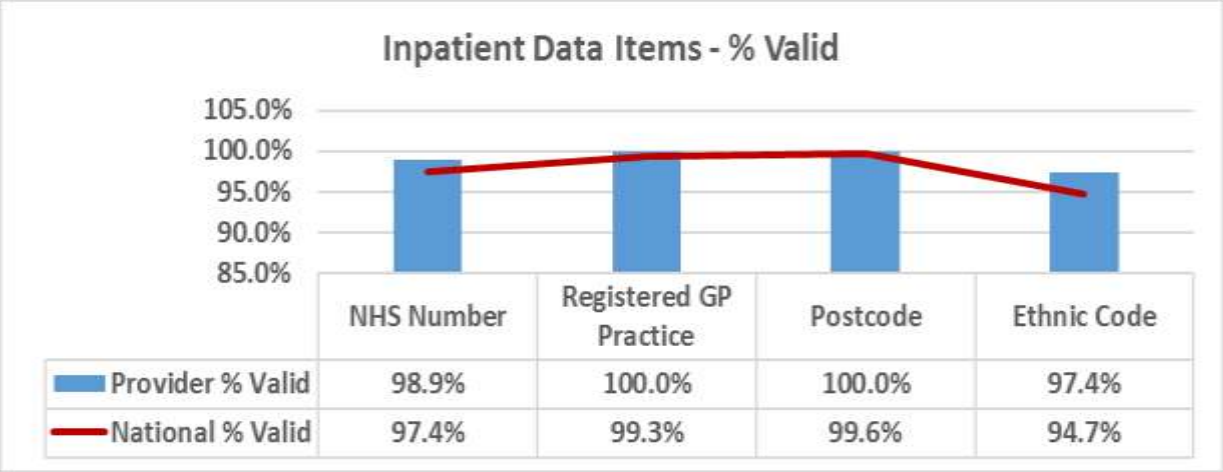
Which include the patient's valid General Medical Practice Code was:

100% for admitted patient care, 100% for outpatient care and 100 % for accident and emergency care

'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 2018-March 2019	Total records completed / populated
Identification of duplicate patient registrations recorded on PAS – merged both electronically and physically	8956
Demographic Corrections - NHS Spine for validation	6610
Missing NHS Numbers against patient records – fields populated	1753
Rejected Discharge Summaries from GPs corrected and sent to valid GP	2342
Open referrals recorded on the system in error – corrected and closed	1437

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

3.1 Patient Safety

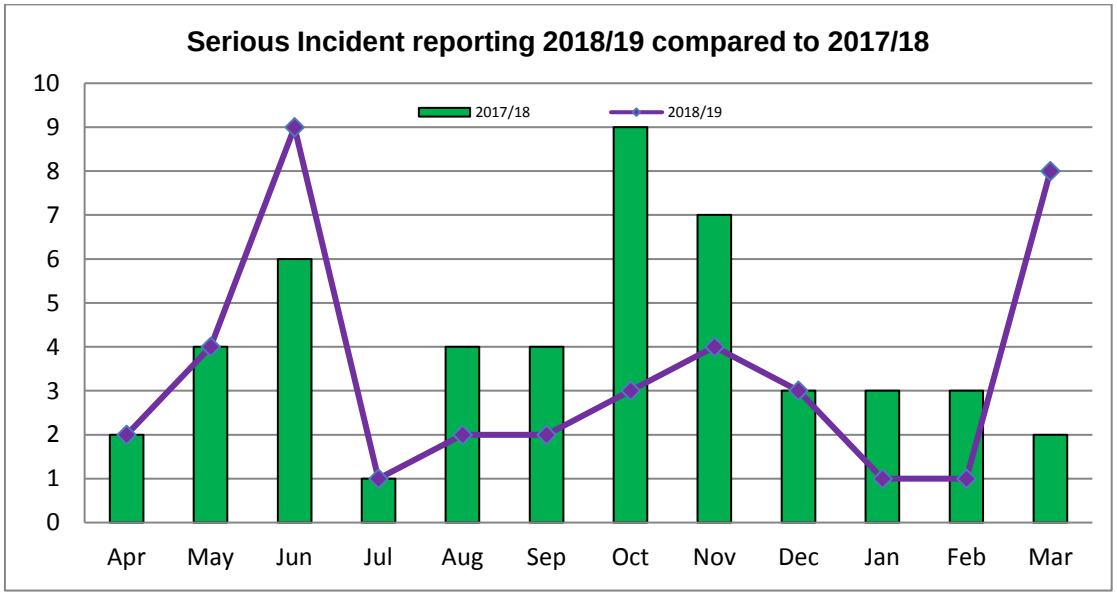
Incident Reporting

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

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.

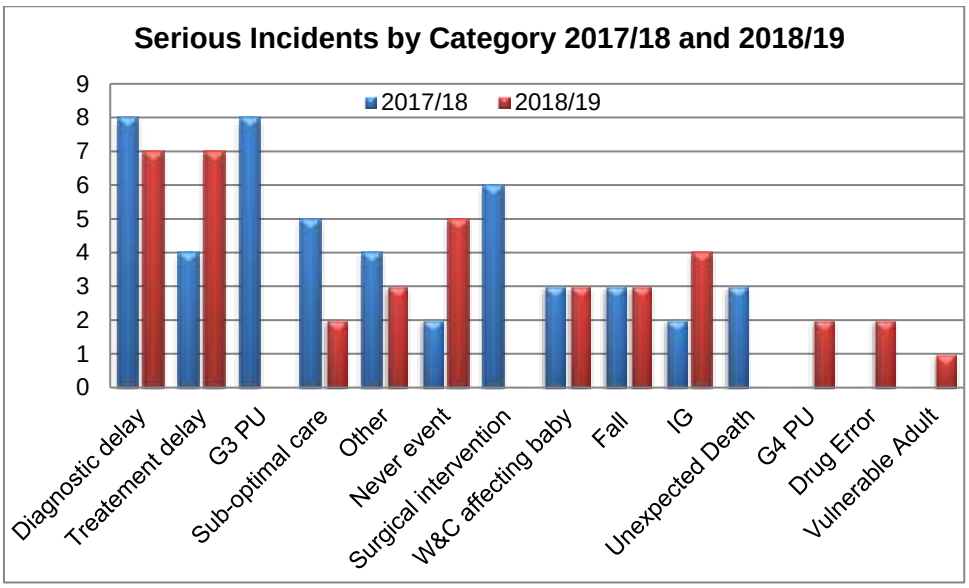
During 2018-19 we once again saw an increase in the total number of incidents being reported compared to the year before which demonstrates that staff are confident to report concerns and know how to. In 2018-19 we have moved into the top quartile of reporting organisations as measured by National Reporting and Learning Systems data.

