The Shrewsbury and Telford Hospital NHS Trust

Safest and Kindest

Annual Report and Annual Accounts 2017/18

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

PATIENT & FAMILY
VISION
MISSION
LEADERSHIP
OUR PEOPLE
OUR VALUES

LEADERSHIP ACADEMY

TRANSFORMING CARE INSTITUTE

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About this document

This document fulfils the Annual Reporting requirements for NHS Trusts. It is presented in accordance with the Department of Health Group Manual for Accounts 2017/18.

We publish a shorter Annual Review as a companion document for patients, communities and partner organisations.

Further copies of this document and our Annual Review are available from our website at www.sath.nhs.uk or by email to communications@sath.nhs.uk or by writing to:

Chief Executive's Office,
The Shrewsbury and Telford Hospital NHS Trust,
Princess Royal Hospital, Grainger Drive, Apley Castle, Telford TF1 6TF

Chief Executive's Office,
The Shrewsbury and Telford Hospital NHS Trust,
Royal Shrewsbury Hospital, Mytton Oak Road, Shrewsbury, SY3 8XQ

This document is also available on request in other formats, including large print and translation into other languages for people in Shropshire, Telford & Wrekin and mid Wales. Please contact us at the address above or by email at communications@sath.nhs.uk to request other formats.

Please contact us if you have suggestions for improving our Annual Report.

Part I. Performance Report

The first section of the Annual Report and Accounts provides an overview of our performance over the past 12 months. This is a brief summary of who we are, what we do and how we have performed against our objectives during the year. There is a more detailed analysis of our performance later in the report.

I.1 Welcome from the Chair

The Shrewsbury and Telford Hospital NHS Trust (SaTH) is currently on a journey to realise its Vision of providing its patients with the safest and kindest care possible. The last 12 months have been challenging – just as it has for the NHS as a whole - yet progress is being made at SaTH.

I joined the Trust at a very important milestone on that journey. This really is an exciting time for me to be part of the organisation because of the resources that have been provided to us to make a real change to the services that we offer to the people of Shropshire, Telford & Wrekin and mid Wales. Reconfiguring hospital services for the benefit of our patients and our workforce is now, after many years, moving forward. I hope that my previous experience as a Chair of two NHS trusts will allow me to add something to the team.

It is going to be hard work, there is no doubt about that. It is one thing to have an idea and another to deliver it. It will need us all to be flexible and to work together to re-design services to maximise the advantage of the significant capital that we have been given.

SaTH's Vision is to provide the safest and kindest care in the NHS

It is already clear to me that the staff within the Trust have been performing to an amazing level given the restrictions both in terms of facilities and staffing levels. I would like to thank them for all of these fantastic efforts. I would also like to assure them that the Board is very clear that capital will not, by itself, solve all of our problems; and we are going to create a robust plan to develop our services. This is already in hand.

Having been through a particularly difficult winter, like most NHS Trusts across the UK, everybody is committed to making the improvements necessary to significantly improve the working environment, and the service that we deliver to the public, in time for the increase in demand we can expect next winter.

In my short time here, it is obvious that the Trust relies heavily on the magnificent support from the volunteer community and I would also like to thank them for their on-going commitment. They offer help and support to so many different areas within the organisation, and that makes everybody's life a little bit easier.

I would like to say thank you to my predecessor, Professor Peter Latchford OBE, who contributed so much to the organisation; and also to Non-Executive Director Paul Cronin for his service to SaTH. I would also like to thank our patients and their families whose feedback is so important to helping us on our journey. And I'd like to take this opportunity to welcome Nigel Lee, who joined the Trust as Chief Operating Officer in February.

It really is going to be an exciting 2018/2019 with lots of changes ahead of us; yet at the end of it we are going to be able to deliver something new and exciting.

I very much look forward to working with everyone as we move forward on this next, crucial step of our journey.

SaTH receives magnificent support from their voluntary community

Ben Reid OBE, Chair

I.1a Chief Executive's Overview: Reflecting on 2017/18

The debate about the future of our hospitals has been making headlines for a long time. In March 2018 we secured the largest single capital announcement the NHS has made in 10 years and the most significant for our county in 70 years. The confirmation of £312 million will allow us to redevelop and transform our two hospitals and the care we can offer through our services.

The announcement means we can go out to speak with the public to explore how these plans will affect them and their families. The plans have been drawn up by our Doctors, GPs and Nurses to provide the best possible healthcare not only for this generation, but for generations to come.

We believe the plans for a single emergency site and a separate planned care site, supported by 24-hour-a-day Urgent Care Centres at both of our hospitals, will not only improve outcomes for our patients, but will also improve conditions for our staff and help us to recruit the best new staff to support the incredible work our teams are already doing in what we all know are difficult conditions.

We have also been focused on establishing our improvement method to support continuous learning and become an outstanding organisation. Since starting our partnership with the Virginia Mason Institute in Seattle we have trained over 2,620 staff and we are now over 700 staff in co-production every week. The Transforming Care Production System (TCPS) work has saved over 3,770 miles a year of clinical staff walking, which equates to approximately 944 hours of time released back for patient care each year, alongside 57,000 safer patient journeys.

Chief Executive Simon Wright presents an award at the VIP Awards

We currently have seven Value Streams under way, releasing our people to identify and implement the changes necessary to improve care. These are looking at the areas of highest risk facing the Trust (including A&E, recruitment, etc) and the improvements I hear at the regular Report Outs and Huddles never ceases to impress me and assure me that we are on course to become a 'Good', and in time, 'Outstanding' organisation. Our 'Lean for Leaders' are really changing the face of SaTH and more will graduate each year.

The Care Quality Commission (CQC) published their report on us in August 2017 and while we remain 'Requires Improvement' it recognises improvement in almost 65% of the Trust to a 'Good' rating. There were many excellent comments in the CQC report that make me extremely positive about the future. Improvement was particularly noticeable in Medical Care, Surgery and End of Life Care. We were also rated 'Good' for caring and one of the key findings of the report was that patients consistently told inspectors how staff cared for them with compassion and kindness.

It is of huge importance that we celebrate the excellent work that takes place across our Trust every day by staff, volunteers and charities and we did this through our second Values in Practice Awards (VIP). The

event saw 11 awards presented to staff and volunteers for their achievements during the year. We celebrated with nearly 300 of our staff their fabulous achievements.

We also hosted our second Charity Fun Day in the summer and it was attended by lots of our staff and patients. Big plans have been put in place for the 2018 Charity Fun Day and VIP Awards as both will form part of our celebrations to mark the 70th anniversary of the NHS.

All of this has happened against the backdrop of one of the busiest winters I can recall the NHS experiencing, which saw many of our staff battle the snow and ice to make their way to work as the worst of the weather hit.

We have delivered the majority of our cancer waiting time targets and received the Health Service Journal National Patient Safety Award for Cancer and, in September 2017, our diagnostic target with over 99%. We also achieved the 92% Referral to Treatment (RTT) target for the first time in over a year. Tackling this issue was one of our top priorities and we continue to hit both milestones as we enter 2018/19 which is great for our patients and marks a fantastic achievement for our staff.

A new Eye Department opened at RSH.

Further good news was the re-opening of our Ophthalmology department to new referrals. The new department, co-designed with our patients and staff, has seen a genuine transformation in care and staffing levels with almost all of our consultant vacancies now filled for the first time in 12 years.

Our Maternity Services remain an area of focus and in June 2017 our internal review, which looked at the quality and safety of the service, was published as part of our commitment to continuous learning and improvement. We wanted to have independent assurance of the quality and safety of care processes, culture and ways of working to help us be the very best we can be for the families we support and care for.

This report will, in conjunction with the review by the Royal Colleges and the report from NHS Improvement, which we expect to be published later in the year, will ensure we have a full picture of our Maternity service and allow us to plan for the future ensuring we do this in the full knowledge of any past failings and those needing improvement and those doing very well.

Our Midwife-Led Units have also remained high on the public agenda this year. In the summer of 2017 full inpatient maternity services at Midwife-Led Units in Bridgnorth, Ludlow and Oswestry were suspended for six months before re-opening in January. The safety of women and babies using our maternity service continues to be our number one priority and, as with all areas of our hospitals, we have contingency plans in place, which have activated, to ensure our midwives are being deployed appropriately to maintain choice as much as possible while ensuring the services we provide are safe.

Finally, throughout this year I have taken great pleasure in catching up with many of our staff for a chat each month with 'Breakfast with the Boss'. It gives us the chance to share how it feels where we work and also the opportunity to get to know each other better. And we don't always talk shop; it is also a lovely opportunity to learn more about one another, each other's interests outside of work and to share a bit about our family lives. By going back to shop floor and working alongside our people, walking across our hospitals when I'm out on the Genba and simply saying hello as we pass on the corridors all helps me to get a sense of how our people are feeling. It is absolutely crucial that every one of our 6,000 people feel able to speak up and be heard.

The next 12 months will see lots of exciting new developments emerging and some old issues finally fixes for good.

Simon Wright, Chief Executive

I.1b 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 & Wrekin and mid Wales.

Our main service locations are the Princess Royal Hospital (PRH, below) in Telford and the Royal Shrewsbury Hospital (RSH, bottom) in Shrewsbury, which together provide 99% of our activity.

Both hospitals provide a wide range of acute hospital services including accident & 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.

Our People

We employ almost 6,000 staff, and hundreds of staff and students from other organisations also work in our hospitals.

In 2017/18 our actual staff employed (headcount) increased by 28 to 5,931. When taking into account those employed on part-time contracts, the full time equivalent (fte) number increased by 21 to 5,047. Our substantive workforce at 31 March 2018 included approximately:

- 523 fte doctors and dentists (10%), a decrease of 44 fte compared with 2016/17;
- 1,429 fte nursing and midwifery staff (28%), an increase of 11 fte;
- 644 fte scientific, technical and therapies staff (13%), an increase of 2 fte;
- 1,391 fte other clinical staff (28%), an increase of 4 fte;
- 1,060 fte non-clinical staff (21%), an increase of 47 fte.

In addition to this, the available workforce at year end included 1,199 staff employed through the Trust's internal bank, in addition to staff working within the Trust via external agencies.

Expenditure on staff accounts for approximately 67% of expenditure, a slight increase on the previous year.

There are approximately 900 volunteers active in the Trust and during the year we worked closely with our main charitable partners (including Leagues of Friends at our two hospitals, and the Lingen Davies Cancer Fund).

Our Finances and Activity

With a turnover in the region of £359 million in 2017/18 we saw:

- 65,003 elective and daycase spells
- 50,982 non-elective inpatient spells
- 6,250 maternity admissions
- 410,916 outpatient attendances
- 123,999 accident and emergency attendances

More details about our activity is provided on page 9 and further information about our financial performance is included in Section I.2d.

Our Organisational Strategy

Further information about our Strategy is available in Section I.1c of this report.

Our Board and Leadership

Strategy and oversight is provided by our Trust Board, with a majority of Non-Executive members, including a Non-Executive Chairman, appointed from local communities and networks by NHS Improvement on behalf of the Secretary of State. Executive members with voting rights at the Trust Board are the Chief Executive, Director of Nursing, Midwifery and Quality, Medical Director, Chief Operating Officer and Finance Director. More information about our board membership is available in Section II.1 of this report.

Our Values

Underpinning our strategy is our framework of Values, developed with staff and patients during 2013/14 and which have since become embedded:

Proud To Care
Make It Happen
We Value Respect
Together We Achieve

Our statutory basis

We are legally established under the National Health Service Act 2006 as a National Health Service Trust and were established in our current form as The Shrewsbury and Telford Hospital NHS Trust in 2003 following the merger of The Princess Royal Hospital NHS Trust and the Royal Shrewsbury Hospitals NHS Trust. Find out more at www.sath.nhs.uk

The Trust as a going concern

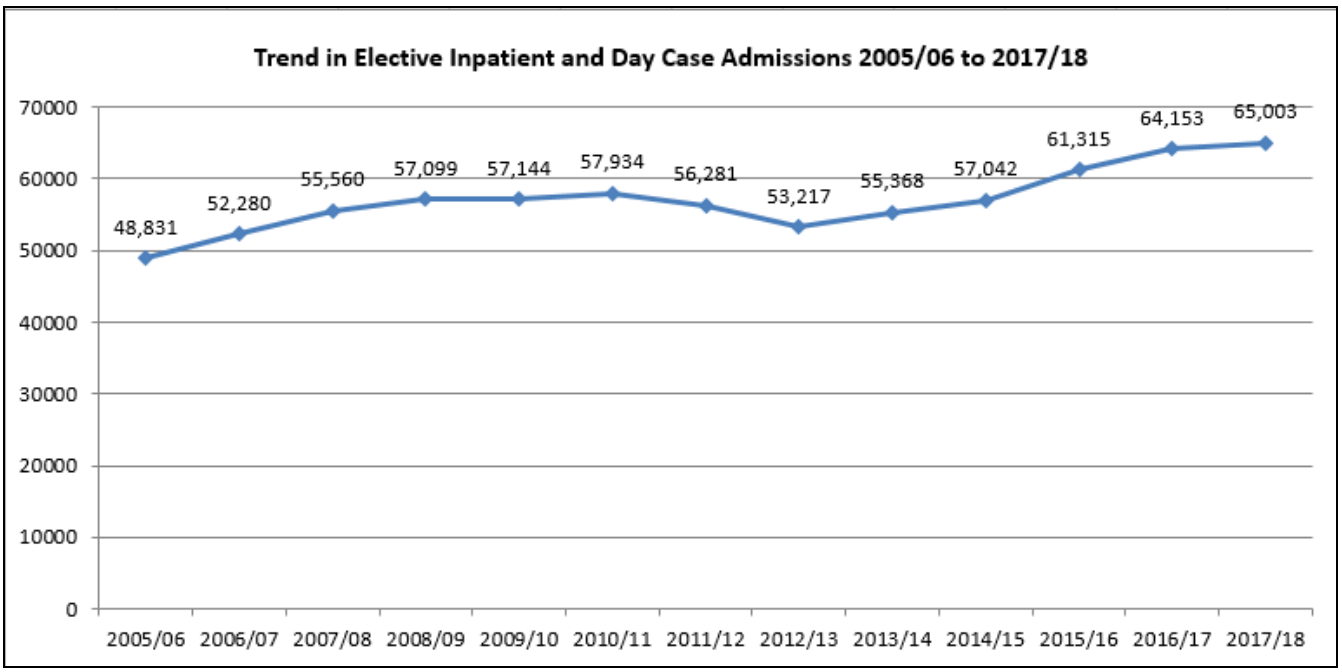
The Board of Directors has concluded that the Trust is able to demonstrate that it is a going concern on the following basis:

- The Department of Health and NHS Improvement will confirm to the Trust arrangements for accessing cash financing for organisations that have submitted a deficit plan for 2018/19. The NHS Improvement Accountability Framework sets out the process where an NHS Trust will be assisted to develop and agreement of a formal recovery plan to address deficit positions.
- Robust arrangements are in place for the delivery of cost improvement plans through Executive Director meetings.

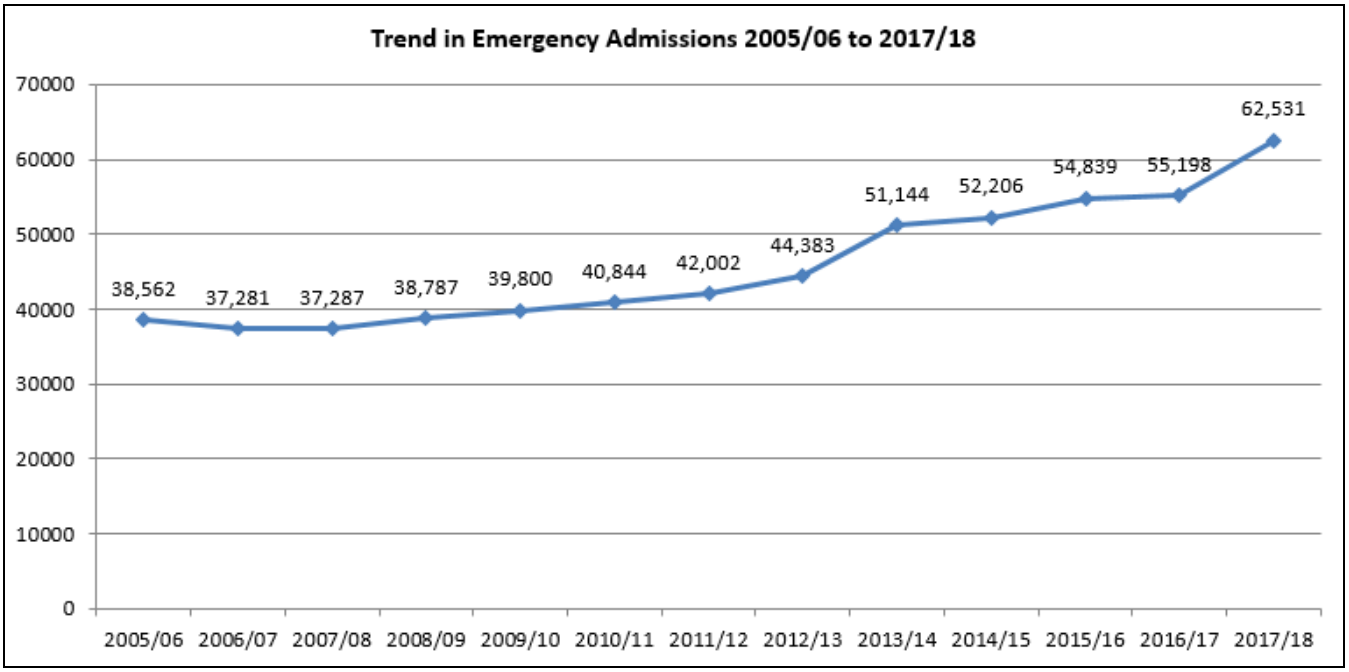
Summary of Service Activity by specialty in the year ended 31 March 2018

		Inpatient/Daycase			Outpatient		
Centre	**Speciality**	**2015/16**	**2016/17**	**2017/18**	**2015/16**	**2016/17**	**2017/18**
Diagnostics	***Chemical Pathology***	-	1	1	615	645	592
	A&E Outpatient & Spells	1,000	951	894	3,856	3,629	3,397
Head & Neck	***Audiological Medicine***	2	1	1	1,390	666	1,010
	ENT – Adult	2,613	2,398	2,281	22,627	22,036	20,410
	ENT - Child	-	-	-	-	-	-
	Maxillofacial Surgery	542	613	726	333	94	71
	Oral Surgery	1,135	690	703	11,233	10,472	10,265
	Orthodontics	-	-	-	6,583	7,451	8,010
	Ophthalmology – Adult	3,396	2,973	3,798	46,129	48,490	45,875
	Ophthalmology – Child	130	41	10	8,073	7,960	8,199
	Ophthalmology - Medical	4	-	3	4	1	2
	Restorative Dentistry	-	-	-	663	583	565
Medicine	***Cardiology***	2,695	2,884	3,083	23,083	22,299	23,127
	Cardiothoracic Surgery	1	-	-	1,330	1,236	1,215
	Dermatology - Adult	7	16	5	17,215	16,763	16,905
	Dermatology – Child	1	4	-	258	253	248
	Diabetic Medicine	3	6	3	6,281	6,808	6,105
	Endocrinology	270	121	106	2,540	2,882	3,136
	General Medicine inc Stroke	22,961	23,145	23,995	6,769	4,613	3,700
	Geriatric Medicine	150	156	254	3,590	5,076	4,926
	Nephrology	422	296	356	5,871	6,915	6,118
	Neurology	281	332	324	8,310	8,490	6,623
	Rehabilitation	40	71	60	-	-	-
	Respiratory Medicine	1,960	2,936	3,044	10,848	11,558	11,554
	Respiratory Physiology	-	1	-	192	203	244
Musculoskeletal	***Pain Management***	543	620	538	1,045	1,027	759
	Rheumatology	-	-	-	15	4	-
	Trauma and Orthopaedics	6,222	6,079	5,826	53,550	50,006	46,940
Surgery, Oncology & Haematology	***Breast Surgery***	931	698	731	17,219	15,879	15,319
	Colorectal Surgery	1,016	923	1,000	11,412	12,559	12,773
	Gastroenterology	17,978	19,096	19,307	8,942	10,446	10,016
	General Surgery	6,579	7,988	7,157	926	924	666
	Hepatology/Hepatobiliary	12	7	5	2,923	2,312	2,482
	Neurosurgery	-	-	-	196	144	0
	Plastic Surgery	-	-	-	3	2	1
	Upper GI Surgery	1,136	1,170	1,044	6,288	6,475	6,407
	Urology	5,293	6,022	6,131	19,482	19,352	19,056
	Vascular Surgery	1,971	928	1,729	6,904	6,304	6,790
	Clinical Haematology	6,658	7,726	8,153	12,293	13,653	14,941
	Clinical Oncology	11,299	11,611	11,468	17,355	18,921	19,942
	Medical Oncology	663	703	1,042	995	686	1,747
Anaesthetics	***Anaesthetics***	1	1	3	459	559	536
Women and Children	***Gynaecology***	4,154	4,363	4,236	19,956	20,110	18,175
	Gynae Oncology	4	8	7	6,188	6,505	6,362
	Obstetrics / Maternity	5,660	6,621	6,250	10,800	12,988	11,446
	Neonatology	3,064	4,594	4,464	825	958	1,039
	Paediatrics	9,308	9,054	8,661	21,460	22,273	20,799
	Psychotherapy	-	-	-	79	40	30
Total		**120,105**	**125,848**	**127,399**	**407,108**	**411,250**	**398,523**