Our previous Quality Account reported 75 serious incidents in 2017/18. This figure has now been revised. In 2017/18 our CCG partners asked us to raise a number of Emergency Department 12 hour waits as serious incidents. None of these incidents resulted in patient harm and it was therefore agreed that they could be downgraded from a serious incident. We therefore reported 48 serious incidents in 2017/18. There were 40 Serious Incidents reported in 2018-2019 compared to 48 in 2017-18 as shown below:



We have agreed with CCG colleagues that one of the 40 serious incidents reported in 2018/19 can be downgraded. This incident was initially classified as a 'never event' relating to misplacement of an NG feeding tube and a concern medication had been passed down the tube into the patients lung. A full root cause analysis investigation indicated the tube was not misplaced at the time of medication being administered and all appropriate policies and procedures had been followed in line with national guidance.

A comparative view of the categories of serious incidents reported in 2017/18 and 2018/19 is outlined overleaf:



We have been working to embed a revised Incident Management Policy in 2018/19 and are continuing to review how we respond to serious incidents.

During 2018/19 we recorded 5 'Never Events' (Never Events are described as 'serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented').

These 5 Never Events were categorised as:

- A wrong site surgery incident in Musculoskeletal theatres;
- A retained foreign object in Paediatric theatres;
- A wrong eye laser procedure in Ophthalmology Outpatients;
- A retained foreign object in Gynaecological Outpatients;
- A misplaced Naso-Gastric tube incident (this has since been downgraded from a Never Event following investigation)

There has been significant learning from these events which includes:

- Our Scheduled Care Group is undertaking a major piece of work looking at improving safety culture in theatres. This includes looking at the use of the WHO safer surgery checklist (the five safer steps), redesigning consent processes, supporting staff to raise safety concerns and 'stop the line' and reducing the numbers of distractions in theatres. This work is being undertake under the Trusts Transforming Care Production System banner and is subject to on-going measurement and audit;
- The retained foreign object in Gynaecology outpatients has led to a review and redesign of the LOCSIPPS (Local Safety Standards for Invasive Procedures) in use in Gynaecology and actions to ensure junior members of staff are effectively supported and supervised. These actions are subject to on-going audit;
- The wrong eye laser incident in Ophthalmology has led to the introduction of a WHO Safer Surgery style checklist for these procedures and a revised policy for marking patient's eyes before procedures are commenced. Once again these actions are subject to on-going audit.

We are pleased to say the Never Event relating to a misplaced Naso-Gastric tube has been downgraded as when the incident was investigated it became clear that all the correct policies and procedures had been followed and that the tube became misplaced after medication was introduced into the tube.

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 2018-19 and our progress against them.

Alert Identifier	Alert Title	Date received - circulated	Closure target date	Closure date	Status
NHS/PSA/W/ 2018/002	Risk of death or severe harm from inadvertent intravenous administration of solid organ perfusion fluids.	17/04/2018 Circulated 18/04/2018	31/05/2018	04/06/2018	Closed
NHS/PSA/RE/ 2018/003	Resources to support the safe adoption of the revised National Early Warning Score (NEWS2)	25/04/2018 Circulated 26/4/18	21/06/2018	26/06/2018	Closed
NHS/PSA/RE/ 2018/004	Resources to support safer modification of food and drink	27/06/2018 Circulated 29/06/2018	01/04/2019	15/03/2019	Closed
NHS/PSA/RE/ 2018/005	Resources to support safer bowel care for patients at risk of autonomic dysreflexia	25/07/2018 Circulated 30/07/2018	25/01/2019	30/01/2019	Closed
NHS/PSA/RE/ 2018/006	Resources to support safe and timely management of hyperkalaemia (high level of potassium in the blood)	09/08/2018 Circulated 09/08/2018	08/05/2019	9/05/2019	Closed
NHS/PSA/RE/ 2018/007	Management of life threatening bleeds from arteriovenous fistulae and grafts	14/11/2018 Circulated 14/11/2018	13/05/2019	13/05/2019	Closed
NHS/PSA/RE/ 2018/008	Safer temporary identification criteria for unknown or unidentified patients	06/12/2018 Circulated 07/12/2018	05/06/2019		Open – closure due 20/6/2019
NHS/PSA/W/ 2018/009	Risk of harm from inappropriate placement of pulse oximeter probes	18/12/2018 Circulated 19/12/2018	18/06/2019	9/05/2019	Closed
NHS/PSA/D /2019/001	Wrong selection of orthopaedic fracture fixation plates	11/02/2019 Circulated 11/02/2019	10/05/2019	08/03/2019	Closed

3.2 Clinical Effectiveness

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; that has been agreed at the IPC committee and then reported to the Trust Board. The programme addresses national and local priorities and encompasses all aspects of healthcare provided across the Trust.

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 Clostridium 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 2018-19 was to have not more than 24 Trust apportioned cases in patients over the age of two years. The number of C Difficile cases at the end of year is 19 so we have achieved our target.

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

Fifteen cases were apportioned to SaTH in first six months of the year (samples taken post 72 hours). This rose slightly to seventeen cases in the second six months. At the end of quarter three we had 17 cases of which the CCG review panel found that 10 were associated with a lapse in care, so this will be taken into account when determining financial penalties.

At year end we have had five cases of MRSA Bacteraemia (bacteria in the blood) so unfortunately we missed our target. Four of these were contaminants for which as specific action plan has been developed.

MRSA new cases (not bacteraemia) – 23 in 2018-19 compared to 26 cases last year—we are reducing the ways that people can pick up the bacteria in the first place. We do this by screening all admissions apart from those in very low risk groups and if MRSA is detected we can then make sure we can offer a clearance regime with topical creams and sometimes milder antibiotics.

Hand Hygiene Compliance Audits - we have been 97% or above for the last 12 months

MRSA Emergency screening - we have been 96% on average for the last 12 months.

MRSA Elective screening, we have been over 96% on average for the last 12 months.

During 2018/19 we were visited by a team from NHS Improvement to review our infection prevention and control processes. The initial visit outlined an improvement plan RAG (Red, Amber, Green) rated against a number of key criteria. We are currently rated ‘RED’ against this action plan but are working hard to improve. Continual progress is being made against the NHSi Action Plan which has been refreshed and cross referenced to the Health Act, with most actions green or amber. Specific areas of work:

- External Support secured from an Infection Prevention and Control Lead Nurse from University Hospitals North Midlands one day a week to support the Infection Control Team;
- Advertising for a replacement Microbiologist;
- The Interim Director of Nursing has taken the role of Director of Infection Prevention and Control to ensure strong leadership at Trust Board level;

- An MRSA Bacteraemia Recovery Action Plan being progressed . Blood culture refresher training for Emergency Departements and Acute Medical Unit has been completed by external representative

and continued by department action remains amber on the NHSI action plan until sustained improvement demonstrated;
- Infection Prevention and Control Nurses have been identified to work with departments and act as first line of contact to address on-going issues. This Implemented across both hospital sites;
- Outbreak Management Policy being revised and new timescales immediately implemented within 3 working days to strengthen practice.

We have prioritised achieving a 'GREEN' rating on our NHSI Infection Control Action Plan as a key quality objective in 2019/20.

Seven Day Services

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.

Shrewsbury and Telford Hospital NHS Trust	CS2: Time to first consultant review within 14hrs	CS5: Access to diagnostics	CS6: Access to consultant directed interventions	CS8: Ongoing consultant review
Spring 2018	79%	97%	94%	87%
Autumn 2017*	70%	N/A	N/A	N/A
Spring 2017	71%	90%	94%	84%

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

- Standard **2**: Time to Consultant Review
- Standard **5**: Access to Diagnostics
- Standard **6**: Access to Consultant-directed Interventions
- Standard **8**: On-going Review

A 7 Day Services Working Group was re-established in November 2016 which is chaired by Mr Mark Cheetham (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, 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. Previously 7 day services have been audited twice yearly as a requirement of NHS England. This Board Assurance Briefing framework is to replace this requirement by NHS England. The submission in February was part of the pilot with the requirement to take to Trust Board twice a year and the second submission will be in June. As a Trust we have a

programme of work organised with Clinical Audit to provide evidence our current position against the standards. There is a requirement to meet the four priority standards by 2020. We know with the future

reconfiguration we will be unable to meet these requirements in all specialities until the reconfiguration is completed.

We have made progress in assessing and improving our current provision of 7 day services standards.

- We have on-going problems delivering standard 2 which is an on-going challenge nationally;
- We have largely delivered standard 5 except for weekend ultrasound and MRI where there is on-going work;
- We have largely delivered standard 6 except for interventional radiology where we have informal cover over the weekend and out of hours. We are pursuing potential partnership arrangements with an adjacent Trust to address this;
- We have not met Standard 8 at an organisational level however the audits have demonstrated that we are close to achieving this standard.

Medical Workforce/Rota Gaps

The main medical workforce rota challenges identified in 2018/19 were predominately in Emergency Medicine and Acute Medicine.

We looked at a number of Trust initiatives to help recruitment in these areas such as:

Emergency Medicine:

- Utilised agency recruitment for Emergency Medicine. We used 19 agencies in total to maximise our candidate pool alongside NHS recruitment. 202 CV's were assessed in total and we also used Remedium to plan a trip to India and Dubai to recruit candidates at source. We have 9 candidates appointed as a result of this trip;
- We worked alongside our media team to re-design all Emergency Medicine adverts and introduced the 'Legacy' recruitment campaign in the BMJ and NHS jobs;
- Introduced Senior Clinical Fellow and Junior Clinical Fellow posts in Emergency Medicine to attract more doctors and grow our own workforce;
- Implemented a CESR programme across the Trust.

Acute Medicine:

- Introduced FY3 posts to enhance the Medical workforce and enable additional cover 7 days per week;
- Introduced IM3 posts to attract junior Registrars to SaTH to build the workforce;
- Worked alongside HEE to take WAST placements in Acute Medicine;
- Used MTI schemes to fill shortage specialties.