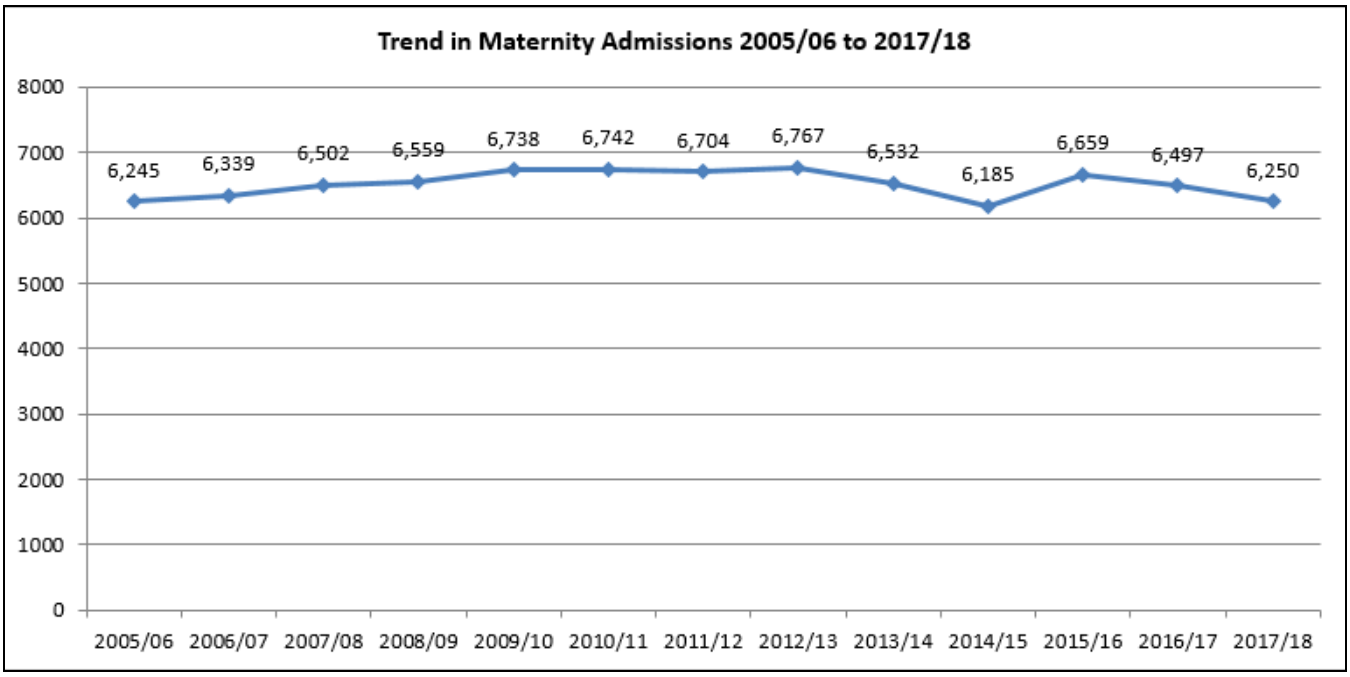
The following graphs show trends in activity from 2005/06-2017/18:



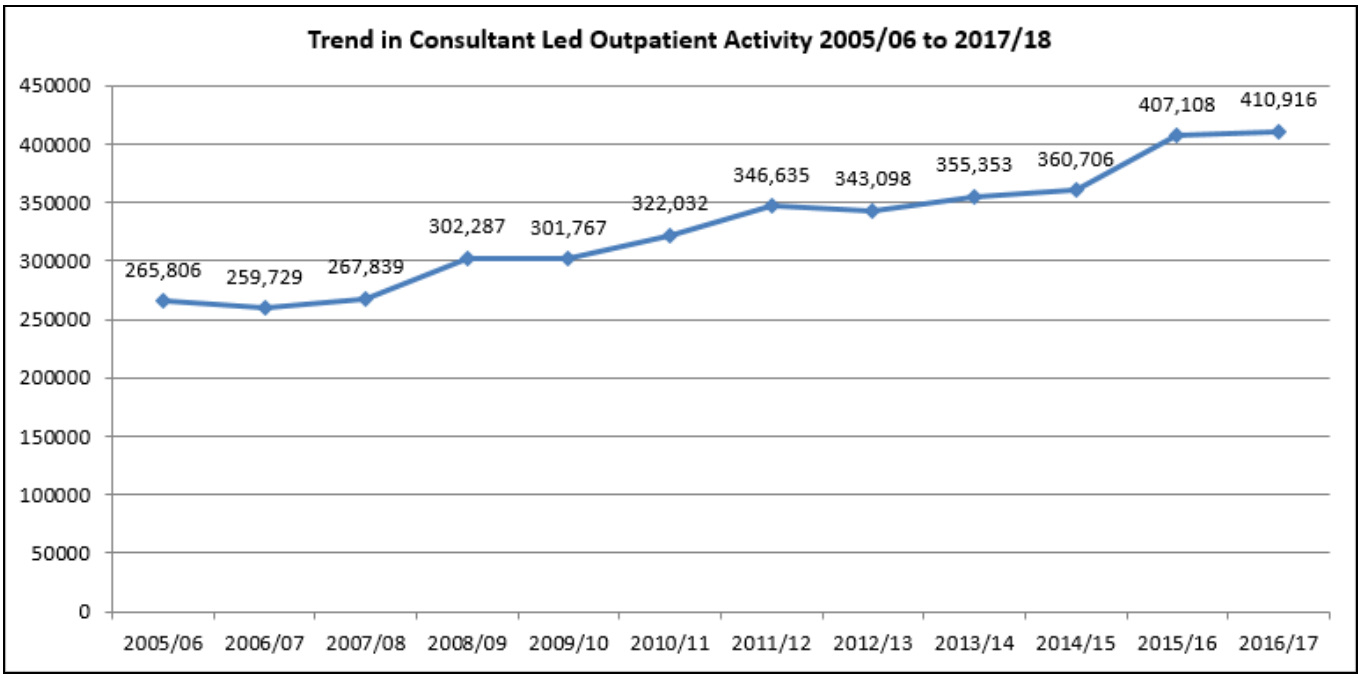
Above: Elective and Day Case activity showed a 1.32% increase this year, compared with a 4.62% increase in the previous year.



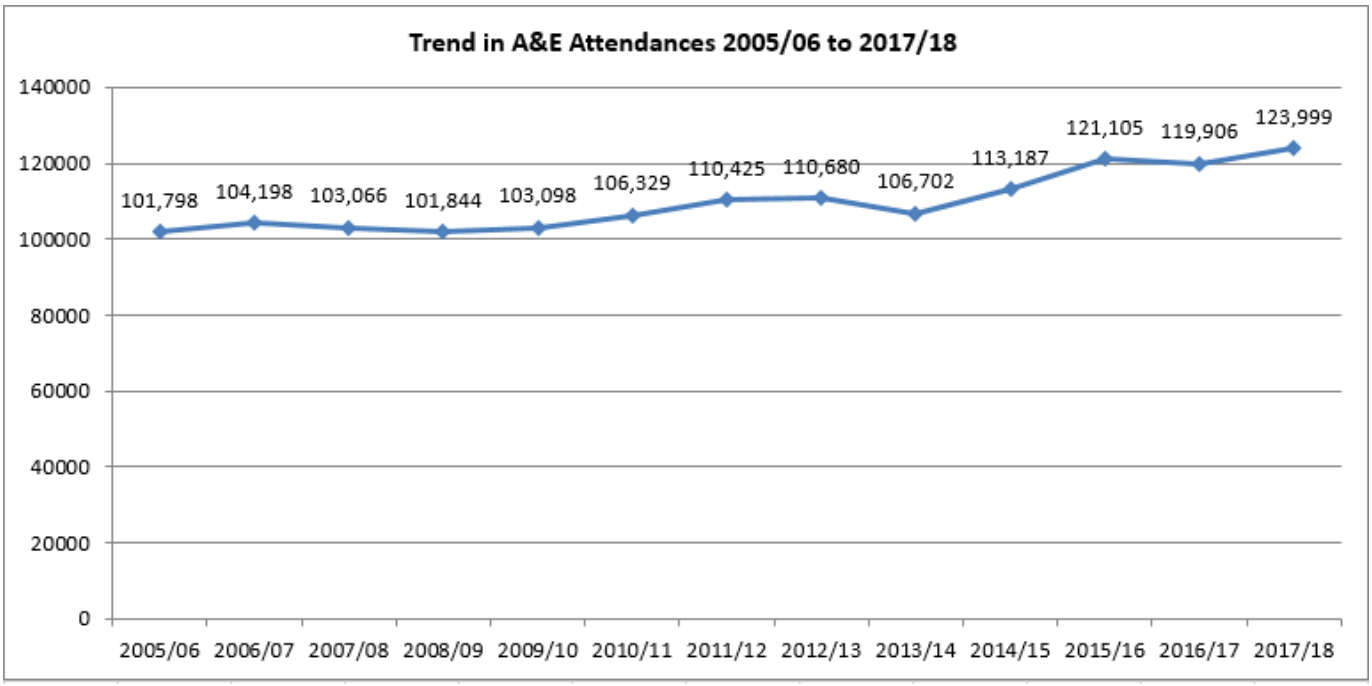
Above: There has been a consistent rise in emergency admissions from 38,562 in 2005/06 to 62,531 in 2017/18. They have increased by 13.28% from 2016/17 to 2017/18.



Above: Maternity admissions have decreased by 3.80% over 2017/18. This followed a decrease of 2.43% over 2016/17.



Above: Apart from a small dip in 2012/13, there has been a general upward trend in consultant-led outpatient activity since 2006/07, including a 0.93% year-on-year increase from 2016/17 to 2017/18.



Above: After a reduction in 2013/14 (reflecting changes in admissions pathway during 2013/14 with GP referrals admitted directly to admissions units rather than via the Accident and Emergency Department), A&E attendances increased over 2014/15 and 2015/16 to their highest ever levels. After a slight fall between 2015/16 and 2016/17, 2017/18 saw attendances at their highest level to date at nearly 124,000, a rise of 3.41% on the previous year. Please note the figures include the Urgent Care Centre (UCC) and Walk-In Centre (WIC) activity at our hospital sites.

I.1c A Forward Look: Strategic context

Nationwide, the NHS is becoming progressively strained with increasing financial pressures and operating with a workforce that is either unavailable or overstretched. As a result organisations have to optimise the best use of resources to service the population's increasing healthcare requirements.

NHS services in Shropshire face these very same challenges; and for the Trust most of this is not new. The additional and longterm difficulties from the duplicate delivery of many services means that care and treatment continues to be provided by a workforce that is working unsustainable rotas within environments that are equally challenged in terms of the facilities and space needed to deliver modern healthcare.

Regardless of the challenges, the safe delivery of care for patients and their families is the single most important priority for SaTH moving in to 2018/19; with the overall goal of providing the safest and kindest care in the NHS. In order for the Trust to progress with achievable and sustainable change that delivers real improvements for patients and the public, the three integrated formal programmes of work described in last year's Operational Plan remain in place for 2018/19.

The coordinating mechanisms for addressing the challenges in quality, workforce, performance and finance within the organisation and across the whole health system are:

- Transforming Care Institute – the Trust's partnership with the Virginia Mason Institute (VMI)
- Sustainability and Transformation Plan (STP) – the health systems overarching strategic plan
- Sustainable Services Programme – the Trust's plan for the delivery of a single emergency site and a single planned care site

These three overarching programmes will drive and steer the changes required to deliver consistent high quality and appropriate care to patients and their families. To be the safest and kindest is an ambition identified by staff and patients alike and is central to the programmes above and all aspects of the Trust's organisational strategy.

For 2018/19 the Trust will deploy parts 2 & 3 of the Operational Plan where appropriate, aimed at building on successes achieved within 2017/18. The Operational Plan provides a mechanism by which services can develop once they are in a position where they have a solid foundation on which to build, essentially focusing on getting the basics right.

Part of delivering a solid foundation is to deliver key Operational Objectives such further development of the Urgent Care Service, progression of the out-of-hospital service and identification of service opportunities within Scheduled care. These will enable the organisation to deliver its Trust Ambitions to:

1. Improve our patient care processes to create empty beds to stop additional patients being placed on wards
2. Reduce our reliance on temporary staffing through a 25% improvement in our vacancy rate
3. Become more efficient in our performance through reducing waste in our processes and embedding our Transforming Care Methodology

The Operational Plan for 2018/19 fits within the strategic direction of the Sustainable Services programme. Following the Treasury's commitment to support a £312 million investment in our hospitals we move to a position of Public Consultation in the summer of 2018. A programme of internal engagement with all staff groups is well under way to further develop the business case and help shape the future provision of acute services within Shropshire.

Whilst the STP and its component parts, including the Trust's Sustainable Services Programme move steadily forward, frontline staff will continue work on understanding their service issues with the support and expertise of the Transforming Care Institute. Now in its third year, we continue to methodically apply the VMI tools of removing waste and non-value added activities and by standardising processes and systems in Trust departments and in the design of new clinical services and facilities as part of SSP.

2018/19 will therefore see the further coming together of large scale, longer term change proposals with improvements and developments that make an immediate difference today. For the Trust to be safest and kindest in the NHS both strategies will need to progress side-by-side.

I.1d Key Performance Indicators (KPIs)

Domain	Indicator	Description	Data Source	Thresholds	Performance in Year Ended 31 March 2018
Access (including A&E and 18 weeks Referral to Treatment [RTT])	Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	The number of patients spending four hours or less in all types of A&E department / The total number of patients attending all types of A&E department	Weekly SitReps	Performing: 95% Underperforming: 94%	76.66%
	12 hour trolley waits	The number of patients waiting in A&E departments for longer than 12 hours after a decision to admit	Weekly SitReps	Performing: 0 Underperforming: >0	62
	1 hour ambulance handovers	Ambulance handovers not completed within 60 minutes	Weekly SitReps	Performing: 0 Underperforming: >0	1656
	30 minute ambulance handovers	Ambulance handovers not completed within 30 minutes	Weekly SitReps	Performing: 0 Underperforming: >0	8320
	RTT – admitted -90% in 18 weeks	Total number of completed admitted pathways where the patient waited 18 weeks or less vs. Total number of completed admitted pathways in quarter	Monthly RTT returns via UNIFY	Performing: 90% Underperforming: 85%	58.73%
	RTT – non-admitted – 95% in 18 weeks	Total number of completed non-admitted pathways where the patient waited 18 weeks or less vs. Total number of completed admitted pathways in quarter		Performing: 95% Underperforming: 90%	95.00%
	RTT - incomplete pathways	Total number of patients on incomplete pathways less than 18 weeks vs. total number on incomplete pathways		Performing: 92%	91.31%
	RTT – greater than 52 weeks	Total number of patients waiting longer than 52 weeks from referral to treatment		Performing: 0	0
	% of patients waiting over 6 weeks for a diagnostic test	To measure waits and monitor activity for 15 key diagnostic tests		Performing: <=1%	0.39%
	28 day readmission	Number of patients not treated within 28 days of last minute elective cancellation	Quarterly return via UNIFY	Performing: 0	4
	Multiple cancellations of urgent operations	Number of last minute elective operations cancelled for non-clinical reasons	Monthly return via UNIFY	Performing: 0	565
Cancer Waiting Times	2 week GP referral to 1st Outpatient	Please see cancer waiting times guidance for definition of these performance standards	Cancer Waiting Times Database	Performing: 93% Underperforming: 88%	93.84%
	2 week GP referral to 1st outpatient – breast symptoms			Performing: 93% Underperforming: 88%	93.51%
	31 day diagnosis to treatment for all cancers			Performing: 96% Underperforming: 91%	100%
	31 day second or subsequent treatment – drug			Performing: 98% Underperforming: 93%	100%
	31 day second or subsequent treatment – surgery			Performing: 94% Underperforming: 89%	100%
	31 day second or subsequent treatment – radiotherapy			Performing: 9 Underperforming: 89%	100%
	62 days urgent GP referral to treatment of all cancers			Performing: 85% Underperforming: 80%	84.58%
	62 day referral to treatment from screening			Performing: 90% Underperforming: 85%	92.85%
	62 day referral to treatment from hospital specialist			Performing: 85% Underperforming: 80%	92.75%
Infection Prevention and Control	MRSA	Actual number of MRSA vs. planned trajectory for MRSA	HPA Returns	Performing: No MRSA bacteraemias	0
	C.Diff	Actual number of C.Diff vs. planned trajectory for C.Diff		No more than 25 C.diff	18
Quality of Care	VTE Risk Assessment	Number of adult inpatient admissions reported as having a VTE risk assessment on admission	UNIFY Mandatory returns	Performing: 95% Underperforming: 90%	95.5%
	Duty of Candour	Number of breaches of duty of candour	Datix	Performing: 0	0
	Breaches of same sex accommodation	The number of breaches	Collection via UNIFY	Performing: 0	4
Workforce	Sickness absence	Number of days sickness absence vs. available workforce	SaTH Returns	Performing: 3.99%	4.4%
	Appraisal	Number of eligible staff receiving appraisal in current performing vs. total eligible staff		Performing: 80% (Stretch target 100%)	86.52%
	Statutory and Mandatory Training	% compliant with statutory and mandatory training requirements		Performing 80%	71.31%

I.2 Performance Analysis

I.2a Director of Nursing, Midwifery and Quality's Report

The Director of Nursing, Midwifery and Quality has Board level responsibility for the Quality agenda, ie patient safety, patient experience and clinical effectiveness. This agenda is supported by the Medical Director. The role also includes Board-level professional leadership and support for the nursing, midwifery and allied healthcare workforce across the Trust.

I was delighted to join SaTH in May 2017 and to have spent the past year working alongside people who are passionate about making improvements for our patients and their families and carers. We are united in our vision to provide the safest and kindest care possible for all of our patients – this has been at the very heart of all the work we have undertaken in the last 12 months.

Key to that has been the development of our Quality Strategy for 2018-2021 called "Safest and Kindest Every Day". This is a document that describes our journey so far to improve standards of care for patients. It will not focus on specific areas or services but will provide a view of our progress as a Trust against the three domains of quality – **safe** and **effective** services that provide as good an **experience** as possible for patients. We will be clear about the milestones that we need to achieve along the way towards our Vision – including achieving a "Good" or above rating from the CQC and excellent outcomes in the national audits and reports of our services. It will take a lot of commitment, but it's about doing the right thing and will be everyone's responsibility.

A few of the improvements that we have made include revising our Incident Management Policy – we are an organisation that is not afraid to report our mistakes so that lessons can be learned; we have introduced Human Factors training in our theatres following never events, and implementing external Effective Investigations training.

Essential to making our hospitals the best they can be is improving our patients' journeys through them, and ensuring that they are discharged as soon as they are fit to leave. No-one wants to be in hospital longer than they need to be and any day spent in hospital without benefit is a day too many. It will also prevent patients waiting longer than they need to in our A&Es. As part of this way of thinking our teams have embraced a number of initiatives, including the national End PJ Paralysis campaign, as it is proven that getting patients dressed and moving helps aid a quicker recovery. We are also using learning from the Red2Green initiative, a simple, visual way to assist in the identification of non-value added time in a patient's journey.

Over the past year we also made a decision to move away from using the most expensive agency nurses and instead increase our workforce and Bank. This ensures continuity of care for our patients and also saves money. Workforce remains a challenge as there is a national shortage of nurses and we are seeing some leave the Trust in their first year. This is something that we are addressing by being proactive in our recruitment though initiatives such as the Nurses' 'Golden Ticket' as well as encouraging our staff to become leaders through our Rising Stars programme. We are also looking at new ways to support our registered staff by taking a multi-professional approach to patient care; and we have invested in developing Nursing Associates.