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	1816 in- patients at Shrewsbury and Telford Hospital NHS Trust died during 2018-19. The number of deaths in each quarter were: 410 in the first quarter 380 in the second quarter 487 in the third quarter 539 in the fourth quarter
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	As of 07/05/2019, 925 case record reviews and investigations have been carried out in relation to 100% of the deaths included in item 27.1 The number of patient deaths in each quarter for whom a case record review was carried out was: 247 in the first quarter 221 in the second quarter 251 in the third quarter 206 in the fourth quarter
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown) with an explanation of the methods used to assess this	5 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. (CESDI 3) These deaths were reported as Serious incidents and a Root cause analysis report undertaken. In relation to each quarter, this consisted of: 3 deaths in the first quarter 0 deaths in the second quarter 1 death in the third quarter 1 death in the fourth quarter The Trust uses the CESDI (Confidential Enquiry into Stillbirths and Deaths in Infants) definitions for scoring the outcomes of reviews: Grade 0 - No sub-optimal care Grade 1 - Sub-optimal care but different management would have made no difference to outcome Grade 2 - Sub-optimal care – different care MIGHT have made a difference to outcome (possible avoidable death) Grade 3 - Sub-optimal care. WOULD REASONABLY BE EXPECTED to have made a difference to outcome (probable avoidable death) The outcomes for the year, by number of deaths are: CESDI 0 841 CESDI 1 76 CESDI 2 6

	Prescribed Information	Statement
		CESDI 3 5
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	1, Patients with Learning Disabilities may not report or exhibit signs of pain and deterioration the same as the general population. Knowledge of their normal response and listening to the family and carers is crucial. 2, Although there is a good knowledge of the management of patients with head injury within the ED setting there appears to be a misconceived bias when alcohol consumption is present and the tolerance of lower GCS is more readily accepted. This can lead to delays in diagnosis and management of severe head injuries. 3. The importance of Trust staff continuing pre-hospital treatment, and the administration of Tinzaparin where a DVT is considered. 4. It is normal practice for trained staff within the A+E to take blood and request specific tests to assist with diagnosis, prior to the Doctor's review. However, there is a variance as to which tests are requested depending on the individual who initiates the request. It is apparent that there is a culture not to document specific investigations requested within the A+E care pathway, despite there being a facility to do this, but rather to write "bloods taken" without any specific details. The requesting of a D-Dimer level has become normal practice despite it being a test that should only be used for specific indications. 5. The investigation is not yet concluded from the 5th incident
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period	1, An assessment of behaviours for non-verbal, and patients with Dementia or LD, to assist staff in recognising deterioration and/or pain, has been added to the nursing assessment document. Additional training is being provided. 2. An SOP for the Deteriorating patient, which includes neuro observations, has been rolled out in ED, and a flashcard developed for staff induction, including temporary staff. 3. Scoping plan to establish the feasibility of a combined ED/AMU document where all information on presentation and subsequent admission is easily identifiable. Review the use of the 'Do not Disturb' tabards worn by nurses during drug rounds to minimise interruptions and distractions. 4. All D-Dimer requests in A&E must only be requested by a clinician. 5. The investigation is not yet concluded from the 5th incident

	Prescribed Information	Statement
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	The actions are still being implemented. An audit of response and escalation to the 'Deteriorating patient' is being undertaken for in-patients and is planned for ED.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period	Following the publication of the previous report for 2017-18, an additional 167 deaths were reviewed via the Trust mortality case note review process. Thematic retrospective 'Deep Dive' reviews conducted during 2018-19: 29 patients were identified from the National Hip Fracture database, who died within 30 days of admission to PRH, during the calendar year 2017. 21 patients were identified as having died of a Pulmonary embolism within 90 days of discharge between February 2017 and January 2018.
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	In the previous report, 2 patients were reported for the period 2017-18, whose deaths were judged to be more likely than not to have been due to problems in the care provided to the patient. (CESDI 3). Following the publication date of the last report, 2 further cases were identified following in- depth review. These were reported to the Coroner, and also as Serious incidents and a Root cause analysis report undertaken. There were no avoidable deaths found as part of the PRH National Hip fracture review of 2017. The methodology was the same as that used the previous year to assess RSH patients. One patient death was considered. (CESDI 2 - different care MIGHT have made a difference to outcome) As far as could be established, due to the limited information post discharge, and the manner of the patients' deaths; for those patients reported as having died of a Pulmonary embolism within 90 days of discharge, none could be directly linked to the care they received while in hospital. 8 were suffering from end-stage cancer, and at least 3 were unrelated to day case procedure admissions. The review was undertaken using the NICE *Baseline assessment tool for venous thromboembolism in over 16s: reducing the risk of hospital-acquired deep vein thrombosis or pulmonary embolism* (NICE Clinical Guideline NG89 Updated March 2018).

	Prescribed Information	Statement
		Most patients had an assessment and the correct form of prophylaxis suited to their risk of bleeding and VTE. Although the results cannot be linked to the patients' deaths, from this small sample, not all the recommendations of the NICE Guideline are implemented and this is being progressed by the VTE group.
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	Revised total for 2017-18 through the mortality case note review process – 1,363 deaths CESDI 0 1210 CESDI 1 129 CESDI 2 20 CESDI 3 4 Plus an additional 50 patients who were either re-reviewed in more depth as part of the hip fracture review, or reviewed for the first time as post discharge PE deaths.

Freedom to speak up Guardians:

The number of concerns raised to Freedom to Speak Up (FTSU) Guardians 2018-2019 totalled 70

Concerns fell into the following categories:

Patient safety: 13

Behavioural/Bullying & Harassment: 14

Management Issues: 33

Other: 10

Actions the Trust is taking to support a positive speaking up culture:

The Trust increased the hours for the FTSU Guardians form 10 hour to 15 hours in August 2018.

In January 2019 recruitment process took place to replace one FTSU Guardian that has moved into a new role as well as recruiting an additional FTSU Guardian to strengthen the team.

Expressions of interest have been sent out to all staff to create a network of FTSU Advocates who will raise the profile of the FTSU Service as well as promote a culture of speaking up to be business as usual.

A communications plan has been devised to further communicate the FTSU role and ensure that all staff should feel that they can speak up without experiencing repercussions for speaking up.

The FTSU Policy has been revised an updated and communicated to all staff and is available on the SaTH website and intranet.

3.3 Patient Experience

Complaints Service and Patient Advice and Liaison Service (PALS)

In 2018/19, the Trust received 680 formal complaints; this equates to less than one in every 1000 patients making a complaint (0.70 complaints per 1000 patients). Learning from complaints continues to be a priority is shared across the Trust through a variety of meetings and training to ensure that as a Trust we learn from poor patient experience. As part of this, there has been a focus on ensuring learning is considered for all complaints, with compliance with this increasing from 55% in 20178 to 86% in 2018/19. There have been on-going improvements in response rates, with an average of 61% of complaints being responded to in time in 2017/18 compared to 71% in 2018/19.

Of the 658 complaints closed in 2018/19, 29% (190) were upheld, 52% (345) were partially upheld and 19% (123) were not upheld. A complaint is deemed to be partially upheld if any aspect of it is upheld in the response and fully upheld if the main aspects of the complaint are deemed to be upheld.

The PALS & Bereavement team continues to support patients and their families with on the spot resolution, and in 2018/19 assisted 1545 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. The onsite registrar service has been expanded at RSH and continues to receive very positive feedback. The Trust will also be implementing the Medical Examiner Service during 2019/20 and the PALS & Bereavement Team has been working to develop processes to support the implementation of this service.

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. 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.

On 2019/20, the Complaints & PALS team will be reviewing how the many thank you letters and cards received across the Trust can be recorded and analysed in a more structure way, to allow learning from good feedback as well, with a pilot planned for quarter one of 2019/20.

Friends and Family Test

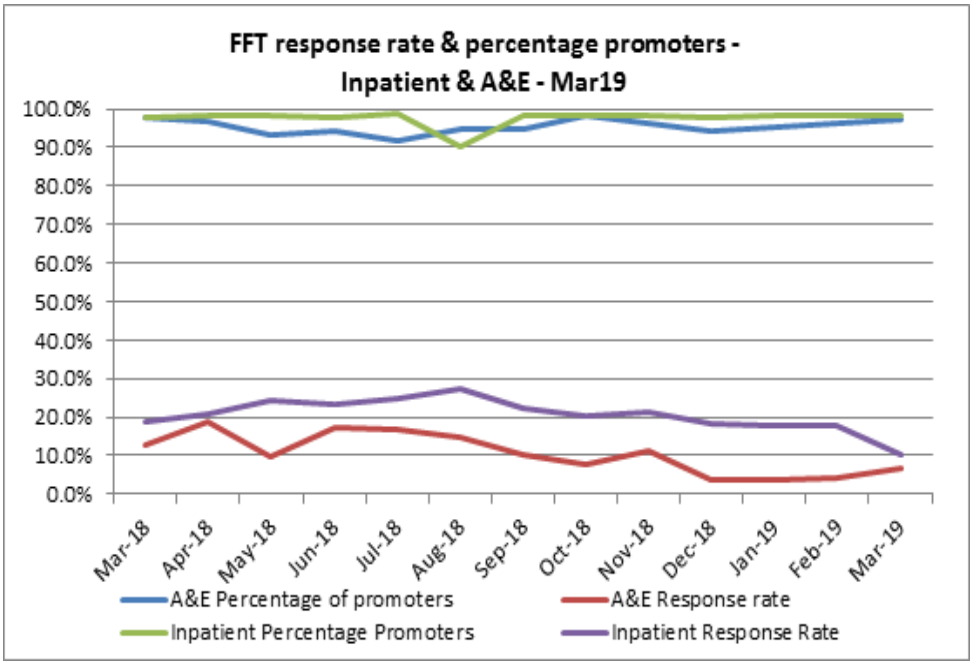
We have taken several approaches to understand and therefore improve the experience that people have of our care at SaTH. One of the approaches that has been used is the Friends and Family Test – a one question measure used across the organisation asking respondents **"Would you recommend the service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

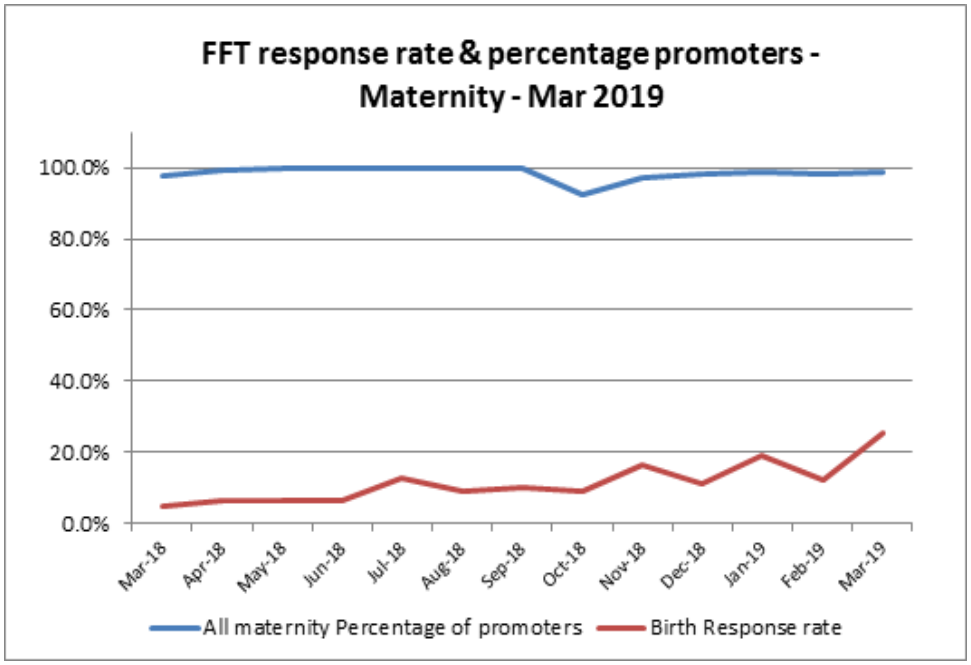
We report monthly to the Quality and Safety Committee the responses made to the survey at a Trust level and also the response rate (the percentage of people that have received treatment) that responded to the question. We believe that there are ways that we can improve this response rate therefore giving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

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

- In Patient responses
- Emergency Department responses
- Maternity responses.