Full inpatient maternity services at Midwife-Led Units in Bridgnorth, Ludlow and Oswestry were suspended for six months in 2017 before re-opening on 1 January 2018. The safety of women and babies continues to be our number one maternity priority and that is why, since the re-opening in January, we have acted promptly on our escalation plans when required, which result in temporarily suspending services at one or more of our MLUs. We know this unforunately causes uncertainty, but we will always work to maintain safety first.

Our internal review into Maternity Services was published in June 2017. This report, in conjunction with the Royal College's review and a report from NHS Improvement, will ensure we have a full picture of our Maternity service and areas that need further improvement, as well as areas where we are doing well.

Following the launch of our Exemplar programme in 2016 we awarded our first Diamond Ward in February. Outstanding care, safety and kindness, leadership, cleanliness, exceeding targets and many other achievements, mean that the Postnatal Ward are the first to win the coveted Exemplar Ward Diamond status.

Deirdre Fowler, Director of Nursing, Midwifery and Quality

Progress Against Operational Objectives 2017/18

I was the lead director for the following operational objectives during the year:

2017/18 Operational Priorities	2017/18 Operational Objectives	Annual Review of Progress
Patient and Family Listening to, and working with, our patients and families to improve healthcare	Plan to address capacity deficiencies occurring at the weekend addressing insufficient discharges by June	• Ward 17 – elective orthopaedics – 25% • Coronary Care Unit (day case) – 75%. The process is now run by the nursing staff completely, using a CLD template however opportunity remains following procedures.
	Implement Red to Green and SAFER programme from April-June	• Patient journey facilitators continue to receive positive feedback from patients/relatives and ward teams. This team, primarily concentrating on nine wards, is also supporting other wards as capacity allows. SAFER principles and Red2Green toolkit re-launched, along with monthly roadshows to help embed the concept with fortnightly corporate induction presentations. During February/March the team and ward areas took part in RPIW around FFA at PRH and CLD at RSH. FFA completion is highlighted as an internal process block which results in longer hospital stays which do not add value for patients. RPIW provided an opportunity for the team to try something different to help improve the process around completion of the forms. At RSH, we were able to try a new process for doctor referrals, which is another identified R2G block in the system • Analysis around R2G delays/blocks in the system continues. Further analysis required regarding top three blocks as well as patients who remain Red for subsequent days with the same reason. Changes made to tracker forms to give more visibility to key issues. Each of the nine wards has access to ward specific performance on KPIs associated with SAFER/Red2Green, displayed monthly on people link boards. Red2Green form will be replaced and information recorded on PSAG, giving greater visibility to actions required and enabling escalation of blocks in the system to team leader/department if response times aren't met within agreed tolerances. • Stranded patient review process in place across both sites and two care groups. Weekly discussion of super stranded (20days+) held and a mechanism for escalation in place with senior professionals both internally and externally to the Trust. • Metrics for reporting developed. Monitored weekly. • Daily check, chase, and challenge process is in place to help identify what needs to happen to each patient that day to add value to their stay. This process is providing a wealth of information in terms of key themes of obstacles within the patient journey that can be addressed at both a local level.
Healthiest Half Million Working with our partners to promote 'Healthy Choices' for all our communities	Conclude LHE maternity review by July (CCG delayed)	• The local maternity system (LMS) programme board has completed the LMS transformation plan in partnership and co-production with stakeholders to ensure vision for maternity services is realistic and sustainable. Final plan submitted to the STP programme board on 25 October and NHSE on 31 October. One of the work streams involving a review of the MLUs is complete in draft and pending submission to the LMS programme board and CCG Boards. Implementations of recommendations are in synergy with the overall LMS plan during Q4 (17/18).
	Manage Midwifery staffing model as per review by July	• Midwifery staffing model forms part of LMS programme board and workforce is an identified workstream of the board. Birth Rate Plus (midwifery safer staffing assessment) in relation to the Trust has been published and presented to LMS Board in June 2017. LMS Board agreed Birth Rate Plus findings will form part of overall LHE transformation of maternity services. Findings will

<table>
<tr><td></td><td></td><td>also be presented to Trust Workforce Committee following completion of MLU review process. Implementation of recommendations in Birth Rate Plus will be in synergy with overall LMS plan during Q4 (17/18).</td></tr>
<tr><td rowspan="2">Safest and Kindest
Our patients and staff will tell us they feel safe and received kind care</td><td>Full roll-out the Exemplar Ward Programme by April</td><td>• Neonatal ward was assessed on 22 March 2018 and final outcome/report due by end of May 2018.
• PRH Critical care ward assessed on 26 April 2018 with final outcome/report due by end of May 2018.
• Mock Exemplar assessment on Gynaecology ward to help Ward Manager identify areas requiring improvement to meet exemplar standards, formal assessment scheduled for August 2018.
• Mock Exemplar assessment conducted on RSH Critical Care, formal assessment scheduled for June 2018
• Summary so far is set out below:-
<table>
<tr><td>Formal (4)</td><td>16 (PRH)
21 PN (PRH)
23 Ne (PRH)
Critical Care (PRH)</td><td>Gold Award - Aug-18
Diamond Award - Feb-18
In progress - May-18
In progress – May-18</td></tr>
<tr><td>Mock (7)</td><td>22 AN (PRH)
24C/E (RSH)
21 PN (PRH)
23 Ne (PRH)
Gynae (PRH)
Critical Care (PRH)
Critical Care (RSH)</td><td>We complete a mock assessment on the ward 2-3 months prior to the formal assessment. This is a ‘fresh eyes’ approach and is useful to highlight any potential issues.</td></tr>
<tr><td>Genba (37)</td><td>25 completed
12 scheduled</td><td>Each ward will receive 3-4 genba walks. This helps raise awareness around the program and offers support and guidance.</td></tr>
</table></td></tr>
<tr><td>Respond and build upon the results and recommendations identified through the CQC assessment in December 2016 from April</td><td>• CQC Safest and Kindest Quality improvement plan paper being submitted to Quality & Safety committee.
• NHSI governance “Well Led” action plan reviewed and approved by Executives and to be presented to Quality & Safety Committee in May and CGE.
• Good and beyond workshop planned for 25 June for SLT to review how we progress further with the Well Led and safe domains.
• Stakeholder meeting to be scheduled to facilitate on-going engagement for key people.</td></tr>
</table>

Performance Against Key Targets 2017/18

The main Key Performance Indicators that I report to our Trust Board meetings in public during the year through our Summary Performance Report are:

Domain	Indicator	Description	Data Source	Thresholds	Performance in Year Ended 31 March 2018
Infection Prevention and Control	MRSA	Actual number of MRSA vs. planned trajectory for MRSA	HPA Returns	Performing: No MRSA bacteraemias	0
	C.Diff	Actual number of C.Diff vs. planned trajectory for C.Diff		No more than 25 C.Diff	18
Quality of Care	Duty of Candour	Number of breaches of duty of candour	Datix	Performing: 0	0
	Breaches of same sex accommodation	The number of breaches	Collection via UNIFY	Performing: 0	**4**

More detailed performance measures are included in the Performance Report presented to the Trust Board. Further review and assurance is through the Trust’s Quality and Safety Committee and Clinical Governance Executive.

I.2b Medical Director's Report

My primary responsibility as Medical Director is to support the medical staff at SaTH to provide care for our patients to the highest achievable quality and safety. This involves clinical outcomes and mortality as markers of quality of care; appraisal and revalidation as the means of quality assurance; and quality improvement through education, research and innovation, and by expanding our workforce.

The Trust has continued its work on improvements from mortality and has been below peer comparators on all four national indicators. There has been on-going work ensuring that priority is given to learning from deaths with the development of focused case note reviews and the introduction of improvements, where necessary. We saw this with patients who have sustained a fractured neck of femur where, at the end of the review, additional theatre sessions were provided, patients were kept in theatre recovery for longer, a physiotherapist was made available at weekends and a single page guideline was developed for the management of hypotension.

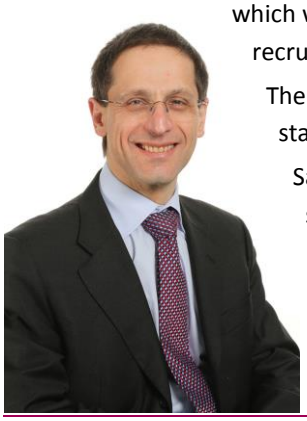
The Trust proudly won a prestigious national Patient Safety Award in July 2017 for the development of an interactive app for cancer patients that helps patients to understand and monitor the side effects of chemotherapy treatment and the long-term follow up of prostate cancer. The app has provided great outcomes and a better experience for patients.

SaTH won a Patient Safety Award in 2017 for the development of an innovative Cancer App

SaTH has achieved the performance target of 95% or above for the assessment of patients for their risk of VTE disease from December 2015 to March 2018, covering over two calendar years and two financial years, which bucked the national trend which saw a dip in performance at other Trusts when winter pressures became apparent.

The doctors at SaTH recognise the importance of their responsibilities for assurance of their practice by the mechanisms of annual appraisal and five-yearly revalidation. SaTH's Trust compliance appraisal figure for doctors, at 99%, for this financial year, is amongst the best in the UK. In addition, all doctors who were due for revalidation in this year engaged in the system, meaning that I did not have to submit any non-engagement recommendations.

We have seen a substantial increase in the number of Keele graduates choosing to work at SaTH this year which demonstrates the effort and dedication put in for and by our students. SaTH was recognised by three GMC survey green flags: for Emergency Medicine induction, experience and education supervision, and Medicine FY2 clinical supervision and innovative OSCE type induction for new foundation doctors. There has also been enhanced skill development for medical staff with partnerships with Army reservists. Leadership training for our FY1 and FY2 doctors in conjunction with 202 Field Hospital has been presented nationally at a Clinical Tutors' Foundation Sharing event.
SaTH again appears in the top 100 NHS organisations for research in terms of the number of patients recruited to clinical trials and the number of clinical trials open. Work is on-going to support more Chief Investigators within our organisation which will strengthen our case to become recognised as a University Hospital. This year saw the recruitment of the 100th patient to the national 100,000 Genome project.



There also has been a substantial commitment from the Trust in workforce expansion of clinical staff of £1.8 million additional investment over the next two years.

SaTH has an exciting future with the announcement of £312 million investment to reconfigure services that will enhance the future of our clinical services to make them sustainable for the people that we serve. The doctors at SaTH will be supporting these developments and, in particular the new care pathways needed to provide for our patients.

Dr Edwin Borman, Medical Director

Progress Against Operational Objectives 2017/18

I was lead director for the following Operational Objectives during the year:

2017/18 Strategic Priorities	2017/18 Operational Objectives	Annual Review of Progress
Safest and kindest Our patients and staff will tell us they feel safe and received kind care	Address capacity consequences arising from growth in direct access and internal usage of CT & MRI by May	• Growth of internal usage is within normal range however GP direct access growth remains high. This is stimulated by new pathways which use imaging as a means of streamlining and encouraging early detection • The third MRI scanner is now installed and went live on 16th April 2018 • Contracted an external provider to help manage capacity and maintain DM01 • DM01 has been sustained • Successful appoints of a consultant Radiographer and a Consultant Radiologist
	Achieve JAG accreditation by June	• Both PRH & RSH Endoscopy Units have full JAG accreditation
Healthiest half million Working with our partners to promote 'Healthy Choices' for all our communities	Full analysis of job plans to be put in place aligned to operational needs by September	• Allocate Job planning software purchased end of September 2017 • Key stakeholder meeting November 2017 • Secondment advertised into Project Lead role February 2018 • Secondee started in post May 2018 • Phase 1 underway including Women's and Children's, Surgical, Oncology and Haematology, Head and Neck and MSK • Full analysis of job plans will be completed by the end of 2018/2019
	Medical Director to conclude on Paediatric service model by July	• This work now forms part of the Trust's bid submission for a formal partnership with Shropshire Community Heath Trust • Further work will continue following the conclusion of the decision of the future of the Shropshire Community Health Trust as this will determine the nature and extent of potential integration of services

Performance Against Key Targets 2017/18

Here are the main Key Performance Indicators that I present to meetings of the Trust Board:

Domain	Indicator	Description	Data Source	Thresholds	Performance in Year Ended 31 March 2018
Quality of Care	VTE Risk Assessment	Number of adult inpatient admissions reported as having a VTE risk assessment on admission	UNIFY Mandatory returns	Performing: 95%	95.5%

More detailed performance measures are included in the Performance Report presented to each Trust Board meeting, with further review and assurance through the Quality and Safety Committee and Clinical Governance Executive. Further information about quality performance can be found in our Quality Account 2017/18 which is included at Appendix 1 to this Annual Report.

I.2c Chief Operating Officer's Report

As Chief Operating Officer I have Board-level responsibility for service delivery across the Trust, leading our Clinical Care Groups which provide hospital and wider services for around half-a-million people across Shropshire, Telford & Wrekin and mid Wales. I also have executive responsibility for major incident and emergency planning.

The NHS and the demands on its services and staff have dominated the news headlines after what has been a particularly gruelling winter. Our Emergency Departments, like others across the UK, have borne the brunt of the challenges that winter brought with it. Our operational teams have been under enormous pressure, and it has been widely reported that attendances at both our EDs have increased.

Our EDs do present an on-going challenge for SaTH, however, we have been working hard to address this. We have made changes to our infrastructure - opening a new Clinical Decisions Unit and creating a new Urgent Care Centre at PRH. We have also had a clear focus on improving patient journeys through our hospitals and getting them home where they want to be, most recently seen in our Easter *'Let's Crack It'* campaign. We are seeing progress. We have also continued to do some great work as part of our transformation work in partnership with the Virginia Mason Institute in Seattle – and our sixth Value Stream will hone in on our EDs.

MRI scanners in the country

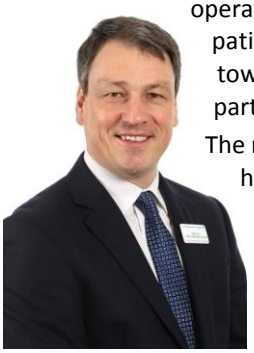
One thing is certain, the on-going dedication of our staff, particularly throughout the winter period, has been incredible; and that resonates in the many, many thank you letters that we have received from patients about the care that they have received over the last few months. I would like to wholeheartedly thank all our staff for their commitment, teamwork and support of each other. They are a credit to SaTH.

Service fragility is something that we are continuing to address, and we are working closely with the operational teams and system partners on all those services that are under the spotlight to improve them for our patients.

There is good news to report. After being closed for just over 12 months, our Ophthalmology department re-opened to new referrals in April, following a successful recruitment campaign. We have recruited a number of new staff to senior positions, including consultant ophthalmologists, and have reduced waiting lists. A clinician is also being trained in Adult Squint Surgery, which means that this service could also re-open to referrals later in the year. This is all now being delivered in a wonderful new facility in the Copthorne Building at RSH.

Our performance for RTT (Referral To Treatment), Diagnostics and Cancer Treatment, we are pleased to report, continues to be consistently good; and is certainly better than many other Trusts across England. We are very proud that we are in the Top 10 for Cancer and RTT, and that performance is all thanks to our clinical teams.

I am also delighted to report that the Trust has gone from having the two oldest MRI scanners in England to now having the three most modern. One of our scanners was paid for thanks to the fantastic fundraising efforts of the League of Friends of the Royal Shrewsbury Hospital, who raised an astonishing £1 million. Two further scanners are also in operation – another at the RSH and a further one at the PRH – and these will be of great benefit to our patients in terms of reducing waiting times, and improving diagnoses and experience. Work continues towards the re-opening our Neurology department to new referrals – and we are working in partnership with other organisations in order to move forward with this.



The recent announcement of the capital for the reconfiguration of our hospital services will have a huge part to play in their delivery. I have joined SaTH at an exciting time, and I look forward to helping to shape the future of our services for the benefit of our patients and our staff so that we can provide the safest and kindest care possible.

Nigel Lee, Chief Operating Officer

Progress Against Operational Objectives 2017/18

I was lead director for the following operational objectives during the year:

2017/18 Strategic Priorities	2017/18 Operational Objectives	Annual Review of Progress
Safest and Kindest Our patients and staff will tell us they feel safe and received kind care	RTT to be recovered by individual specialties as per care group model	• Significant improvement in 18 week Referral to Treatment (RTT) performance in 17/18. SaTH delivered the 92% standard from September. In January 2018, there was a directive from the National Emergency Performance Programme (NEPP) team to cancel all routine outpatients and operations in January, which then significantly impacted on the Trust's ability to deliver the 92% standard at year end. However, the Trust will recover performance in Quarter 1 of 2018/19
	RTT trajectory delivered as per care group model	• The overall RTT performance was achieved; however, neurology, ophthalmology and dermatology were services under the spotlight in 2017/18.
Patient and Family Listening to and working with our patients and families to improve healthcare	Stream patients effectively, finalise the Urgent Care Centre at PRH and address the Urgent Care Centre deficiencies at RSH by June	• A new GP streaming service was introduced and co-located in the Emergency Department at PRH from October 2017, to stream suitable patients to be seen by GPs and Urgent Care Practitioners. This service sees circa 25 patients per day through this service. Also on the PRH site we opened a CDU co located within the ED.
	Complete workforce review or PRH/RSH A&E department and address 6pm-12am capacity shortfall by June	• This work was undertaken and now there is a full workforce plan, which will be implemented over the next two years. There are still gaps in the consultant and middle grade rotas which are currently being covered through locums.
	Realign Scheduled Care & Unscheduled Care beds from April - October	• The realignment of beds took place in October 2017, however we were unable to realise the full potential of alignment due to increase in emergency activity resulting in escalation capacity remaining open in summer months.
	Secure Cancer delivery by addressing Dermatology consultant workforce by May	• Locum consultant sourced and in place. Capacity was also utilised at the Shropshire Skin Clinic.
Healthiest Half Million Working with our partners to promote 'Healthy Choices' for all our communities	Review capacity requirements in respect of public health campaigns and NICE guidance by September	• Public health campaigns are factored in to our plans and additional capacity put in place to address demand. Demand and capacity models are reviewed on quarterly basis to reflect increases in referrals or further campaigns.
Safest and Kindest Our patients and staff will tell us they feel safe and received kind care	Conclude review of demand and capacity impact arising from direct to test by May	• Radiology conducted the review, which concluded some capacity shortfall' Recruitment has been underway and continues.
	Linked to bed realignment, agree and implement the new bed profile in relation to the new nursing structure from April – October	• The workforce requirement for the revised bed complement was confirmed. However, escalation capacity remained open in the summer months, and recruitment activity for nursing continues.
	Conclude arrangements to transfer 70 patients per week to community provision from April - October	• SATH2Home is well established now across Telford and Shrewsbury and in 2017/18 discharged on average 22 patients to this service. We also worked with our Local Authority partners to increase the number of complex discharges and packages of care.
	Develop and implement solutions to better align support service activity and workforce by October	• The Therapy service produced an electronic data capture mechanism for capacity and demand, linked to the clinical portal, and implemented in basic form in Sep 17. This has been further developed and is set for wider implementation during Q1 18/19

My performance information is continued on the next page, where you will find the Key Performance Indicators that I report to Trust Board.

Performance Against Key Targets 2017/18

Here are the main Key Performance Indicators that I report to the Trust Board and how we performed during the year:

Domain	Indicator	Description	Data Source	Thresholds	Performance in Year Ended 31 March 2017
Access (including A&E and 18 weeks Referral to Treatment [RTT])*	Four-hour maximum wait in A&E from arrival to admission, transfer or discharge	The number of patients spending four hours or less in all types of A&E department / The total number of patients attending all types of A&E department	Weekly SitReps	Performing: 95% Underperforming: 94%	76.66%
	12 hour trolley waits	The number of patients waiting in A&E departments for longer than 12 hours after a decision to admit	Weekly SitReps	Performing: 0 Underperforming: >0	62
	1 hour ambulance handovers	Ambulance handovers not completed within 60 minutes	Weekly SitReps	Performing: 0 Underperforming: >0	1656
	30 minute ambulance handovers	Ambulance handovers not completed within 30 minutes	Weekly SitReps	Performing: 0 Underperforming: >0	8320
	RTT – admitted -90% in 18 weeks	Total number of completed admitted pathways where the patient waited 18 weeks or less vs. Total number of completed admitted pathways in quarter	Monthly RTT returns via UNIFY	Performing: 90% Underperforming: 85%	58.73%
	RTT – non-admitted – 95% in 18 weeks	Total number of completed non-admitted pathways where the patient waited 18 weeks or less vs. Total number of completed admitted pathways in quarter		Performing: 95% Underperforming: 90%	95.00%
	RTT - incomplete pathways	Total number of patients on incomplete pathways less than 18 weeks vs. total number on incomplete pathways		Performing: 92%	91.31%
	RTT – greater than 52 weeks	Total number of patients waiting longer than 52 weeks from referral to treatment		Performing: 0	0
	% of patients waiting over 6 weeks for a diagnostic test	To measure waits and monitor activity for 15 key diagnostic tests		Performing: <=1%	0.39%
	28 day readmission	Number of patients not treated within 28 days of last minute elective cancellation	Quarterly return via UNIFY	Performing: 0	3
	Multiple cancellations of urgent operations	Number of last minute elective operations cancelled for non-clinical reasons	Monthly return via UNIFY	Performing: 0	565
Cancer Waiting Times	2 week GP referral to 1st Outpatient	Please see cancer waiting times guidance for definition of these performance standards	Cancer Waiting Times Database	Performing: 93% Underperforming: 88%	93.84%
	2 week GP referral to 1st outpatient – breast symptoms			Performing: 93% Underperforming: 88%	93.51%
	31 day diagnosis to treatment for all cancers			Performing: 96% Underperforming: 91%	100%
	31 day second or subsequent treatment – drug			Performing: 98% Underperforming: 93%	100%
	31 day second or subsequent treatment – surgery			Performing: 94% Underperforming: 89%	100%
	31 day second or subsequent treatment – radiotherapy			Performing: 94% Underperforming: 89%	100%
	62 days urgent GP referral to treatment of all cancers			Performing: 85% Underperforming: 80%	84.58%
	62 day referral to treatment from screening			Performing: 90% Underperforming: 85%	92.85%
	62 day referral to treatment from hospital specialist			Performing: 85% Underperforming: 80%	92.75%

More detailed performance measures are included in the Performance Report presented to each ordinary meeting of the Trust Board, with further review and assurance through the Trust Board, Senior Leadership Team and through our operational performance systems.

I.2d Finance Director's Report

As Finance Director I have Board-level responsibilities for effective systems of financial management and control, and the development and management of our contracts and performance systems. I am also the lead director for our Estates, Information and IT services.

The long-term health economy solution to the Trust's workforce fragility will continue to be progressed through 2018/19 and the completion of the outline business case and development of a full business case.

Following the Treasury's commitment to support SaTH and the NHS Future Fit scheme, public consultation - led by the CCGs - is due to commence in quarter one of 2018/19. The Trust will continue progressing with year two of its five-year Transformation Plan to deliver sustainable services across both hospital sites to improve recruitment and ultimately improve the level and range of care provided.

This service model establishes Urgent Care Centres on each of the two hospital sites, builds a new modern scalable emergency care centre and seeks to establish new centres of excellence in cancer care, ophthalmology and bariatric surgery. Plans also allow for a long overdue overhaul of ward, theatre and critical care areas supported by enhanced diagnostic and imaging capability.

(above) or RSH (below) could look.

The 2017/18 financial year represented year two of its five year medium-term plan. In setting the plan for the year the Trust was required to achieve a control total deficit of £6million, subject to the receipt of Sustainability and Transformation Funding (STF) £9.3million.

The effect of workforce challenges has led to increased spending in respect of Agency staffing and an inability to secure the full level of cost improvement savings. This combined with reduced Income has resulted in the Trust recording an in the year deficit of £12.017 million. Significantly, in failing to limit the in-year overspend to the level agreed with NHSI, the Trust has been unable to secure the full level of available STF money. The level of STF monies withdrawn has amounted to £5.383 million and as a consequence the Trust will end the year with a deficit of £17.400million.

In 2017/18 the Trust successfully delivered its capital programme of £11.8million, including £1.6million investment in A&E streaming at PRH and £1.5million investment in diagnostic equipment.

In order to understand the Trust's financial sustainability, the Trust needs to identify any movements in its underlying financial position. The Trust had planned to carry forward a recurrent deficit of £12.5million into the 2018/19 financial year however, will be taking forward a deficit of £20.46million, a movement of £7.96million. The recurrent position establishes a £3million reserve to underpin the revenue consequences of the capital development described in the above.

Clearly there remains much that still needs to be achieved over the coming years and workforce will continue to be a challenge however, our plans demonstrate that through the continuing commitment and imagination of our staff, the Trust can, with confidence, fully expect to respond successfully to the year ahead.

Neil Nisbet, Finance Director

Progress Against Operational Objectives 2017/18

I was the lead director for the following operational objectives during the year:

2017/18 Operational Objectives	Annual Review of Progress
Capacity review to be completed by Meridian Consultancy by September	• Meridian have concluded their work with the Trust and implementation of the work undertaken is in the process of being embedded.
Progress SSP from April	• Agreement has been given by NHSE to progress to public consultation. • Consultation is expected to start end of May/early June for 14 weeks. • Work has continued throughout the year in partnership with patients, staff and the public on the service model, workforce needs and patient pathway development. • The draft Outline Business Case for the SSP is to be approved by the Trust Board in July 2018 with the final Outline Business Case for the SSP to be approved by the Trust Board in December 2018.
Address specific high risk areas in line with Trusts Capital Programme from April	• Capital schemes to address specific high risk areas: – Ward Block Calorifiers – completed. – Continuation of Fire Safety – Fire Compartmentation completed in accessible areas. Wards 21 to be closed to decant from Ward 22 to enable the start of fire works. Next risk-based phase of fire door upgrade works and fire alarms completed. – Subway Duct - Phase 2 (Boiler House to Main Hospital) – Structural works and permanent surface completed. – RSH Ward Block Lifts – All 3 lifts now upgraded and in use. Scheme completed. • Other agreed 2017/18 Capital Schemes: Ophthalmology Phase 1 and 2 completed. Phase 3 to be undertaken as part of 2018/19 Capital Programme.
Complete schemes where there is pre committed spend from April	• Schemes completed. MRI Enabling work at PRH completed and machine in use; both scanners in situ at RSH – replacement scanner in use; additional machine operational 16th April 2018.
Commence procurement exercise to create a Strategic Asset Partner for financing the Hospital reconfiguration business case from April	• The Trust has been given the approval to spend up to £312 million of capital. The vehicle to receive this is yet to be confirmed. • The Trust is however amenable to other funding sources, including the Regional Health Infrastructure Company (RHIC).
Review current PAS system and construct a business case by September	• Patient Administration System (PAS) contract extended until 2020 to give time to build investment case for an Electronic Patient Record (EPR) – The PAS is not standing still but is keeping pace with new developments in NHS information and will be taken to its latest release this quarter to include the new emergency care data set (ECDS). • Procurement and Resources Directorate are in contact with third parties for EPR options appraisal and investment case that will withstand Treasury scrutiny.
Reduce the recurrent deficit to £15.4 million in 17/18 and £12.1 million by 18/19	• The Trust planned to carry forward a recurrent deficit of £12.5 million into the 2018/19 financial year however, will be taking forward a deficit of £20.5 million, a movement of £8.0 million. The effect of workforce challenges has led to increased spending in respect of Agency staffing and an inability to secure the full level of cost improvement savings.
Deliver a control total deficit in the years 17/18 and 18/19 as set by NHSI of £6.063 million and £2.778 million retrospectively	• The Trust recorded an in year deficit of £12.017 million. Significantly, in failing to limit the in year overspend to the level agreed with NHSI, the Trust has been unable to secure the full level of available STF monies. The level of STF monies withdrawn amounted to £5.383 million and as a consequence the Trust will end the year with a deficit of £17.400 million.
Deliver required CIP savings targets during 17/18	• Against the combined CIP and rectification plan of £10.003 million, £7.434 million was achieved at the end of the financial year. • The shortfalls are against the original CIP schemes and are due to the non-delivery of Pay CIP schemes, namely agency reduction linked to bed realignment.

I.2e Workforce Director's Report

As workforce Director I am the lead director for staff engagement and experience, empowering and developing our workforce, and ensuring effective systems for workforce planning.

There has been much focus over the past 12 months on recruitment in the NHS and we have further developed our 'Belong to Something' campaign, including an innovative campaign to invite nurses to join our Bank Staff. The campaign is one of SaTH's largest ever drives to attract nurses from all over the West Midlands and includes adverts on buses that travel around the region. We now also offer weekly pay for Bank Staff.

Improvements to the way we advertise jobs and recruit new staff are being implemented through our Transforming Care Institute's Recruitment Value Stream, while we continue to attend recruitment events to promote SaTH as a great place to work. During 2017/18, we recruited 83.82 Whole Time Equivalent (WTE) Staff Nurses, 83.82 WTE Health Care Assistants and 16.68 Consultants (including those appointed on a locum basis).

We continued our focus on developing our future workforce and have supported 86 apprenticeships this year while navigating our way through the new apprentice levy. New role developments are critical to support us having a sustainable local workforce and we welcomed further cohorts of Trainee Nurse Associates, Theatre Scrub Practitioners, and Advanced Clinical Practitioners; and are recruiting other roles to support our teams.

Our Leadership Academy launched in June. It will support all our leaders to successfully fulfil their roles and reach their potential. We know leadership is a critical success factor to cultural development; to develop a culture that is innovative, safe and kind we will continue to ensure all leaders have the necessary support to develop their skills, knowledge and behaviours. As part of our Leadership Academy we held our sixth annual Leadership Conference in October under the theme of 'Leading a Safety Culture'. The speakers challenged and encouraged us to see how we can all work together to create a culture of safety for our patients, staff and ourselves.

Our hospitals have been incredibly busy over the past 12 months, but despite this, our workforce has been incredible once more and this is why we continue to improve our VIP (Values In Practice) Awards, to celebrate the outstanding achievements and contributions of our staff and volunteers who deliver such high quality care to patients. The awards are now an established annual event and plans are taking place to make the 2018 celebrations bigger and better than ever before as we mark the 70th anniversary of the NHS.

Our Flu Busters campaign keeps on getting better and better and this year a record number of our frontline healthcare workers had their flu jab. With more than 76% of frontline staff vaccinated it not only exceeds the all-important target of 70% but makes our 2017/18 campaign the most successful flu campaign to date. We were pleased to be asked to speak at the national Flufighters conference on our approach

For the last few years we have seen improvement in NHS Staff Survey results on how it feels to work here. However, our latest results are different and the results in a number of areas have declined. Whilst much of the feedback our people are telling us mirrors the national picture, this is not the employment experience we want our people to have. We want SaTH to be a great place to work and that is why we arranged a number of 'SaTH Conversations' on the back of the results which will help us to give focused attention on what will make a difference.

Part of wanting to make SaTH a great place to work means we continue to look at ways to support our existing staff – as well as our new recruits. We continued our focus on health and wellbeing and have introduced further interventions to support mental wellbeing, championed early intervention and continued to promote a healthy lifestyle.

I am really pleased with progress we made in recruitment and supporting our workforce over the past 12 months, and our aim is to continue this over the next 12 months.

Victoria Maher, Workforce Director

Progress Against Operational Objectives 2017/18

I was lead Director for the following Operational Objectives during the year:

2017/18 Strategic Priorities	2017/18 Operational Objectives	Annual Review of Progress
Safest and Kindest Our patients and staff will tell us they feel safe and received kind care	Construct plans to address medical staff risk by September	A 5-year workforce transformation plan has been developed and approved. In addition a specific medical workforce plan for medicine has been signed off by board.
	Develop a trajectory for agency usage improvement by April	A plan was created; agency usage was greater than plan. A significant reduction in Tier 5 was achieved this year.
Leadership Innovative and Inspiration Leadership to deliver our ambitions	Implement programme of work associated with the new Leadership Academy from May/June	The academy was launched in July, a full syllabus was developed. To date 718 have accessed the Academy from across the Trust.
	Review capacity for Lean for Leaders from April	Capacity reviewed, 126 of our staff were Lean for Leaders trained within 2017/18.

Performance Against Key Targets 2017/18

Here are the main Key Performance Indicators that I present to the Trust Board:

Domain	Indicator	Description	Data Source	Thresholds	Performance in Year Ended 31 March 2017
Workforce	Sickness absence	Number of days sickness absence vs. available workforce	SaTH Returns	Performing: 3.99%	4.4%
	Appraisal	Number of eligible staff receiving appraisal in current performing vs. total eligible staff		Performing: 80% (Stretch target 100%)	86.52%
	Statutory and Mandatory Training	Number of spells or attendance with valid number/Total number		Performing 80%	71.31

Detailed performance measures are included in the Workforce section of our Trust Board each month with further review and assurance through the Care Group Boards and Confirm and Challenge sessions and the Trust's Workforce Committee.

I.1f Director of Corporate Governance's Report

I am responsible for ensuring effective systems of governance and risk management within the Trust, and I am also the Company Secretary. My wider responsibilities include legal services, security, facilities, communications and health & safety. I am also the Lead Director for Community Engagement and social action through our members and volunteers.

Last year the Trust held its second Charity Fun Day as part of plans to open our doors to the local community, and this year we plan to make the event bigger and better as part of our plans to celebrate the 70th anniversary of the NHS.

The SaTH Charity was re-launched this year and it is now much more visible among our staff and more recognisable to our supporters and our patients. SaTH Charity is a registered charity that is making a real difference to our patients, affected friends and family, and members of staff in our hospitals.

The first cohort to 'graduate' from the People's Academy

A particular highlight of the past 12 months was the launch of our People's Academy. It is extremely important to us that we improve the way we involve the public—the people we serve—in conversations about the services we provide, and that is why the Academy was created. Feedback about the Academy has so far been positive, with people telling us it provides a good insight into the NHS and how it works in Shropshire, Telford & Wrekin and mid Wales.

When it comes to sustainability, SaTH is committed to being a good citizen. Our approach is to "think globally, act locally" by promoting sustainability, supporting local businesses, engaging with our communities, reducing waste and costs, and improving the physical and emotional wellbeing of our patients, staff and visitors. During the past 12 months more than 2,000 trees were planted by volunteers at both sites and more than 10,000 crocuses were planted by local schoolchildren at PRH.

Action has been taken to improve the parking experience for our patients, visitors and staff. We created overflow parking areas for staff to create more than 40 additional spaces at each site and have introduced and online parking permit application system. A Trust-wide sustainable travel and transport plan has also been implemented and we encourage the use of active and sustainable modes of transport.

I'd like to thank our volunteers for their contributions over the past 12 months. We have more than 900 volunteers who provide excellent support for our staff throughout the Trust, plus almost 300 linked to the League of Friends. This year the Trust replaced its two existing MRI scanners as part of a £1.7million investment, but the fundraising efforts of the League of Friends meant we could invest in a third scanner, meaning even more patients can be seen. The Lingen Davies charity has also been extremely supportive.

It has been another busy year for the Trust in terms of communications. Over the past year there has been a major focus on our programme to reconfigure our hospitals, and I am delighted this is now a step closer to becoming a reality following the announcement that more than £300m capital funding has been secured.

It has been a busy 12 months for our Facilities Department, too. Our Cleanliness Technicians and Catering Staff continue to do excellent work to improve the services we offer patients. Security is an important element of a safe environment for staff and visitors and our Security Team have helped to once again drive down intentional violence against members of staff with some of the best results in the NHS for taking action against offenders.

Reflecting on the year's achievements, I am delighted to report on the progress made within the Directorate delivering above and beyond on all our objectives.

Julia Clarke, Director of Corporate Governance

Progress Against Operational Objectives 2017/18

I was the lead director for the following operational objective in 2017/18:

2017/18 Strategic Priority	2017/18 Operational Objective	Annual Review of Progress
Patient and Family Listening to and working with our patients and families to improve healthcare	Continue to develop environmental and social sustainability through the Good Corporate Citizen programme	• Assessed through NHS Sustainable Development Unit's *Making You a Good Corporate Citizen* tool, SaTH is the ninth highest scoring (best performing) Trust nationally in 2017. 26 Trusts making progress submitted a return from 474 eligible Trusts • In May 2017, the Trust won the Travel and Transport award and was "highly commended" in three other categories at the NHS Sustainable Development Unit Annual Sustainability Awards • 2017 saw the Trust move into the 4th year of its 5 year Sustainable Development Management Plan • The Trust continues to work with public and private sector partners in successfully delivering our sustainability objectives
	Improving patient experience and involvement through engagement and opportunities with our communities and partners	• Launched a People's Academy to gain a better understanding of the NHS and SaTH and provide opportunities for the public to get involved with our organisation • Increased presence at community events and developed an on-going engagement programme across Shropshire, Telford & Wrekin and Powys • Improved processes to ensure the public know how we use feedback to improve services, eg changes to outpatient appointment letters • We continue to improve and build links with local community and 3rd Sector organisations. • Increased the number of hospital volunteers and developed new roles for example maternity volunteers and End of Life Volunteers • Worked with volunteer/community organisations to create green spaces at PRH and RSH. Eg last year in partnership with Shropshire Wildlife Trust our local communities supported planting 2,000 trees across both hospital sites • Organised series of health lectures which have been attended by hundreds of members of the public • Annual Trust Fun Day held in July 2017

More information about our Sustainability work can be seen on the next page.

Sustainability

Our sustainability programme is determined, in no small part, by the UK Government's target to cut carbon emissions by 80% by 2050; and the NHS Carbon Reduction Strategy 2020, which requires every NHS organisation to have a plan to work towards the reduction target.

Our five-year Sustainable Development Management Plan commenced in 2014 and we drive sustainability within all areas of our business. We scored 65% in our most recent self-assessment against the NHS Sustainable Development Unit 'Good Corporate Citizen' criteria; this was the ninth best score nationally, with only 26 Trusts making a return in 2017.

SaTH picked up the Travel and Transport Award at the NHS Sustainability Awards in May 2017

We see clear connections between doing things more sustainably to both improve the wider environment and reduce the environmental effects of our business and saving money. We encourage our staff, patients and visitors to make sustainable choices, such as how they access our hospitals so that there is a lower impact, as well as realising health and wellbeing benefits.

We have a series of action plans relating to carbon and energy savings, waste reduction and recycling, water conservation, sustainable procurement, promoting green travel and behaviour, promoting biodiversity, and engaging with our community. Many of these plans and ambitions are delivered with our local health economy partners and local authorities (Shropshire, Telford & Wrekin and Powys), and private sector innovators such as Veolia. We also contribute to national stakeholder discussions and policy development. We have been recognised for our commitment to sustainability in multiple categories at the national NHS Sustainability Awards for the last four years in succession.

Some key achievements over the past year include:

- Installed a number of LED lighting schemes to help reduce our energy usage.
- Commenced new domestic waste contract with the aim of zero waste going to landfill. Most of the waste is taken to a local energy-from-waste facility and used to generate electricity.
- Installed additional food waste digesters in our main kitchens. The benefits are therefore three-fold: fewer blockages, lower water usage and lower energy usage for hot water production.
- Successfully established an equipment reuse scheme which has extended to a number of external partners. The Trust saved around £16k through reuse instead of purchase
- Encouraged more people to cycle to our hospitals by offering our tax efficient cycle-to-work scheme all year round. We also offer a bespoke travel planning service for our staff
- Negotiated discounted bus travel for our staff with the regional operator, and successfully installed an additional bus stop to service the rear of the RSH site.
- Implemented an inclusive lift sharing scheme and allocated lift share only parking spaces to reduce single occupancy vehicles.
- Implemented parking restrictions at our hospitals whereby staff residing within a one mile exclusion zone are not automatically entitled to a car parking permit, although life circumstances are taken into account. Has the potential to reduce the number of vehicles driving to our hospitals by around 400 cars each day.

Signed.....

Simon Wright, Chief Executive

Date.....25 May 2018

Part II. Accountability Report

II.1 Corporate Governance Report
II.1a Directors Report

The Shrewsbury and Telford Hospital NHS Trust is an NHS Trust established in accordance with the National Health Service Act 2006 and related legislation. It is led by a Board of Directors responsible for all aspects of the Trust's performance including high standards of clinical and corporate governance. This section of the Annual Report provides information about the members of the Board and how the Trust is governed.

The members of the Trust Board at year end are outlined below, including a summary of their experience, registered interests and terms of office. During the year there were several changes with the Board. Peter Latchford OBE left the Trust as Chair after the end of his term of office and was replaced by Ben Reid OBE in February 2018. Colin Ovington was Interim Director of Nursing and Quality from March until May 2017, when Deirdre Fowler took up permanent appointment as Director of Nursing, Midwifery and Quality. Debbie Kadum retired as Chief Operating Officer in December 2017. Sara Biffen was interim Chief Operating Officer until Nigel Lee took up the post in February 2018. Paul Cronin left his post as a Non-Executive Director during the year.