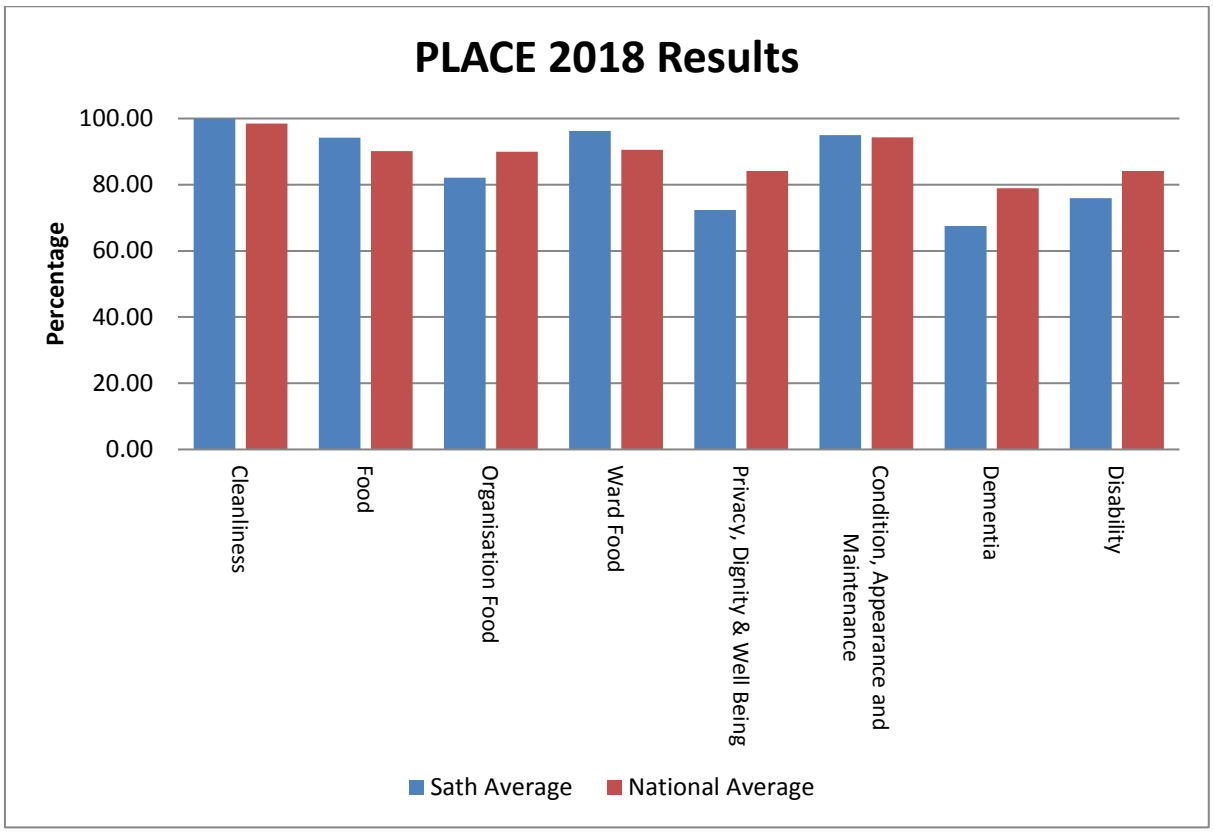
Our performance against this metric in 2018-19 is as shown below:





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.



Site	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity & Well Being	Condition, Appearance and Maintenance	Dementia	Disability
RSH	99.89	94.68	80.12	96.98	68.94	94.63	66.22	75.84
PRH	100.00	93.83	84.00	95.49	75.64	95.20	68.76	75.99
Sath Average	99.95	94.25	82.09	96.22	72.33	94.97	67.51	75.91
National Average	98.47	90.17	89.97	90.52	84.16	94.33	78.89	84.19
SATH Average 2018	99.72	92.39	84.57	93.77	73.92	92.90	56.45	78.35

The annual PLACE inspection in 2018 took place at the Royal Shrewsbury Hospital and Princess Royal Hospital only as the MLUs were not open to patients at the time of the assessments.

As the chart above shows we scored above the national average in Cleanliness, Food, and Ward Food and at the national average for Condition, Appearance and Maintenance.

For Privacy, Dignity & Well Being, Dementia and Disability we scored lower than the national average. The reasons for this are mainly around our 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 wards.

Section Four: Statements from external organisations

4.1 Statements from our Partners

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

HealthWatch Shropshire response to the SaTH Quality Account 2018 – 19

HealthWatch Shropshire (HWS) welcomes the opportunity to comment on the Quality Account Priorities 2018 – 19

HWS welcomes the focus SaTH has put on learning from incidents and the attempts to reduce the moderate and severe harm caused by incidents. There is no indication if the aim of 'learning faster and better' has been achieved. The reduction of number of falls is welcome although it is difficult to understand the scale of the reduction. The reduction in the high-risk medication errors that caused some form of harm is to be commended. It is disappointing that the proposed reduction in hospital acquired pressure ulcers is not reported.

The implementation of 'safety huddles' and the focus on communication and learning is again welcome and we look forward to seeing evidence of the continuing improvements in patient safety this is producing.

Having eliminated the practice of 'additional patients being placed inappropriately' we are pleased that the work to reduce the number of 'stranded patients' will continue. We look forward to seeing the impact of measures such as this has on the additional pressures created in the Emergency Department and welcome the focus of improving patient experience of the ED in the coming year.