Members of the Trust Board: Chair and Non-Executive Directors

Ben Reid OBE, Chair (from February 2018)

Ben Reid, a qualified accountant lives in Worcestershire, and is Group Chief Executive of the Mid-Counties Co-operative - which has outlets in Shropshire and mid Wales - a position he has held for 30 years. He is a former Director of the Co-operative Group and a former Director of the Co-operative Banking Group. Alongside his current role, Mr Reid has held Non-Executive appointments including Chair of Walsall Healthcare NHS Trust (2004-2016) and most recently, Chair of Dudley and Walsall Mental Health NHS Trust. He has also held senior level positions with Lincolnshire Area Health Authority. Mr Reid's previous Board roles include West Midlands Chair of the Learning and Skills Council, Chair of West Midlands Regional Assembly and Chair of various regeneration bodies.

- Term: February 2018 to January 2021 (first term)
- Political activity: None
- Interests declared at year end: Group CEO of the Midcounties Co-operative; Board member of the International Co-operative Alliance; Deputy Chair of Wolverhampton University; Regional Council Member of the CBI
- Declared interests expiring during the year: None

Mr Harmesh Darbhanga, Non-Executive Director

Harmesh graduated with an honours degree in Economics from the University of Wolverhampton. He has worked in a variety of senior roles in local government and has over 26 years' experience in accountancy and audit having worked both in the public and private sector. He is currently a local government Finance Manager for Projects where his main responsibilities are for the Medium-Term Financial Strategy, Financial Appraisals and providing analytical and accounting support on key projects. Harmesh has extensive board

level experience having previously served as an Independent Board Member of Severnside Housing and more recently as Non-Executive Director and Locality Support Member at Shropshire County Primary Care Trust.

- Term: September 2017 to March 2019 (second term)
- Political activity: None
- Interests declared at year end: None
- Declared interests expiring during the year: None

Mr Clive Deadman, Non-Executive Director

Clive brings 30 years' experience from senior commercial, finance and business development roles. He studied Chemistry at Cambridge University and worked in Africa before spending eight years in the Venture Capital industry. Since joining the utility sector in 1992, Clive has held a range of executive director roles in electricity distribution, water and wastewater utilities. Clive holds a number of directorships in the housing and utilities sector. He is currently a Non-Executive Director for Metropolitan Housing Trust, one of the largest owners and operators of social housing in the UK, a position he has held since 2013.

- Term: February 2018 to July 2019 (second term)
- Political activity: None
- Interests declared at year end: Director of Metropolitan Housing Trust, Chairman of Energy Innovation Centre Investment Forum, Director and Shareholder of 1905 Investments Ltd. Lecturer at Cranfield University, Director of MML Ltd, Director of CPD Ltd
- Declared interests expiring during the year: Director of Ombudsman Services Ltd, Council Member and Fellow of Institute of Asset Management

Dr David Lee, Non-Executive Director

David has been a GP for 30 years and has worked in medical leadership roles within both the NHS and the independent sector. He is currently the Medical Director of CSC, a multi-national corporation that provides information technology services and professional services. He combines this leadership role with work as a GP in Shropshire. David is a committed proponent of clinical leadership and the benefit of effective clinical leadership for patients using health services and for the organisations responsible for providing or commissioning them. In addition to his medical qualifications gained from Manchester University, David has an MBA from Leeds University and is currently training as an executive coach. Dr Lee and his family moved to Shropshire 12 years ago.

- Term: December 2016 to December 2018 (first term)
- Political activity: None
- Interests declared at year end: Medical Director of CSC (Computer Sciences Corporation), Sessional GP within Shropshire working principally at Alveley Medical Practice, Director of Massive Heart Consulting Ltd
- Declared interests expiring during the year: None

Mrs Terry Mingay, Designate Non-Executive Director

Terry started her career in the NHS as a general and subsequently a mental health nurse 38 years ago in London. She worked in London and in the West Midlands, holding a variety of posts including Nurse Director, Human Resources Director, Deputy Chief Executive and Managing Director of a Community Health NHS Provider. Upon retirement from salaried employment in 2011, Terry established herself as a freelance healthcare consultant with much of her work involved in clinical quality initiatives. Between 2011 and 2015 she spent a large proportion of time undertaking consultancy projects with both Shropshire and Telford and Wrekin Clinical Commissioning Groups, which gave her an insight and interest in the

areas that SaTH serves. She is currently a Board member of a Social Housing Provider and a Trustee of a hospice in Staffordshire.

- Term: December 2016 to December 2018 (first term)
- Political activity: None
- Interests declared at year end: Trustee of Katharine House Hospice, Board member of Walsall Housing Group
- Declared interests expiring during the year: None

Mr Brian Newman, Non-Executive Director

Brian has over 30 years' experience at managing director level in a variety of international businesses, including, for eight years, as MD of GKN plc's global Wheels Division, which has headquarters in Telford. He also has considerable Trade Association board experience including as chairman of the board of the British Fluid Power Association. Brian, who is a Freeman of the Shrewsbury Drapers Company, is married with three adult sons.

- Term: April 2016 to March 2020 (second term)
- Political activity: None
- Interests declared at year end: Director - Beckbury Associates Limited, Director - The Woodard Corporation Ltd, Director - Pressure Technologies PLC
- Interests expiring during the year: None

Dr Chris Weiner, Non-Executive Director

Chris is a Public Health specialist with extensive experience in the NHS and also local government. Over the years, he has worked in NHS organisations to improve health and well-being in both Telford and Shrewsbury. He moved to Shropshire more than 20 years ago and considers this to be very much home for himself and his family.

- Term: December 2016-December 2018 (first term)
- Political activity: None
- Interests declared at year end: Associate Medical Director, NHS England
- Interests expiring during the year: Clinical Director at Wiltshire Health and Care

Professor Peter Latchford OBE, Chair (until December 2017)

Peter has been Chair, Chief Executive and troubleshooter for a variety of public service organisations, in health, housing, regeneration, community cohesion, enterprise, infrastructure, local authority, museums, skills, business support, and crime. He is Director of Black Radley Ltd which provides specialist consultancy services in enterprise development, governance and strategic planning. He is also Visiting Professor of Enterprise at Birmingham City University and Trustee of the LankellyChase Foundation. He was awarded an OBE for services to business and the community in the New Year's Honours of 2012.

- Term: November 2013 to October 2017 (first term)
- Political activity: None
- Interests declared at year end: Director and Shareholder in Spark UK Ltd, Director of Black Radley Ltd, Director of Black Radley Culture Ltd, Director of Black Radley Systems Ltd, Director of Black Radley Insight Ltd, Director of Sophie Coker Ltd, Trustee of the Lankelly Chase Foundation, Visiting Professor at Birmingham City University, Lecturer at Warwick University, Fellow of Royal Society for Arts and Manufacturing (RSA).
- Declared interests expiring during the year: None

Mr Paul Cronin, Non-Executive Director (Until January 2018)

Paul has been the Chief Executive of Severn Hospice, a local charity that provides palliative and end-of-life care for adults in Shropshire, Telford & Wrekin, north Powys and Ceredigion, since 2003. Paul started his career in the NHS with Shropshire Health Authority 33 years ago and has held a variety of roles, including Chief Executive posts at the Cardiothoracic Centre – Liverpool NHS Trust, Wirral Health Authority and North Cheshire Hospitals. While with Severn Hospice, Paul has led the development of Compassionate Communities across Shropshire and is passionate about citizens and organisations working together in partnership to provide support to the most frail and vulnerable in our communities.

- Term: August 2016 to January 2018 (first term)
- Political activity: None
- Interests declared at year end: Chief Executive of Severn Hospice, Trustee of Compassionate Communities UK
- Declared interests expiring during the year: None

Members of the Trust Board: Chief Executive and Executive Directors

Mr Simon Wright, Chief Executive

Simon was appointed as director at Warrington and Halton Hospitals NHS Foundation Trust in June 2007. Simon started his management career with nine years in the independent health sector before joining The Walton Centre for Neurology and Neurosurgery NHS Trust in 1997. He joined Salford Royal Hospitals Trust in 2001 as general manager, later becoming associate director. He helped lead Warrington and Halton Hospitals from turnaround to strong performing NHS Foundation Trust with a track record of operational delivery during his time there. He took on the role of deputy chief executive in July 2013 alongside his chief operating officer role. Simon has a MSc from Lancaster University. He is married with one son and enjoys music, sport and reading.

- Appointed: September 2015
- Political activity: None
- Interests declared at year end: None
- Interests expiring during the year: None

Mr Neil Nisbet, Finance Director

Neil joined the Trust in April 2011, having previously been a Finance Director for 12 years and most recently Director of Organisational Resources and Director of Finance at Wolverhampton City PCT.

- Appointed: April 2011
- Political activity: None
- Interests declared at year end: None
- Interests expiring during the year: None

Mrs Deirdre Fowler, Director of Nursing, Midwifery and Quality (from 1 May 2017)

Deirdre completed her nurse training in Dublin in 1988 and subsequent midwifery training in 1994 at Croydon and Carshalton Faculty of Midwifery. Throughout her career, Deirdre has predominantly worked in women's healthcare in a variety of roles, including in community and acute services. In 2002 Deirdre joined the faculty of midwifery at the University of Nottingham as a lecturer before returning to the NHS as a matron in Lincolnshire in 2010. Deirdre became Head of Midwifery and General Manager for Women's Services at Doncaster and Bassetlaw NHS Foundation Trust in 2011, then acting Director of Nursing. Deirdre was appointed as Director of Nursing, Midwifery and Quality at Hinchingbrooke Health Care NHS Trust in May 2014and led Hinchingbrooke's journey of improvement out of special measures to a CQC rating of 'Good'.

- Appointed: May 2017.
- Political activity: None
- Interests declared at year end: None
- Interests expiring during the year: None

Dr Edwin Borman, Medical Director

Edwin joined the Trust as Medical Director in April 2013. Prior to this, he was Clinical Director for Anaesthetic, Critical Care and Pain Services at University Hospitals of Coventry and Warwickshire NHS Trust. Throughout his career Edwin has taken a keen interest in the standards of medical practice, education, ethics, equality and diversity, representation and leadership. This has included chairing the British Medical Association's (BMA) Junior Doctors Committee and its International Committee, serving for over 20 years as a BMA Council member and for 14 years as a GMC Council member.

- Appointed: April 2013
- Interests declared at year end: None
- Interests expiring during the year: None

Mr Nigel Lee (Chief Operating Officer (From March 2018)

Nigel began his career as a helicopter pilot in the Royal Air Force, in both Search and Rescue and Special Forces roles. He served in Northern Ireland, the Falkland Islands and Iraq. He has also worked in broader defence roles, in procurement, strategic planning and in multi-national headquarters. His experience in healthcare began as hospital director for the BUPA hospital on the Wirral, before Divisional Director roles at Alder Hey Children's Hospital and Aintree University Hospital. He has had senior operational roles with the Cheshire and Merseyside Major Trauma Network, as well as with a range of service configuration developments in the Merseyside area. Nigel joined SaTH from his role as Director of Secondary Care for the North Wales Health Board, where he was responsible for three hospital sites, Women's Services and the Specialist Cancer Centre.

- Appointed: March 2018
- Political activity: None
- Interests declared at year end: None
- Interests expiring during the year: None

Debbie Kadum, Chief Operating Officer (until 17 December 2017)

After training as a nurse Debbie completed her orthopaedic nursing certificate and joined Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust in 1986. She held a series of nursing roles including seven years as a ward sister before moving into clinical and senior management roles. This included two years as clinical co-ordinator for the Midlands Centre for Spinal Injuries, a stint as Acting Executive Nurse and most recently over two years as Deputy Director of Operations. In 2005 Debbie moved to Chester as Divisional Manager for Diagnostic, Therapy and Pharmacy Services, later becoming Divisional Manager for Medicine before her appointment as Divisional Director for Urgent Care in 2010. Debbie joined SaTH as Chief Operating Officer in December 2012. Debbie has lived in Shropshire for over 30 years, and is married with two children, and one grand-daughter.

- Appointed: December 2012
- Political activity: None
- Interests declared at year end: None
- Interests expiring during the year: None

Mr Colin Ovington, Interim Director of Nursing and Quality (from 6 March 2017 until 30 April 2017)

Colin has spent 11 years of his career working at Board level in four nurse director posts in acute trusts. His career started in the North East, followed by training in Cumbria and Leeds, and jobs that took him to Derbyshire, Nottingham, London, Bedford, Stafford and Birmingham.

- Appointed: March 2017 as Interim Director of Nursing and Quality.
- Political activity: None
- Interests declared at year end: None
- Interests expiring during the year: None

Mrs Sara Biffen, Acting Chief Operating Officer (18 December 2017 –March 2018)

- Appointed: December 2017 as Acting Chief Operating Officer
- Political activity: None
- Interests declared at year end: None
- Interests expiring during the year: None

Declaration from Directors

Each Director confirms that as far as he/she is aware there is no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken "all the steps that he or she ought to have taken" to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Board Meetings

The Trust Board met eight times during the year. Meetings of the Trust Board are held in public. Board papers are published on the Trust website. Information about attendance at Trust Board meetings is included in the Annual Governance Statement at Appendix 3.

The Board received reports from the five committees chaired by the Non-Executive Directors: Audit Committee, Performance Committee (including Charitable Funds), Quality and Safety Committee, Remuneration Committee, and Workforce Committee.

In addition the Trust Board received reports from the Senior Leadership Team (chaired by the Chief Executive). These reports ensure that the Trust Board can reach informed and considered decisions and ensure the Trust meets its objectives.

Register of Interests

The Trust holds a register of interests of the members of the Trust Board. Directors are asked to declare any interests that are relevant or material on appointment and should a conflict arise during their term. The register of interests, which is updated and published annually, is maintained by the Board Secretary and available to the public via our website at **www.sath.nhs.uk** within the papers of the Trust Board meeting. A copy can be obtained from the Trust or viewed by appointment. The declarations of interests of the members of the Trust Board during the year are included from pages 28-32.

Audit Committee

The Audit Committee's chief function is to advise the Board on the adequacy and effectiveness of the Trust's systems of internal control and its arrangements for risk management, control and governance processes and securing economy, efficiency and effectiveness (value for money). The audit committee met regularly throughout the year. Chaired by Non-Executive Director Harmesh Darbhanga, the committee comprises three Non-Executive Directors (including the committee chair). The other committee members during the year were Dr Chris Weiner and Clive Deadman). Other Non-Executive Directors are welcome to attend. Committee meetings are attended regularly by the internal and external auditors, Finance Director, Director of Corporate Governance and Head of Assurance. Other Executive Directors attend by invitation. The committee met on six occasions during the year. This included one special meeting to review the annual accounts

Disclosure of Personal Data Related Incidents

The Trust takes its responsibilities for protecting patient information seriously, and we expect high standards of information governance from our staff.

There were 3 significant incidents relating to person identifiable information which were formally reported at the Trust in 2017/18.

II.1b Statement of Chief Executive and Directors' Responsibilities

Statement of the Chief Executive's Responsibility as the Accountable Officer of the Trust:

The Chief Executive of NHS Improvement in exercise of powers conferred on the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum.

These include ensuring that:

- There are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- Value for money is achieved from the resources available to the Trust;
- The expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- Effective and sound financial management systems are in place; and
- Annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....

Simon Wright, Chief Executive

Date.....25 May 2018

II.1b Statement of Chief Executive and Directors' Responsibilities

Statement of Directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- Make judgements and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts
- Assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern
- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the Board

Signed.....

Simon Wright, Chief Executive

Date.....25 May 2018

Signed.....

Jill Price, Deputy Finance Director

Date.....25 May 2018

Annual Governance Statement

The Trust has produced a full Governance Statement which details the governance framework of the Trust, including the governance responsibilities of committees, how the Trust identifies and assesses risk, the principal risks to achieving the organisational objectives, and serious incidents occurring in the last year.

The statement details how the organisation ensures the effectiveness of its systems of internal control and any issues that have occurred during the year.

This statement can be found in full in Appendix 3: Financial Statement / Annual Accounts.

II.2 Remuneration and Staff Report
II.2a Remuneration Report

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in The Shrewsbury and Telford Hospital NHS Trust in the financial year 2017-18 was in the salary banding of £170,000 to £175,000 (2016-17, £170,000 to £175,000). This was 6.89 times (2016-17, 6.99 times) the median remuneration of the workforce, which was £25,049 (2016-17, £24,666In 2017-18, 23 (2016-17, 25) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £172,000 to £306,000 (2016-17, £172,000 to £302,600).

Total remuneration includes salary, non-consolidated performance-related pay (not applicable to any member of staff in 2017-18 or 2016-17), benefits in kind as well but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Table 11.2a - 1: Salary entitlements of senior managers (members of the Trust Board). This information is subject to audit. This information has been audited.

	2017-18						2016-17					
Name and Title	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000	Salary (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £	Performance pay and bonuses (bands of £5,000) £000	Long term performance pay and bonuses (bands of £5,000) £000	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Professor Peter Latchford Chairman (to 31.12.17)	20-25	-	-	-	-	20-25	30-35	-	-	-	-	30-35
Mr Ben Reid Chairman (from 01.02.18)	5-10	-	-	-	-	5-10	-	-	-	-	-	-
Mr Simon Wright Chief Executive	155-160	-	-	-	160-162.5	320-325	155-160	-	-	-	32.5-35	190-195
Voting Directors												
Mrs Deborah Kadum Chief Operating Officer (to 17.12.17)	85-90	-	-	-	0	85-90	115-120	-	-	-	-	115-120
Mrs Sara Biffen Interim Chief Operating Officer (from 13.11.17)	40-45	-	-	-	85-87.5	125-130	-	-	-	-	-	-
Mr Nigel Lee Chief Operating Officer (from 18.02.18)	10-15	-	-	-	Not available	10-15	-	-	-	-	-	-
Dr Edwin Borman Medical Director	170-175	-	-	-	32.5-35	200-205	170-175	-	-	-	-	170-175
Mrs Deirdre Fowler Director of Nursing and Quality (from 01.05.17)	105-110	-	-	-	202.5-205	310-315	-	-	-	-	-	-
Mr Neil Nisbet Finance Director	135-140	3,800	-	-	18.5-20	160-165	135-140	1,100	-	-	-	140-145
Non-Executive Directors												
Mr Paul Cronin Non Executive Director	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Mr Harmesh Darbhanga Non Executive Director	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Mr Clive Deadman Non Executive Director	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Mr David Lee Non Executive Director	5-10	-	-	-	-	5-10	0-5	-	-	-	-	0-5
Teresa Mingay Designate Non Executive Director	5-10	-	-	-	-	5-10	0-5	-	-	-	-	0-5
Mr Brian Newman Non Executive Director	5-10	-	-	-	-	5-10	5-10	-	-	-	-	5-10
Christopher Welner Non Executive Director	5-10	-	-	-	-	5-10	0-5	-	-	-	-	0-5
Band of Highest Paid Director's Remuneration (FYE)	170-175						170-175					
Median Total Remuneration	25,049						24,666					
Ratio	6.89						6.99					

Table 11.2a - 2: Pension entitlements of senior managers (members of the Trust Board). This information is subject to audit. This information has been audited.

Name & Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2018	Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Mr Simon Wright Chief Executive	7.5-10	0	40-45	100-105	611	118	735	
Dr Edwin Borman Medical Director	0-2.5	5-7.5	75-80	225-230	1,482	119	1,615	
Mrs Deborah Kadum Chief Operating Officer (to 17.12.17)	0	0	35-40	115-120	867	0	0	
Mr Neil Nisbet Finance Director	0-2.5	2.5-5	50-55	155-160	1,021	81	1,112	
Mrs Ellen Fowler Director of Nursing and Quality (from 01.05.17)	7.5-10	27.5-30	30-35	100-105	441	201	646	
Ms Sara Biffen Interim Chief Operating Officer (from 13.11.17)	2.5-5	5-7.5	40-45	110-115	678	61	746	
Mr Nigel Lee Chief Operating Officer (from 18.02.18)	10-12.5	0	15-20	0	57	140	198	

Remuneration for directors is set by the Trust's Remuneration Committee. Director salaries are reviewed at appointment then, annually, a benchmarking exercise is undertaken to ensure remuneration remains appropriate. Remuneration figures represent actual remuneration rather than full-year effect.

II.2. Remuneration and Staff Report
II.2b Staff Report

We employ almost 6,000 staff and hundreds of staff and students from other organisations also work in our hospitals.

This report provides details about the make-up of our workforce, which at the end of 2017/18 increased by 28 to 5,931. When taking into account those employed on part-time contracts, the full-time equivalent (FTE) number increased by 21 to 5,047. Expenditure on staff accounts for approximately 67% of overall Trust expenditure, the same as the previous year. A more detailed breakdown of staff numbers can be found in the table below:

Table 11.2b – 1: Full-time equivalent (FTE) staff by group

Staff Group	FTE	Percentage
Doctors and dentists	522.90	10.4%
Nursing and midwifery staff	1429.28	28.3%
Scientific, technical and therapies staff	643.86	12.8%
Other clinical staff	1390.64	27.6%
Non-clinical staff	1059.97	20.1%
Total	**5046.65**	

The following table provides details of the number of senior managers by Agenda for Change (AfC) pay band:

Table 11.2b – 2: Senior manager by Agenda for Change (AfC) pay band. Senior managers in this instance are classed as those who are not clinically-qualified and are either a member of the Executive Team or a member of staff who reports directly to a member of the Executive Team.

Senior Managers by AfC Band	Headcount	Percentage
Band 8a	1	3.23%
Band 8b	7	22.58%
Band 8c	14	45.16%
Band 8d	8	25.81%
Band 9	0	0.00%
Personal Salary	1	3.23%
Total	**31**	

The following table provides details of the composition of staff:

Table 11.2b – 3: Composition of all staff (full and part-time)

Gender	Headcount	Percentage
Female	4749	80.07%
Male	1182	19.93%
Total	**5903**	

The following two tables show the composition of the Trust Board and senior staff at the end of the year:

Table 11.2b – 4: Composition of the Trust Directors

Role	Gender	Total
Chief Executive	Male	1
Director of Nursing, Midwifery and Quality	Female	1
Finance Director	Male	1
Medical Director	Male	1
Chief Operating Officer	Male	1
Director of Corporate Governance	Female	1
Workforce Director	Female	1
Total	**(4 male and 3 female)**	**7**

Table 11.2b – 5: Composition of senior managers

Role	Gender	Total
Senior Manager	Female	23
	Male	8
Total		31

The following table provides sickness absence data for the period from 1 April 2017-31 March 2018:

Table 11.2b – 6: Sickness absence

Sickness Absence Information	
Sickness Absence %	4.21%
% Over Target Sickness of 3.99%	0.22%
Total FTE Calendar Days Lost	77,109
Average FTE Calendar Days Lost Per Employee	15
No. Ill Health Retirements	5
No. Voluntary Resignation - Health	12

Equality and Diversity

We seek to integrate Equality and Diversity into all our service provision and staff management. To help us do this we have adopted the NHS Equality Delivery System (EDS2) and the NHS Workforce Race Equality Scheme (WRES) and we publish our results and objectives on our Trust website. We continually review our processes and activities and involve a range of stakeholders in our decision-making as well as continuing to work according to our Trust Values in all that we do.

Key activities in 2017-18 have included continuation of the Prince's Trust scheme for young people, the extension of our Values-Based Recruitment and selection programmes, increased workplace-based training opportunities (including apprenticeships, volunteering etc) and sustained engagement with community-based stakeholder groups across Shropshire, Telford & Wrekin and mid Wales.

We recognise that to make effective changes in Equality and Diversity, it must form a key element of our own performance framework. The Trust is monitored on Equality and Diversity indicators and publishes an annual update to the Trust Board each year.

We recognise the value that all our staff give to the care of our patients directly and indirectly. As one of the largest employers in the Shropshire and Telford & Wrekin area, this is reflected in the Trust employing a diverse workforce that is representative of the communities we serve.

Some Key Staff Diversity Data:

- 50% of the Trust Board is male and 50% female, of the executive directors on the Board 57.14% are female and 42.86% male
- Of the Trust's senior managers 74.19.% are female and 25.81% male
- 12% of staff identify themselves as from an ethnic minority background (compared to a local population figure in Shropshire and Telford & Wrekin of around 6.7% according to the 2011 census);
- 19.55% of staff are aged between 16 and 30 with 26.15% of staff aged between 41-50;
- 2.21% of staff identify themselves as having a disability (however 19.71% do not declare whether they do or do not have a disability, as it is not compulsory to declare this information to an employer).

Staff policies applied during the financial year

For giving full and fair consideration to applications for employment by the company made by disabled persons, having regard to their particular aptitudes and abilities:

The Trust is committed to the full and fair consideration of applications for employment from disabled people. Its policy, HR40 Employing People with Disabilities, reflects current practice in terms of a guaranteed interview scheme for applicants with disabilities who meet the essential criteria of the role. The Trust is continuing to review and cluster all its Human Resources (HR) policies to make them more user-friendly and, in particular, revised Recruitment and Equality & Diversity policies will be published during 2017-18. Equality Impact Assessments are carried out for each cluster of policies to ensure they reflect best practice in workplace standards and take into account the current legislative requirements in relation to people with disabilities. The Trust Board is committed to the Equality Delivery System (EDS2) as a means of monitoring and reporting on its progress in all protected characteristics and we are working towards the introduction of the Workforce Disability Equality Scheme (WDES) in 2018-19 to improve the experience of our staff with disabilities.

For continuing the employment of, and for arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company:

For existing staff, the Trust runs an Alternative Employment Register for those who become unable to carry out their substantive contract so they can look at all the alternative posts that are available within the Trust which match their skill set, to enable them to carry on working within the Trust. Additional supportive training is also identified on a case-by-case basis where appropriate.

Otherwise for the training, career development and promotion of disabled persons employed by the Trust:

All members of staff, regardless of disability or any protected characteristic, have access to development and training opportunities through the Trust's education programmes and this is monitored and reported annually to the Board. Access to promotion opportunities is available through the nationally recognised NHS Jobs portal for advertising of jobs.

Expenditure on consultancy

'The Trust's expenditure on consultancy for 2017/18 was £897,000 and this was predominantly payments to Meridian Productivity Ltd (Waiting List payments review) and McKinsey & Co (Community Trust bid).

Off-payroll engagements

Following the Review of the tax arrangements of public sector appointees published by the Chief Secretary to the Treasury on 23 May 2012, departments and their arm's length bodies must publish information on their highly paid and/or senior off-payroll engagements.

The Trust is required to disclose:

• All off-payroll engagements as of 31 March 2018, greater than £245 per day and that last longer than six months (see table 1 below).

• All new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, greater than £245 per day and that last for longer than six months (see table 2 below).

• Any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018 (see table 3 below).The Trust has strengthened its controls in this area and does not have any cases where assurances have not been received or terminations have taken place as a result of assurances not being received.

All existing off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 11.2b – 7: All off-payroll engagements as of 31 March 2018, of more than £245 per day and lasting longer than six months

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:	Number
Number of existing engagements as of 31 March 2017	0
Of which, the number that have existed:	
for less than one year at the time of reporting	-
for between one and two years at the time of reporting	-
for between 2 and 3 years at the time of reporting	-
for between 3 and 4 years at the time of reporting	-
for 4 or more years at the time of reporting	-

Table 11.2b – 8: All new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £245 per day and lasting longer than six months

For all new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	-
Number assessed as caught by IR35	-
Number assessed as not caught by IR35	-
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to IR35 status following the consistency review	-

Table 11.2b – 9: Off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	Number
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on-payroll and off-payroll that have been deemed Board members, and/or, senior officials with significant financial responsibility, during the financial year. This figure should include both on-payroll and off-payroll engagements.	-

Exit Packages and Severance Payments

No exit packages or severance payments were made during 2017-18. Ill health retirement costs are met by the NHS Pensions Scheme and are not considered within the Trust's Exit Packages and Severance Payments data.

Staff costs

Table 11.2b – 10: Staff costs between 1 April 2017 and 31 March 2018

Staff costs				
			2017/18	2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	170,816	1,226	**172,042**	173,214
Social security costs	17,436	-	**17,436**	16,839
Apprenticeship levy	929	-	**929**	-
Employer's contributions to NHS pensions	22,201	-	**22,201**	21,719
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff		33,387	**33,387**	23,958
Total gross staff costs	**211,382**	**34,613**	**245,995**	**235,730**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**211,382**	**34,613**	**245,995**	**235,730**
Of which				
Costs capitalised as part of assets	971	53	**1,024**	1,110

Table 11.2b – 11: Average number of employees (WTE basis) between 1 April 2017 and 31 March 2018

Average number of employees (WTE basis)				
			2017/18	2016/17
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	557	66	**623**	600
Ambulance staff	-	-	**-**	-
Administration and estates	1,031	53	**1,084**	1,017
Healthcare assistants and other support staff	1,084	158	**1,242**	1,221
Nursing, midwifery and health visiting staff	1,449	189	**1,638**	1,604
Nursing, midwifery and health visiting learners	33	-	**33**	38
Scientific, therapeutic and technical staff	582	25	**607**	601
Healthcare science staff	288	-	**288**	284
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**5,024**	**491**	**5,515**	**5,365**
Of which:				
Number of employees (WTE) engaged on capital projects	19	1	**20**	23

Table 11.b – 12: Reporting of compensation schemes, exit packages, between 1 April 2017 and 31 March 2018

Reporting of compensation schemes - exit packages 2017/18	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	-	-
Total resource cost (£)	£0	£0	**£0**

Table 11.b – 13: Reporting of compensation schemes, exit packages, between 1 April 2016 and 31 March 2017

Reporting of compensation schemes - exit packages 2016/17	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	-	-
Total resource cost (£)	£0	£0	**£0**

Tables 11.b – 14: Other (non-compulsory) departure payments

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	-	-
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Signed..... .....

Simon Wright, Chief Executive

Date.....25 May 2018

Appendix 1

Quality Account 2017/18

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Quality Account

01 April 2017 - 31 March 2018

Table of Contents

Section One: Introduction and Background

1.1 Chief Executive statement on quality

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

The Trust Board gains assurance on the work of all our staff to improve and sustain high levels of quality care through the systems and process put in place through the clinical teams and Care Groups. The Quality and Safety Assurance Committee supports this assurance process as a critical component of our governance framework. This is chaired by a Non-Executive Director which is a formal committee of the board which scrutinises the internal monitoring of care and the progress made on plans to improve.

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

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

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

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

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

Simon Wright, CEO

1.2 What is a Quality Account?

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

1.3 About the Trust

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

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

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

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

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

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

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

1.4 Our Strategy and Values

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

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

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

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

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

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

1.5 Our Partners in Care

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

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

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

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

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

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

- Local Authorities (see above)
- NHS Commissioning Bodies (see above)
- Primary care services
- Other providers of health and care services for Shropshire, Telford and Wrekin and mid Wales
- Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (specialist orthopaedic hospital)
- Shropshire Community Health NHS Trust (community services)
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust (specialist mental health and learning disabilities) (from 01 April 2018 Midlands Partnership NHS Foundation Trust)
- West Midlands Ambulance Service NHS Foundation Trust (ambulance and patient transport)
- Welsh Ambulance Services NHS Trust (ambulance and patient transport)

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

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

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

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

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

2.1 Progress against priorities for improvement 2017-2018

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

What is important is that these priorities are not only for one year – they are usually based on existing work and will continue into the future.

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

	to.	their families know when they are due to go home.
We will make sure that we prepare people correctly before they go home – for example teaching them about new medication or ensuring that they can dress themselves or make a cup of tea safely	We will make sure that everything they need is ready for them, including medication, information and equipment which is part of the R2G work.	Patient journey facilitators continue to receive positive feedback from patients / relatives and the ward teams they are supporting. This team who were primarily refocusing and concentrating on nine ward areas across both hospitals, a mix of care group wards, are also supporting other wards as capacity allows e.g. ward 21, and 22 S and R. The SAFER principles and Red2Green toolkit has been relaunched, along with monthly road shows to help embed the concept and fortnightly corporate induction presentations. We see fewer delays due to lack of medication or equipment that we are responsible for providing due, in part, to the work of the R2G Patient Journey Facilitators. The national inpatient survey tells us that we are "about the same" as other acute providers in this respect.
We want to make sure that we liaise correctly with other care providers so that people's needs are met when they go home and that they do not come to any harm because we have not done so	Where necessary we will speak to other providers (such as district nurses) who may be supporting people at home to make sure that they are ready	We aim to liaise with our colleagues in other care providing organisations such as Shropshire Community Health NHS Trust who provide district nursing care to ensure that people get the support that they need when they get home. .We will continue to work with our partners to ensure that everyone is discharged from hospital with a plan of care that is appropriate for their needs and measure our progress through the results of the National inpatient survey, which in 2016 was 6.1/10 –

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

Priority Two: Making it possible for people to tell us their stories to help us improve their care NHS Outcomes Framework Domain 4: Ensuring people have a positive experience of care Strategic Priority: Embed a customer focussed approach and improve relationships through stakeholder engagement strategies		
Why is this a priority for us? We have used feedback in the form of patient stories for some	**What will success look like?** We will have a variety of methods to capture patient	**How have we done?** We are using video to capture stories, and are training staff to

time at our Trust Board meetings. We think that we can do more to capture the views of people or their families that have used our services, not only when things have gone well but where they think their feedback will show us where we can improve. Patient stories are just one way of patients, their families and carers telling us what they think of their experience of our services but it is one that we will concentrate on this year to further develop this valuable feedback method. We will continue to ask people about their experience of our services through local surveys, the Friends and Family Test and through our Complaints and PALS service.	stories – for example by video, in person, in writing and through feedback to our partners. We will make sure that if someone wishes to provide feedback we will work with them to do this in the best way for them We will ensure that if a patient story is presented to a group of people such as the Trust Board that we will show how we have made changes or have actions to carry out as a result of that feedback so that we can really demonstrate a difference that the feedback has made. The Board are able to follow up on the actions from feedback from the Care Groups, through visits to clinical areas and analysis of patient feedback. We will work with a variety of other groups such as Healthwatch or the Young Health Champions to make sure that people who sometimes do not get their voices heard are able to do so	do this using Trust equipment such as iPads. Patient representatives are part of the Transforming Care Partnership teams providing valuable patient perspectives to help us improve. Staff across the Trust have completed Story Telling training facilitated by patient leaders, and are actively encouraged to gather stories when appropriate. We are exploring different ways of closing the loop and ensuring that staff and public are aware of improvements made as a result of feedback. One way we do this is through the results of nationally and locally led surveys We are going out to seldom heard groups to gather feedback and will continue to strengthen links with local communities.

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

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

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

2.2 Our "Safest and Kindest" Quality Improvement Action Plan

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

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

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

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

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

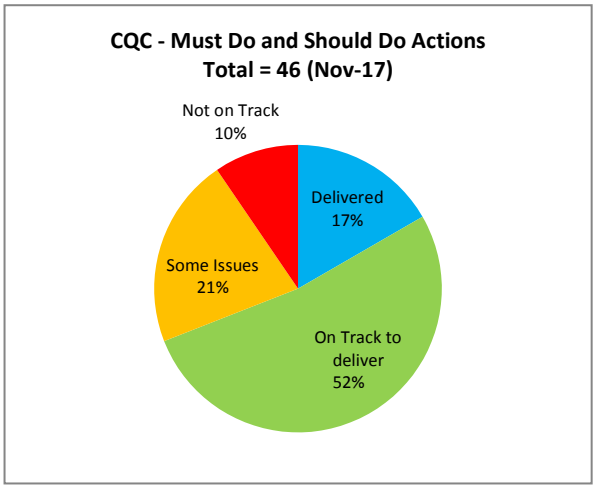
The "Safest and Kindest" Quality Strategy 2017-2018 identifies what Shrewsbury and Telford Hospital intends to achieve in terms of quality and safety. The 'Safest and Kindest" Quality Improvement Plan' denotes how this will be achieved and a Standard Operating Procedure (SOP) has been devised to provide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

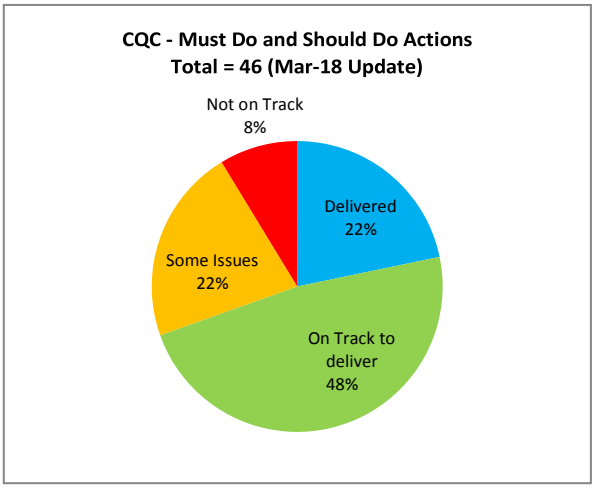
- Trust overarching CQC plan
- Maternity and Gynaecology and Paediatrics
- Medicine
- Surgery
- Critical Care
- End of Life Care
- Children and safeguarding
- West Midlands Quality Review Service reviews.

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

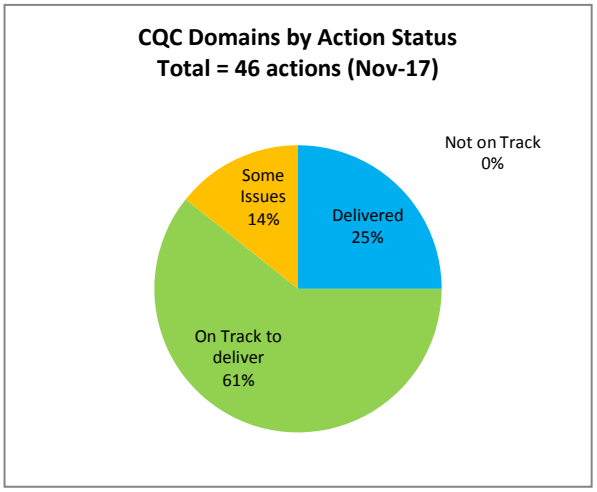
accordance with the domain. In addition, each action has been identified with a CQC theme so the Trust can identify trends and the top five themes.

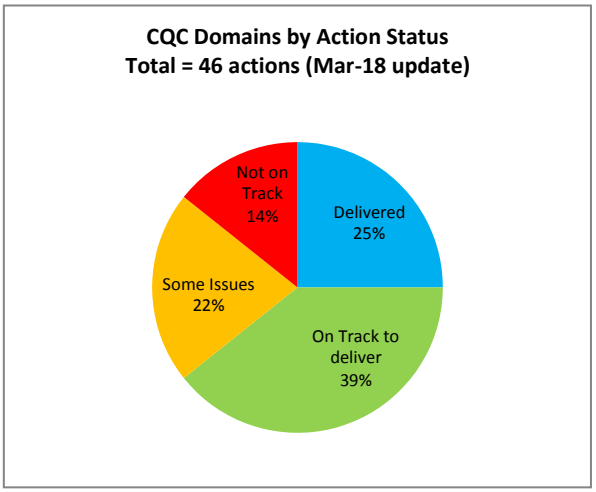
November 2017 v March 2018 comparison – CQC "Must do" and "Should do" actions by status



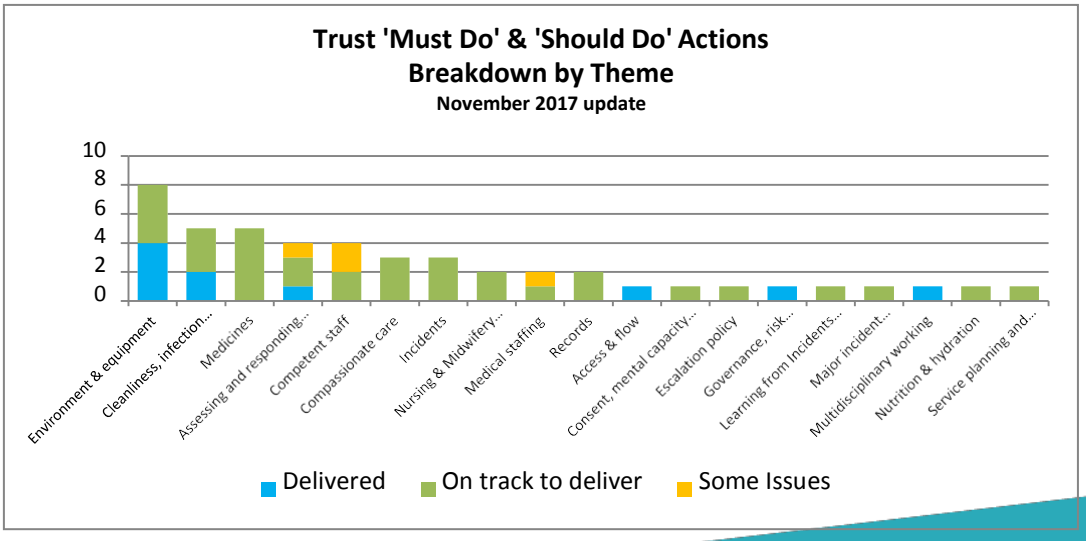


November v March comparison – CQC Domains by Actions status





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



Reasons for "Not on Track" in March 2018:

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

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

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

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

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

2.3 National Quality Indicator results

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

Indicator	2017/18	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17
The value and banding of the summary hospital level mortality indicator (SHMI) for the trust for the reporting period	62	65	87	48	Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: this figure falls within the "as expected" category Shrewsbury and Telford Hospital NHS Trust has taken the actions highlighted elsewhere in this Quality Account to improve services and therefore this rate.	64
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period	17.51	30.56	67.52	9.49	Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: we review all data regularly. Shrewsbury and Telford Hospital NHS Trust has taken the actions to improve this percentage and the so the quality of services by continuing to place utmost importance on high quality of care to palliative patients	21.27
The Trust's reported outcome measure scores for: Groin hernia surgery Varicose vein surgery Hip replacement surgery Knee replacement surgery	 0.102 0 0.417 0.335	 0.089 0.096 0.448 0.324	 0.140 0.134 0.536 0.404	 0.055 0.068 0.31 0.242	Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: Patient Reported Outcome Measures are an important way that we measure how well a patient feels the procedure went and how it has impacted on their life Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this indicator and so the quality of services by: encouraging patients to complete the questionnaires following the procedure and using the information to develop our services further	 0.159 0.152 0.563 0.434
The percentage of patients aged: 0-15 and	 10.86	 8.17	 16.14	 0.10	Shrewsbury and Telford Hospital NHS Trust considers that these percentages are as described for the following reasons:	 9.90

Indicator	2017/18	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17
16 and over Readmitted to a hospital which forms part of the trust within 28 days of the being discharged from a hospital which forms part of the Trust	7.90	7.41	10.68	3.58	In common with other Trusts, a large number of readmissions are not related to the previous episode of care. The Trust has taken the following actions to improve these percentages and so the quality of its services: By individualised care pathway management to ensure that people go home at the right time with the right support in place	7.66
The Trust's responsiveness to the personal needs of its patients during the reporting period *(Most recent data available on the HSCIC website dated May 2018)*	68.2		86.2	54.4	Shrewsbury and Telford Hospital NHS Trust considers that this data is as described for the following reasons: The score is a composite of five of the areas explored in the inpatient survey commissioned by the CQC every year. Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve the indicator and percentage and so the quality of its services by collecting and analysing information across a range of services and patient groups and taking action where indicated.	
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends ***Qtr 2 1st July - 30th September 2017-2018***	62	80	100	43	Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: Our annual staff survey 2017 also highlighted a decreasing score for this specific advocacy question Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage and so the quality of its services, by: A full staff survey action plan has been approved by Trust Board and aims to focus an organisational wide response to address and improve specific key findings	80
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period	95.58	95.00	99.90	93.47	Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: VTE assessment is embedded practice that is closely monitored and followed up routinely by the clinical teams. Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage and so the	95.68

Indicator	2017/18	National Average	Highest Performer	Lowest Performer	Trust Statement	2016/17
					quality of its services by continuing with the monitoring of compliance and ensuring that clinical teams are aware of the requirement to continue with this to ensure we comply	
The rate per 100,000 bed days of cases of C Difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	11.74	12.46	87.60	1.30	Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: We monitor and report C Diff infection incidence on a monthly basis. Shrewsbury and Telford Hospital NHS Trust has taken the following actions to improve this percentage and so the quality of its services by continued vigilance around infection prevention and control processes and mandatory training for staff	6.99
Number of patient safety incidents	5505	5,226	15228	1133	Shrewsbury and Telford Hospital NHS Trust considers that this percentage is as described for the following reasons: The Trust continues to develop an improving reporting culture 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
Rate of patient safety incidents per 100 admissions	44.63	42.84	111.69	23.47		35.93
Percentage of patient safety incidents that resulted in severe harm or death	0.18	0.4	1.98	0.0		0.0
Friends and Family Test covering services for inpatients and patients discharged from A&E family or friends. AE: Percentage Recommended Trust	94	85	100	67	Shrewsbury and Telford Hospital NHS Trust considers this data is as described for the following reasons: the percentage of people responding to the Friends and Family Test is monitored by the Trust on a monthly basis. 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.	96
Friends and Family Test covering services for inpatients and patients discharged from A&E family or friends. INPATIENTS: Percentage Recommended Trust	98	96	100	82		99
Friends and Family Test covering services						

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

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

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

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

We have mapped our Quality Priorities against the three domains of Quality – Patient Safety, Clinical Effectiveness and Patient Experience. We have included information about how we aim to improve against these domains in our Quality Strategy "Safest and Kindest Every Day".

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

	Learning faster and better - to improve the learning from incidents especially those considered to be near miss or low harm to reduce the number of moderate and severe harm incidents	Complete the review of all incidents that have not been reviewed over winter 2017-2018 and develop clarity of understanding of themes and trends Increase incident reporting across the Trust Value Stream #5 will develop incident reporting by improving processes	Reduction of moderate and severe harm caused compared to 2017-2018 5% reduction in the number of reported: • High risk medication errors • Falls resulting in moderate or severe harm • Hospital acquired pressure ulcers
	All wards and clinical areas have safety huddles embedded as practice	Carry out baseline assessment of each ward and clinical areas practice of huddles to get a view of current state and to develop implementation plan Implement huddles in all clinical areas with agreed standard items for discussion Ensure learning from Value Stream #5 is rolled out in PDSA process	Reduction in incidents Improved patient experience scores Staff report better feedback from incidents

Domain	What do we want to do better?	How are we going to do that?	How will we know when we have?
Effectiveness	**NHS Outcomes Framework:** Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm Domain 3: Helping people to recover from episodes of ill health or following injury **SaTH Strategic Objective 2018-2019:** **PATIENT AND FAMILY** Listening to and working with our patients and families to improve healthcare **SAFEST AND KINDEST Our patients and staff will tell us they feel safe and received kind care**		
	Eliminate the practice of additional patients being placed inappropriately	Timely, safe discharge before lunchtime so that beds are available	Reduction in additional patients Improved satisfaction

		for patients coming into the hospital	Reduced complaints
	We have fewer patients who are in hospital for six or more days (Reduction of stranded patients)	Discharge planning begins on admission with an estimated date of discharge agreed Links to collaborative working with the patient and their family	Length of stay Patient feedback Reduction in patients medically fit but still in hospital

Domain	What do we want to do better?	How are we going to do that?	How will we know when we have?
Experience	**NHS Outcomes Framework:** Domain 4: Ensuring that people have a positive experience of care **SaTH Strategic Objective 2018-2019:** **PATIENT AND FAMILY** Listening to and working with our patients and families to improve healthcare		
	Coproduction is business as usual within the Trust	In 2018-2019 develop the links with the patient panel and agree on process for coproduction across areas of the Trust including service development, attendance on committees and groups, taking part in Exemplar and other clinical walkabouts	The Patient Panel new group will be set up ToR agreed Areas of responsibility agreed Examples of outputs
	Support for Carers	Work collaboratively with the carers of people with long term conditions and who are at the end of their lives to develop strategies to help them whilst their family member is in hospital	Agreed strategies will be achieved and examples can be given.

	Improved communication on the wards so that patients and their carers are aware of and are fully involved in their plans of care and the arrangements for discharge	Knowing who the ward manager is on the ward they are on Nurse in charge of the shift does rounds of patients at least twice a shift including when visitors are there so that they can answer any questions and ensure that planning is collaborative	Point prevalent survey to measure effectiveness FFT responses In patient survey
	Improved experience of ED	Better flow through the department Reduce 12 hour waits Ensure regular rounds when in ED	Measure experience of patients in ED

2.5 Statements of Assurance

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

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

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

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

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

Participation in Clinical Audits

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

National Clinical Audit and the Patient Outcome Programme (NCEPOP)

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

During 2017-2018 there were 64 national clinical audits and national confidential enquiries that covered services that Shrewsbury and Telford Hospital NHS Trust provides.
During that period Shrewsbury and Telford Hospital NHS Trust participated in 54 national clinical audits and five national confidential enquiries in which it was eligible to participate.

Key:

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

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

National Clinical Audit or Confidential Enquiry		*Eligible*	*Participating*	*Submission rate (%) / Comment*
Acute Myocardial Infarction (MINAP)*		✓	✓	100%
Adult Cardiac surgery*		×	N/A	Not applicable
ANS and BSCN standards for intraoperative monitoring (IOM) for Spinal Deformity Surgery		×	N/A	Not applicable
Anxiety and Depression*		×	N/A	Not applicable
British Association of Urological Surgeons	Cystectomy*	✓	✓	100%
	Nephrectomy audit*	✓	✓	100%
	Percutaneous Nephrolithotomy (PCNL)*	✓	×	Awaiting reply
	Radical Prostatectomy Audit*	✓	✓	100%
	Female Stress Urinary Incontinence Audit*	×	N/A	Not applicable
	Urethroplasty Audit*	×	N/A	Not applicable
British Thoracic Society (BTS)	Asthma (adult) - BTS	✓	✓	100%
	Bronchiectasis (adult)	✓	✓	100%
	Bronchiectasis (paediatric)	✓	×	Problems with identification of patients
	Bronchoscopy	✓	✓	89% PRH; 97% RSH
Breast and Cosmetic Implant Registry (BCIR)		✓	✓	100%
Cardiac Rhythm Management Audit (CRM)*		✓	✓	100%
Care in Emergency Departments (CEM)	Asthma (adult & paediatric)	✓	✓	100%
	Consultant sign-off in the A&E Department	✓	✓	100%
	Fractured Neck of Femur	✓	×	Data being collected locally for comparison
	Pain in Children*	✓	×	
	Procedural Sedation in Adults*	✓	×	
	Severe sepsis & septic shock	✓	✓	100%
Case Mix Programme (CMP)*		✓	✓	100%
Child Health Clinical Outcome Review Programme (NCEPOD)	Cancer in Children, Teens and Young Adults*	✓	×	No eligible cases
	Children with Chronic Neurodisability*	✓	✓	100%
	Young People's Mental Health*	✓	✓	83%
Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Primary Care*	×	N/A	Not applicable
	Pulmonary rehabilitation*	×	N/A	Not applicable
	Secondary Care*	✓	×	Ongoing data collection – data clerk being recruited
Congenital Heart Disease (CHD)		×	N/A	Not applicable
Dementia in General Hospitals*		✓	✓	100%
Elective surgery (National Proms Programme)*		✓	✓	100%

National Clinical Audit or Confidential Enquiry		*Eligible*	*Participating*	*Submission rate (%) / Comment*
Endocrine and Thyroid National Audit*		✓	✓	100%
Falls and Fragility Fractures Audit programme (FFFAP)	Fracture Liaison Service Database*	✓	×	
	Inpatient Falls*	✓	✓	100%
	National Hip Fracture Database (NHFD)*	✓	✓	On-going
GIRFT (Getting It Right First Time) Surgical Site Infection		✓	×	Data presented locally due to problem submitting data to GIRFT and lack of advice regarding this
Head & Neck cancer (Saving Faces)*		✓	✓	On-going
Heart Failure Audit*		✓	✓	100%
Inflammatory bowel disease (IBD) Registry, Biological Therapies Audit*		✓	×	
Investigation and Detection of urological Neoplasia in patients referred with suspected Urinary Tract Cancer (IDENTIFY)		✓	×	Consultants not aware of audit
Learning Disability Mortality Review Programme (LeDeR)*		✓	✓	100%
Major Trauma Audit (TARN)*		✓	✓	100%
Management of Intra-abdominal sepsis - one-off project		✓	×	Lead surgeon and Research manager not aware of this research project
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Maternal mortality surveillance and mortality confidential enquiries*	TBC	TBC	Awaiting reply
	Perinatal Mortality Surveillance*	✓	✓	100%
	Maternal morbidity confidential enquiries*	TBC	TBC	Awaiting reply
Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	Acute Heart Failure*	✓	✓	100%
	Non-invasive ventilation*	✓	✓	33%
	Perioperative diabetes*	✓	✓	Currently submitting data
Mental Health Clinical Outcome Review Programme	Safer Care for Patients with Personality Disorder (NCISH)*	×	N/A	Not applicable
	Suicide in children and young people (CYP) (NCISH)*	×	N/A	Not applicable
	Suicide, Homicide & Sudden Unexplained Death (NCISH)*	×	N/A	Not applicable
	The Assessment of Risk and Safety in Mental Health Services (NCISH)*	×	N/A	Not applicable
National Audit of Breast Cancer in Older People (NABCOP)*		✓	✓	On-going
National Audit of Care at the End of Life (NACEL)		✓	✓	Currently collecting data
National Audit of Intermediate Care (NAIC)*		×	N/A	Not applicable
National Bariatric Surgery Registry (NBSR)*		✓	✓	100%
National Bowel Cancer (NBOCA)*		✓	✓	100%

National Clinical Audit or Confidential Enquiry		Eligible	Participating	Submission rate (%) / Comment
National Cancer Diagnosis Audit (NCDA)		×	N/A	Not applicable
National Cardiac Arrest Audit (NCAA)*		✓	✓	100%
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)*		×	N/A	Not applicable
National Clinical Audit of Psychosis	core audit*	×	N/A	Not applicable
	EIP spotlight audit*	×	N/A	Not applicable
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)*		×	N/A	Not applicable
National Comparative Audit of Blood Transfusion programme	Audit of Transfusion Associated Circulatory Overload (TACO)*	✓	✓	100%
	Audit of Patient Blood Management in Scheduled Surgery*	✓	✓	100%
	Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients*	✓	✓	100%
National Diabetes Audit - Adult	Core Diabetes Audit*	✓	×	The information required cannot be extracted from our existing databases
	Foot Care Audit*	✓	×	Did not participate
	Inpatient Audit (NaDia) 2016*	✓	✓	100%
	Inpatient Audit (NaDia) 2017*	✓	✓	100%
	Pregnancy in Diabetes	✓	✓	100%
	Transition*	TBC	TBC	Awaiting reply
National Emergency Laparotomy audit (NELA)*		✓	✓	100%
National Joint Registry (NJR)*		✓	✓	100%
National Lung Cancer Audit (NLCA)*		✓	✓	100%
National Maternity and Perinatal Audit (NMPA)*		✓	✓	100%
National Maternity Survey 2017		✓	✓	46.2% return rate
National Paediatric Diabetes Audit (NPDA)*		✓	✓	Awaiting reply
National Vascular Registry*		✓	✓	100%
Neonatal intensive and special care (NNAP)*		✓	✓	Numbers are variable depending on the audit indicator
Neurosurgical Audit Programme*		×	N/A	Not applicable
Oesophago-gastric Cancer (NAOGC)*		✓	✓	100%
Ophthalmology Audit (cataract)*		✓	✓	100%
Paediatric intensive care (PICaNet)*		×	N/A	Not applicable
Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)*		×	N/A	Not applicable
Perioperative Quality Improvement Programme		×	N/A	Not applicable
Prescribing Observatory for Mental Health (POMH-	Assessment of side effects of depot and LA	×	N/A	Not applicable

National Clinical Audit or Confidential Enquiry		Eligible	Participating	Submission rate (%) / Comment
UK)	antipsychotic medication*			
	Monitoring of patients prescribed lithium*	×	N/A	Not applicable
	Prescribing antipsychotics for people with dementia*	×	N/A	Not applicable
	Prescribing for bipolar disorder (use of sodium valproate)*	×	N/A	Not applicable
	Prescribing high-dose and combined antipsychotics on adult psychiatric wards*	×	N/A	Not applicable
	Prescribing Clozapine*	×	N/A	Not applicable
	Rapid tranquilisation*	×	N/A	Not applicable
	Use of depot/LA antipsychotics for relapse prevention*	×	N/A	Not applicable
Prostate Cancer Audit*		✓	✓	100%
Pulmonary Hypertension		×	N/A	Not applicable
Seizures and Epilepsies in Children and Young People (Epilepsy12)*		✓	✓	Awaiting reply
Sentinel Stroke National Audit Programme (SSNAP) *		✓	✓	On-going
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme*		✓	✓	100%
Seven Day Hospital Services Self-Assessment Survey		✓	✓	100%
Surgical Site Infection Surveillance Service		✓	✓	100%
UK Cystic Fibrosis Registry		×	N/A	Not applicable
UK Parkinson's Audit*		✓	✓	100%
6th National Audit Project of the Royal College of Anaesthetists - Perioperative Anaphylaxis in the UK		✓	×	No eligible cases

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

Examples of actions taken following national audits		
Title		Action
Care in Emergency Departments (CEM)	Asthma (adult & paediatric)	• The outcomes of the audit were discussed at a cross site Consultant meeting and actions identified to ensure that medication is given appropriately and in a timely way.
	Consultant sign-off in the A&E Department	• New Cas card completed which includes consultant sign-off. These are now in use.
	Severe sepsis and septic shock	• We have 98% of staff that have completed the sepsis booklet with the remaining either on long term sick or maternity leave at present. • There has been a sepsis training session over 3 days that covered all of the staff including regular bank staff • Transforming Care Institute have a Value Stream dedicated to improving the care of patients with sepsis
Dementia in General Hospitals*		• A trial to introduce and promote the use of Butterfly boxes

Examples of actions taken following national audits		
Title		***Action***
		(snack boxes) is currently taking place and is planned to be rolled out throughout the Trust. • To ensure all staff are using an appropriate pain assessment (Abbey pain scale) where appropriate a video has been uploaded on to the intranet page, training undertaken on wards and newsletters have been developed to include this. • To improve the Patient living with Dementia and carers experience, we plan to engage with carer's networks and hand out carer's information packs /discharge leaflet. • To become a Dementia Friendly Community & Environment, we are planning to introduce dementia friends training on a monthly basis
Learning Disability Mortality Review Programme (LeDeR)*		• Increased training in Capacity Assessment and documentation. • Reported via Trust Mortality Group to Quality and Safety Committee
Major Trauma Audit (TARN)*		• Junior doctors teaching includes major trauma assessment. • Silver trauma issues communicated with all ED STAFF and speciality doctors including surgical and orthopaedic team.
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE)	Perinatal Mortality Surveillance*	A detailed action plan has been developed, and progress with this is updated on a quarterly basis. Some of the action points include: • All maternity staff received additional training around symphyseal fundal height measurement in the identification of FGR during 2016/17. A workbook with assessment has been developed and will be launched in April 2018 in order to reinforce their training • SaTH are in the process of recruiting two WTE in order to enable the 3rd trimester scan recommendations within RCOG guidance. • Educating women to contact maternity services and attend promptly if they are concerned about a reduction and/or a change in the pattern of in fetal movements has been prioritised. • 'How active is your baby' leaflet is now provided within the mid trimester information pack (24-28 weeks gestation) to all women. • Midwives have been educated on both the reduction **and** change in pattern of fetal movements. • There has been a complete review of fetal monitoring in labour since 2016 with an emphasis on improved training. All staff members required to assess CTGs are trained in the relevant aspects of CTG interpretation • Consistent and regular monitoring of the fetal heart during the transfer from an MLU to the Consultant Unit since 2017. • Initiation of a Birth Options clinic since January 2018 that allows exploration of women's views around their birth choice and then a clear record of agreed decisions. • Improved alignment of midwifery and medical handovers with an improvement in the quality and completeness of clinical information shared at handover. Further work around the improved use of SBAR will take place in 2018.

Examples of actions taken following national audits		
Title		***Action***
National Diabetes Audit - Adult	Inpatient Audit (NaDia) 2016*	• Intervention and education taking place through diabetes in reach • Online modules for the safe use of insulin are now available.
National Lung Cancer Audit (NLCA)*		A detailed action plan has been developed, which includes the following actions: • Performance status assessment and potential radiological diagnoses of lung cancer to be documented during the MDT • A deep dive audit is planned to further investigate patients whose potential performance status deterioration impacted on ability to undergo anti-cancer treatment • To investigate ways in which patients diagnosed via emergency routes can be reduced, there will be a meeting with CCG's to discuss the possibility of piloting CT screening of targeted populations locally • To implement the National Optimal Lung Cancer Pathway (NOLDP) the following actions will be undertaken: - Set up working group to process map current pathway and identify areas that would need addressing in order to meet requirements - Business case for two additional lung cancer nurse specialists to meet this part of requirements - Set up Nurse Led Follow-Up Clinics - Develop nodule pathways
Neonatal intensive and special care (NNAP)*		• Plan for improvement in admission temperature and 2 year follow-up rates. These domains have shown substantial improvement in 2017 compared to 2016. • Need to increase rate of Magnesium sulphate administration to mothers of babies delivering before 30 weeks of gestation. This has been highlighted to the Obstetric team (who are responsible for the delivery of this intervention to mothers).
Surgical Site Infection Surveillance Service		• All Surgical Site Infections: A review of the patient is carried out, looking at pre, intra and post operation risk factors, once completed the consultant and ward mangers are asked to comment. • High Infection rates are reviewed over time, looking for common links and trends.