It is unclear to what extent patient representatives are currently involved with co-production across the work of the Trust. It would be useful to see some detail around the results of the National In-patient survey and The SaTH carer's survey to understand the improvements that have been made.
2019 -2020.

These are welcomed but it is unclear how working 'to improve the numbers of smoke free pregnancies', albeit a very important focus, will ensure that 'women who come to us to give birth need to know they are coming to a safe, high quality service.'

The priority to improve the staff survey response to the question 'care of patients is my organisations top priority' as a key staff survey measure highlights the fact there is no reporting on the 2018 staff survey within the Quality Accounts as there has been in previous years.

Complaints

It is disappointing to see a further rise in the level of formal complaints per patient during the year. It would be useful to see an indication of the outcome of complaints to understand how many were upheld or partially upheld. It is reassuring to see the increase in the consideration of learning taken from complaints and the increase in timely response rates.

Safety incidents and Serious incidents

The report acknowledges a rise in the total number of patient safety issues but fails to quantify the rise.

The report asserts that the rise is a product of increased staff confidence and knowledge about reporting. When looking at the staff survey results for 2018 the answers to the questions around staff confidence in reporting concerns do not support this assertion at all. The numbers of staff expressing confidence has fallen over the last few years and in several questions is at the worst reported level for all acute trusts. The Quality Account does not acknowledge that the rise could be because the actual number of incidents have grown.

It would be useful to see a breakdown of the serious incidents by category as has been shown in previous years. There seems to be some confusion about the number of serious incidents, in last year's Quality Accounts it was reported that 'there were 75 serious incidents reported in 2017 -2018'. In these Quality Accounts, it is reported 'there were 40 serious incidents reported in 2018-19 compared with 48 in 2017-18'

PLACE Inspections

The improvement the Trust has achieved in the score it receives for the environment being able to support the care of those with dementia is to be welcomed although it continues to score well below the national average and we look forward to further improvements.

Brian Rapson Information Officer

HealthWatch Telford and Wrekin response to the SaTH Quality Account 2018-19

Thank you for your email. Please find some comments to the quality accounts in light of timings.

The selected Quality Priorities can make a difference, if there is a drive to improve outcomes for people by all. The quality account appear factual and makes interesting reading.

Are there actions other than those we have identified for each area that we could be doing? No – maybe include some comments from patients to reflect what people are actually saying.

How can we involve patients, their families and carers and the wider community in the improvement of our services? There has been less engagement this year, but we have been invited to the essential meetings and allowed to contribute. We have forwarded comments made by patients to senior managers

and there seemed to be a commitment to make things better where possible. The People's academy has been good step forward for introducing people into the NHS. PaCE has been another way of involving people. Maybe encourage people to leave independent feedback through HealthWatch and other organisations so information can be independent through increased engagement activities across both sites.

Is there any other information you would like to see in our Quality Accounts? – maybe include some comments for patients to reflect what people are actually saying, some quotes would make interesting reading. This includes staff comments as this can make a difference to patients and relatives experiences.

Do you have any comments about the formatting of the Quality Account? – I like the bullet points, straight to the point and easy to understand. Though some areas may be difficult to understand for some people without NHS experience. Some further explanations are needed for example page 19, National Gastrointestinal Cancer Programme and submission rate 86%.

Will this be available in easy read, audio and visual formats?

Many thanks and kind regards

Paul Shirley
General Manager/Chief Officer and Engagement Manager

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Mrs Barbara Beale
Director of Nursing & Quality
The Shrewsbury and Telford Hospital NHS Trust
Stretton House
Mytton Oak Road
Shrewsbury
SY3 8XG

19th June 2019

Dear Barbara,

NHS Shropshire Clinical Commissioning Group and NHS Telford and Wrekin Clinical Commissioning Group are pleased to have had the opportunity to review Shrewsbury & Telford Hospital NHS Trust (SaTH) Quality Account for 2018/19.

In preparing this statement, key intelligence regarding quality, safety and patient experience has been reviewed to scrutinise the accuracy of the information reported in the account. It is the CCGs' view that the account accurately reflects the achievements made by SATH in 2018/2019 and the ongoing areas of concern.

It is acknowledged that 2018-2019 was an extremely challenging year for SaTH. It is therefore agreeable that this year's quality account highlights the improvement priorities, providing a focus on key areas such as the Emergency Department, Maternity services, Staff Engagement and Infection Prevention and Control.

SaTH has worked collaboratively with commissioners to continually improve the quality of services and progress a comprehensive quality framework. This includes nationally mandated quality indicators alongside locally agreed quality improvement targets. The report demonstrates learning from feedback from the CQC inspections. There are robust arrangements in place within SATH to agree, monitor and review these actions. A focussed CQC Trust Quality Improvement Plan (QIP) to respond to the 'Must do' and 'Should Do' actions has been identified. It is welcome that the Trust is implementing actions plans from the 'ground up'.

The staff survey results are a priority area for improvement, with the results being in the lowest quartile across the country. Progress against the actions to promote staff safety and experience will be closely monitored and reported on through CQRM during 2019/20. The CCGs are fully aware of the workforce issues faced by the Trust and the impact this can have on staff morale. Therefore it is agreeable that this remains a significant problem and the CCGs support this as a continued priority for 2019-2020.

The CCGs recognise the work that has been undertaken in 2018/19 to improve the reporting culture to support incident reporting and investigations. We have been invited to attend HRCR meetings, have established monthly SI review meetings, attended a Never Event learning session. In addition have supported Exemplar visits and have carried out monthly quality assurance visits, speaking with staff and patients on each announced visit. It has been positive to see Safety Huddles embedded across clinical areas. The CCGs would welcome a wider sharing of the learning and changes that have been made as a result of the incidents reported and also the need to improve how staff receive feedback on incident findings on an ongoing basis.

The CCGs has been fully sighted on the challenges of flow in ED and acknowledge this remains a significant challenge. A 10% improvement on the 4hr target to admit or discharge patients seen ED is required but we recognise there are still improvements to be made in flow. The CCG therefore support this as another key priority for improvement in 2019-20. Work to reduce the numbers of 'stranded' patients this also to remain a priority area.

Maternity services have been under considerable scrutiny over the last two years and have been subject to a number of CQC 'must do' actions. Notices served for must do improvements included: medical review for women regarding: CTG, MEOWs, reduced fetal movement, triage and delivery ward hand over. The CCGs has also been fully sighted on the issues of the Midwife-Led Units and the work the Trust has undertaken to maintain safe care. Given the closures of the Midwife-Led units at Ludlow, Bridgnorth and Oswestry during 2017-2018 and Shrewsbury in 2019, the CCGs would have expected to see a statement in the Quality Account which identifies that maternity and workforce issues across the Trust which have the potential for high risks.

The Trust have been rated 'red' in terms of progress against the NHSI infection control action plan. It is noted that continual progress is being made against the NHSI Action Plan. The CCG agree that one of the main IPC challenges is the lack of capacity to isolate patients with infection effectively and would support the Trust to review and find solutions to this in 2019/20. The Trust missed the target for MRSA Bacteraemia, having five cases, against a target of zero. Four of these were contaminants, the specific action plan developed for this will continue to be monitored through IPC committee meetings. The target for C Difficile was met in2018/19 with 19 C-Difficile apportioned cases, against a target of 24. During 2019-2020 both CCGs would wish to see continued senior leadership to ensure antimicrobial stewardship is embedded across the Trust and monitored. The CQUIN for antibiotic review of patients with sepsis was not achieved. The percentage of antibiotic prescriptions reviewed by a competent clinician within 72 hours following the three criteria was 22% (against a target of 90%).

In conclusion, based on the information provided, the CCGs believe the 2018-2019 Quality Account provides an accurate picture of the challenges the Trust faces and evidence of improvements in key quality and safety measures. The CCGs recognise the Trust's commitment to working closely with commissioners and the public to ensure the ongoing delivery of safe, high quality services and we look forward to continuing this collaborative working in the forthcoming year.

Yours sincerely

Christine Morris

Chief Nurse for NHS Shropshire and Telford &Wrekin Clinical Commissioning Groups

26/06/2019 Powys Teaching Health Board Feedback
R. Lyles: Quality & Safety Commissioning Lead

Shrewsbury and Telford Hospital
Quality Account 01/04/2018 – 31/03/2019

1) Do you think that we have selected Quality Priorities that can really make a difference to people?

   An area quite significant within PTHB Quality & Safety commissioning Unit is monitoring Never Events incidents within commissioning services. This area has not been identified within the Quality Account Report considering there were 5 never events within the end of the financial year and there were some positive actions and lessons learnt implemented to reduce trends mainly within the surgical services.

2) Are there actions other than those we have identified for each area that we could be doing?

   Within the CQRM Agenda, there should be a section for PTHB/commissioners to feed-back from within their area, changes within the Health Board, new services, such as My Life/My Wishes which has an effect on admissions of Palliative Care as an example.

3) How can we involve patients, their families and carers and the wider community in the improvement of our services?

   Involving a representative from PTHB as they can share their experience as a Welsh patient within an English Trust

4) Is there any other information you would like to see in our Quality Accounts?

   Incident Reporting 3.1 – need to add good communication and working partnership with PTHB, involving any SI relating to Powys residents. Sharing of 72 hour reports, sharing RCA and full investigation and feedback from PTHB/Commissioners.

5) Do you have any comments about the formatting of the Quality Account?

   Excellent format, clear and good presentation of data and run charts.

RC Lyles
Quality & Safety Commissioning Lead
24/06/2019

KPMG

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

We are required to perform an independent assurance engagement in respect of Shrewsbury and Telford Hospital NHS Trust's Quality Account for the year ended 31 March 2019 ("the Quality Account") and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:

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

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 2018 to May 2019;
- papers relating to quality reported to the Board over the period April 2018 to May 2019;
- feedback from the Commissioners dated May 2019;
- feedback from Local Healthwatch dated May 2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated June 2018, November 2018 and January 2019;
- the latest national staff survey dated February 2019;
- the Head of Internal Audit's annual opinion over the trust's control environment dated May 2019.
- the Annual Governance Statement dated 28 May 2019; and
- the Care Quality Commission's Inspection Report dated 29 November 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 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 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;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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

Limitations

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

27 June 2019

4.2 Changes made to the Quality Account following receipt of statements

Page	Change Made	Date
9	Inclusion of comparison of numbers of hospital acquired pressure ulcers in 2017/18 and 2018/19 following feedback from HealthWatch Shropshire	20/6/19
29/30	Inclusion of data quality statement relating to SUS records following external audit review	24/6/19
32	Clarification of number of serious incidents reported in 2017/18 following feedback from HealthWatch Shropshire	20/6/19
32	Inclusion of comparative information on categories of serious incidents reported in 2017/18 and 2018/19 following feedback from HealthWatch Shropshire	20/6/19
33	Outline of information around Never Events and actions taken following feedback from Powys Health Board	26/6/19
36	Inclusion of statement on medical rota gaps following external audit review	21/6/19
40	Inclusion of numbers of complaints upheld/partially upheld and not upheld in 2018/19 following feedback from HealthWatch Shropshire	20/6/19

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.

4.4 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.

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

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

Statement of Directors responsibilities in respect of the Quality Account

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

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

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

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

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

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

Bev Tabernacle, Deputy CEO

Ben Reid, Chairman