Reviewing reports of local clinical audits

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

Summary of examples of actions taken following local audits	
Audit Title	***Recommendations / Actions***
CLINICAL SUPPORT - PATHOLOGY & RADIOLOGY	
Anatomical Marker, Jul-Dec 2017 (3982)	• RSH x-ray department has purchased generic anatomical markers for every general x-ray room • Findings of the audit were discussed at staff meetings to

Summary of examples of actions taken following local audits	
Audit Title	***Recommendations / Actions***
	encourage the use of anatomical markers • A re-audit is planned to ensure improvements have been made
Ankle Audit 2017 (3981)	• Written positioning techniques and suggested improvements were produced and emailed to every Radiographer. A hard copy is available for reference in each general department • A pictorial 5 point checklist was emailed to Radiographers
CT Doses re-audit (3791)	• A Diagnostic Reference Level (DRL) for SaTH Low Dose Lung nodule CT will be included within 6 months
CT KUB imaging (3939)	• Poster showing accepted levels for the scan has been produced and displayed in the department • A re-audit has been undertaken
Familial hypercholesterolaemia – NICE Quality Standard 41 (3828)	• Staff were reminded to annotate in notes when dietary literature is given to patients and to discuss with females who are on medication re potential pregnancy • A re-audit is planned as per NICE 5 year rolling programme
Hand Imaging 2016 (3980)	• Written positioning techniques highlighting the appropriate anatomy imaged were produced and emailed to every Radiographer. A hard copy is available in each general department • Examples of images showing optimum and poor position were produced and emailed to every Radiographer • A separate audit of general use of anatomical markers was produced
Reporting times for major trauma 2017 (3918)	• Significant improvement since last year. • Outsourced reporting has now commenced therefore a re-audit is planned for next year for comparison.
CLINICAL SUPPORT - PHARMACY	
Are in-patients provided with enough information about their medicines? re-audit (3323)	• Discussion with pharmacist educational interventions program (PEIP) staff and questions amended • Further study/research to be undertaken by Aston Undergraduate to further understand the barriers
CLINICAL SUPPORT - THERAPIES	
Dietitian Home Enteral Feeding (HEF) service for children (3439)	• Referrals to clinic have been reviewed and prioritised • A re-audit is planned
Physiotherapy assessment of all patients aged 65 and over, and all patients aged 50-64 deemed high risk of falling on Medical Wards at the Royal Shrewsbury Hospital, NICE Clinical Guideline CG161 (3882)	• Training has been provided to all physiotherapy staff on Medicine on the correct completion of social histories. This training is on-going and is now provided to all new starters. • A plan to produce a 'user guide' for therapists in the frailty team, which will include referral pathways, such as falls services • Training to the physiotherapy medical team at RSH is planned and will include a rotational training program • A re-audit is planned
CORPORATE – TRUST WIDE	
DCT and AND Audit – 2017 (3752)	• On-going educational sessions are planned to promote use of MCA form 1 &2 to evidence capacity decisions in training across the Trust • Further discussions are to be held to consider the implementation of ReSPECT across the healthcare economy. • A re-audit has been undertaken

Summary of examples of actions taken following local audits	
Audit Title	***Recommendations / Actions***
Deprivation of Liberty Safeguards – referrals (3957)	• The practice of safe bays within the Trust on some wards has not significantly reduced the Deprivation of Liberty Safeguards referrals for urgent authorisations. There will be continuous monitoring through re-audit
End of Life 2017 (3821)	• A new version of the End of Life Care Plan will be implemented in Spring 2018 • A re-audit is planned following implementation of the new documentation
SCHEDULED - ANAESTHETICS, THEATRES & CRITICAL CARE	
Deaths following anaesthesia (2156)	• The Trust has commenced a new mortality review process. Any anaesthesia-related issues will be highlighted in the new process by the respective care group.
Epidural/Dural Tap re-audit 2016 (3809)	• A questionnaire has been designed, in consultation with the labour ward manager and the postnatal ward manager, and with the other obstetric anaesthetists. It is implemented, and a box is on the postnatal ward for this purpose.
Handover of post op patients to recovery staff (3782)	• Feedback to anaesthetics team that recovery staff would like slightly more information on anaesthetics problems, intra-operative problems and the post-operative plan particularly for frail and complex patients • A re-audit is planned
Management of Accidental Dural puncture and its outcome in obstetrics re-audit (3722)	• A questionnaire has been designed, in consultation with the labour ward manager and the postnatal ward manager, and with the other obstetric anaesthetists. It is implemented, and a box is on the postnatal ward for this purpose.
SCHEDULED - HEAD, NECK AND OPHTHALMOLOGY	
Dental abscess management (3697)	• Further advanced airway management training is in place to support the anaesthetists
NHSLA Casenote & Stamp Max Fax 2016 (3692)	• Systematic checking of notes ideally to ensure that entries are as consistent and detailed as possible • A re-audit is in-progress
Surgical management of OME – NICE Clinical Guideline CG60 (3398)	• Encouraging examination of general ENT health and developmental status in children with OME is now part of CPD • A proforma for use in clinic to ensure NICE guidelines are met is under development • A re-audit is planned as per NICE 5 year rolling programme
Timing of audiometry before middle ear surgery (3432)	• A check at pre-assessment with a trigger to refer to audiology if >3months since last audiogram has been introduced • Arrangements are underway for morning slots for patients on the day of surgery are being
SCHEDULED - MSK	
Accuracy of hip fracture classification for National Hip Fracture database (NHFD) (3598)	• A hip fracture poster and NHFD categories poster has been displayed in the T&O meeting room & theatre coffee room • A local teaching session with junior doctors and nurses responsible for NHFD coding, focus teaching on areas identified has taken place • A re-audit is planned
Outcomes against National Hip Fracture Database (NHFD) (3614)	• A single page guideline for the management of hypotension based on NICE guidelines to guide junior doctors called to see

Summary of examples of actions taken following local audits	
Audit Title	***Recommendations / Actions***
	patients with fractured neck of femur has been produced • During winter additional physiotherapy will be available at weekends from November to April
Telephone follow up hip and knee arthroplasty (3967)	• Telephone follow up has proven safe and effective, and arrangements have been made for this service to continue
Transfusion rate in hemiarthroplasty for hip fracture – NICE Clinical Guideline CG124 (3732)	• There is now an extended Trauma theatre session on a Thursday evening to accommodate these patients in accordance with national guidelines
SCHEDULED - SURGERY, ONCOLOGY & HAEMATOLOGY	
Bladder CBCTS – 109 (3891)	• Bladder protocol and associated documentation have been reviewed • A re-audit is planned
CT 7 3 2d1R – 95 (3797)	• T quality system has been fully updated to conform to changes in BSI standard
Endoscopy Unit Patient Satisfaction Questionnaire (10) - re-audit (3768)	• Bookings have now become centralised at RSH and under one management who have the overall responsibility of all endoscopy bookings. Endoscopy unit managers and the bookings teams work closely together to ensure an efficient service • Unit managers have reviewed patient information leaflets sent regarding delays and dietary advice
Management of Suspected Neutropenic Sepsis against NICE Guidance and Trust Policy (3348)	• The Acute Oncology Team are developing a risk assessment tool recommending when to change from IV to oral antibiotics in low risk patients
NHSBSP guidelines and use of vacuum-assisted excision (VAE) for B3 pathology - a 5 year audit (3715)	• This audit demonstrates that this saves money and reduces the steps in the patient's pathway. Therefore full implementation is planned
Surgical Casenote Audit 2017 (3723)	• Senior review of medical notes during and after ward rounds to take place • Regular reminders to staff members about GMC guidelines with results that failed to meet standards • An annual re-audit is planned
Use of biphosphonates in patients with newly diagnosed multiple myeloma - re-audit (3807)	• Document reasons for choice of bisphosphonate in letters/notes if NOT using zolendronic acid • Documenting creatinine clearance and dose adjustments in notes is on-going
Weekend Handover of Surgical Inpatients (3765)	• Rota change implemented to move "twilight" junior doctors shifts (across all junior doctor grades) back to Fridays to allow more effective clinical handover between staff directly involved in weekend on call shifts • Implementation of new handover process and documentation is planned
UNSCHEDULED – EMERGENCY ASSESSMENT & MEDICINE	
Assess completion of diabetic foot examinations within 24 hours of admission (3501)	• Nursing admission document has been amended to include foot assessment in patients with diabetes • A teaching session has been added to the FY1 and FY2 training programme and raised at governance. • A re-audit is planned
Headaches – NICE Clinical Guideline CG150 (3829)	• Creation of a Headache letter template • A re-audit is planned as per Trust NICE 5 year rolling

Summary of examples of actions taken following local audits	
Audit Title	***Recommendations / Actions***
	programme
HPA Urine Compliance - 2016 PRH (3607)	• ED Cas Cards have been updated to include a section for urine dip stick testing
Mental Health in Emergency Department (3859)	• ED Cas Cards have been updated to include a Mental Health section
Think Glucose - patient experience survey 2014 - re-audit (3052)	• On-going ward nurse training is reinforced by study days, general training and opportunistic ward teaching
VTE Assessments on AMU: A Snapshot Audit (3822)	• Two consultant acute physicians on both sites do a full ward round of the AMU and ensure the VTE assessment is done on seeing the patient • New care bundle (post take ward round bundle) has been placed in the post take ward round section of the medical assessment document to ensure it has been completed
WOMEN & CHILDREN'S	
Child Protection 2016 re-audit (3676)	• Regular checks on documentation will now form part of a quality improvement programme • A re-audit is planned
Completion of Local Safety Standards for Invasive Procedures (LOCSSIPs) in gynaecology clinics 2017 (3741)	• Juniors were given a short teaching session on the correct completion of gynaecology LOCSSIPs forms • A re-audit has been planned
Compliance of completion of Local Safety Standards for Invasive Procedures (LocSSIP) documentation (3840)	• Results have been displayed on the communication board on the neonatal unit and presented to Neonatal-Maternity Governance • The proforma has been modified and has now been implemented
Failed Outpatient Hysteroscopy (3671)	• To identify likely difficult patients (using TCI form) – procedure to be assigned to a particular clinician/ allocate extra time for this patient /book for hysteroscopy under GA. This is done at present due to increase awareness • A re-audit is planned
Infants at risk of perinatal transmission of blood-borne viruses (3813)	• Maternity are in the process of streamlining neonatal alerts for Hep C in 'high risk' women
Inotrope treatment episodes NNU Time to treat & choice of treatment (3837)	• Education for neonatal team for persistent pulmonary hypertension (PPHN) & inotrope use is to be scheduled in teaching programme • Pharmacy have amended the labels to include time of prescription. This is in the process of being implemented • To ensure urgent medications and emergency situations are prioritised during handover periods, this has been shared as a message of the week (newsletter)
Initiation of enteral feeds in very-low-birth weight preterm infants (3418)	• The Nutrition Guideline has been updated and is now on the intranet. • Liaison with SaTH Infant Feeding Advisor with regards to facilitating early expressing in mothers post delivery - SaTH ha achieved Stage 3 Baby Friendly Accreditation from UNICEF
Ovarian cancer - Initial management (3869)	• There has been a change in local practice following a serious case review, it is now compulsory that all patients have a documented Risk of Malignancy Index (RMI).
Sedation in children (3739)	• Play therapy leaflet for parents to be designed • Support for innovative Play concepts has been implemented

Summary of examples of actions taken following local audits	
Audit Title	***Recommendations / Actions***
	• This project has been accepted for the MRPS meeting in Birmingham Children's Hospital for a poster presentation • A re-audit has been planned
Unplanned extubation in the Newborn (3786)	• The 10 point plan has been introduced in the neonatal unit

Research and Development

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

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

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

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

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

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

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

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

Some of the successes of 2017-18

- SaTH received 2 highly commended awards at the CRN awards earlier this year for Commercial studies delivering to time and target and Best Overall performance.
- One of our clinicians has been appointed the Chief Investigator to a suite of 3 commercial studies involving Ulcerative Colitis

- The top recruiting site in the UK for a commercial study evaluating productivity loss and associated costs in cardiovascular patients.
- In the top 10 recruiting sites in the country for an observational commercial cancer study.
- SaTH 4th top recruiter in the UK into the STAMPEDE study for newly diagnosed advanced prostate cancer
- SaTH 3rd top recruiter out of 20 into an observational study looking at the treatment pathways of men with prostate cancer.
- A 101 year old patient was recruited into a study here at SaTH!

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

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

Priority	Number	Scheme	Have we achieved the CQUIN?
National	1a	Improvement of Health and Wellbeing of NHS staff	Not Achieved
National	1b	Healthy food for NHS staff, visitors and patients	Pending confirmation. Trust view is this is achieved.
National	1c	Improving the uptake of flu vaccinations for front line clinical staff	Achieved
National	2a	Timely identification of sepsis in emergency departments and acute inpatient settings	Partial achievement
National	2b	Timely treatment of sepsis in emergency departments and acute inpatient settings	Partial achievement
National	2c	Antibiotic Review	Partial achievement
National	2d	Reduction in antibiotic consumption per 1000 admissions	Pending confirmation
National	4	Improving services for people with mental health needs who present to A&E	Achieved with partial award in Q2.
National	6	Offering advice and guidance – improve access for GPs to consultant advice prior to referring patients in to secondary care	Achieved
National	7	NHS E Referrals – all providers to publish all of their services and make all first outpatient appointment slots available on the E referral service	Achieved
Specialised Services	WC4a PICU	Paediatric Networked Care – non PICU centres	Pending confirmation – trust view is this is achieved.
Specialised Services	GE3	Hospital Medicines Optimisation	Pending confirmation
Specialised Services	DESP 2016	Diabetic Eye Screening Programme	Pending confirmation. Trust view is this is achieved.

Statements from the Care Quality Commission

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

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

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

Our ratings for Shrewsbury and Telford Hospital NHS Trust

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

Our ratings for Royal Shrewsbury Hospital

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

Our ratings for Princess Royal Hospital

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

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

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

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

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

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

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

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

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

Our commitment to Data Quality

Information Governance Toolkit Attainment Levels

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

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

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

Overall Score: 70%

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

Data Quality Report 2017

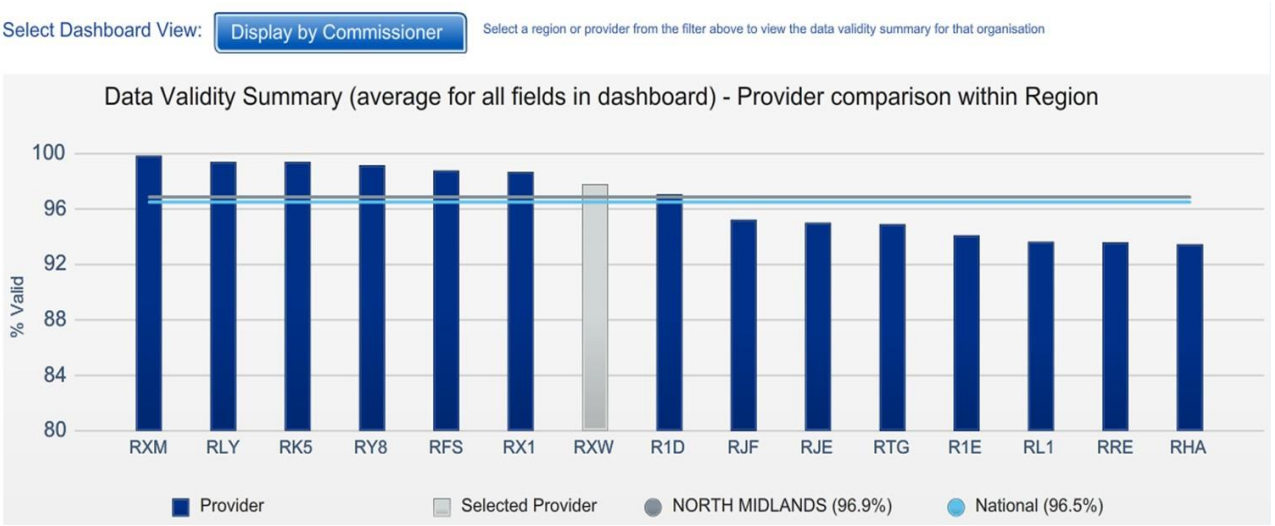
Shrewsbury and Telford Hospital NHS Trust recognises the central importance of having reliable and timely information, both internally to support the delivery of care, operational and strategic management and overall governance, and externally for accountability, commissioning and strategic planning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

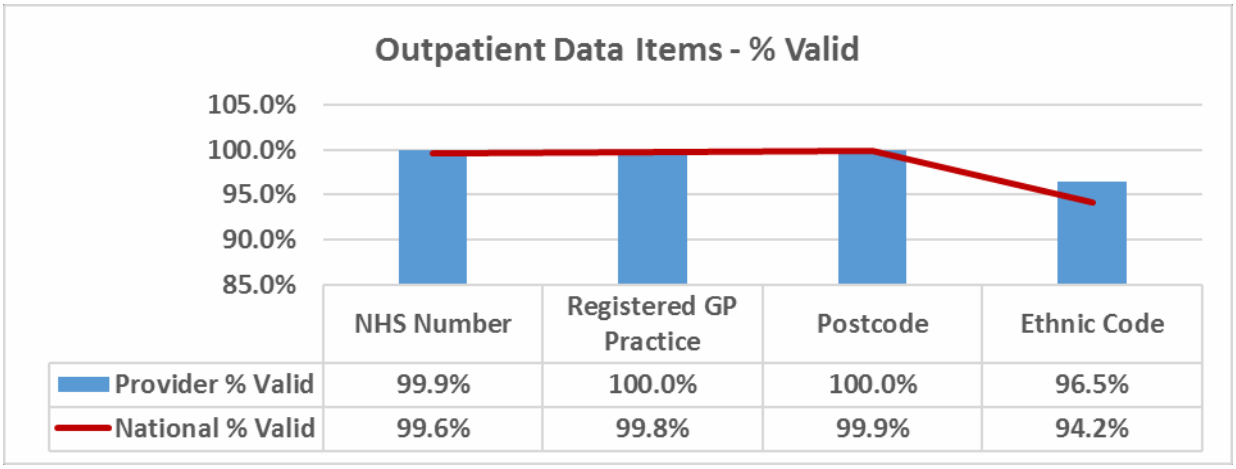
High quality and meaningful information enables people at all levels in the Trust (including external stakeholders) from frontline staff to Board level Directors to:

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

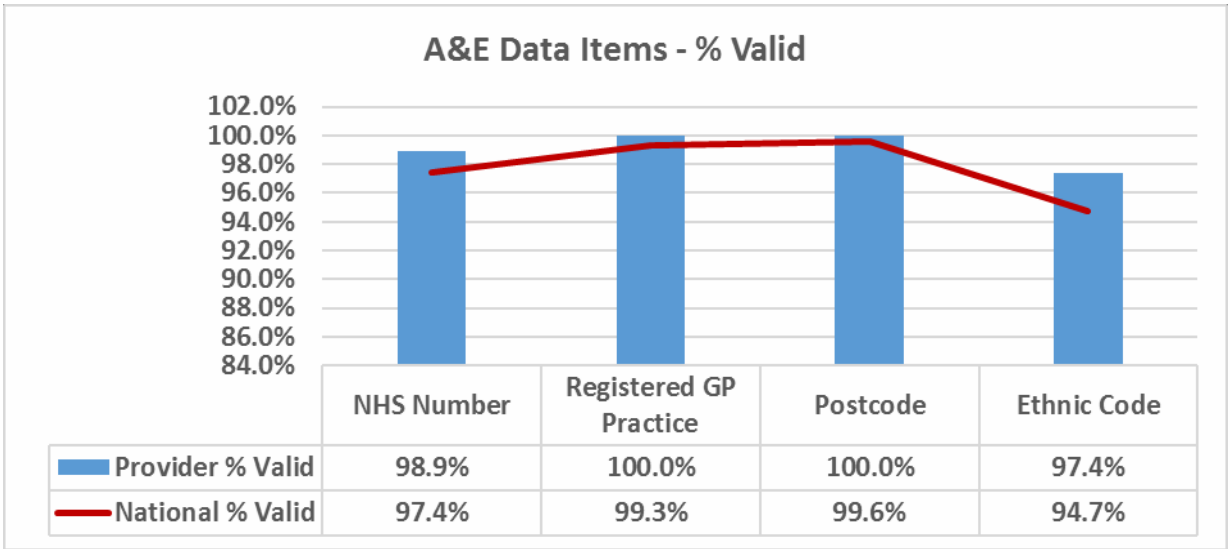
The Information Governance Toolkit Requirement 506 states that organisations must have documented procedures and a regular audit cycle in place to check the accuracy of service user data. The above audit covers key data items identified in NHS Digital guidance for Acute Trust Data Sets.
The Data Quality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

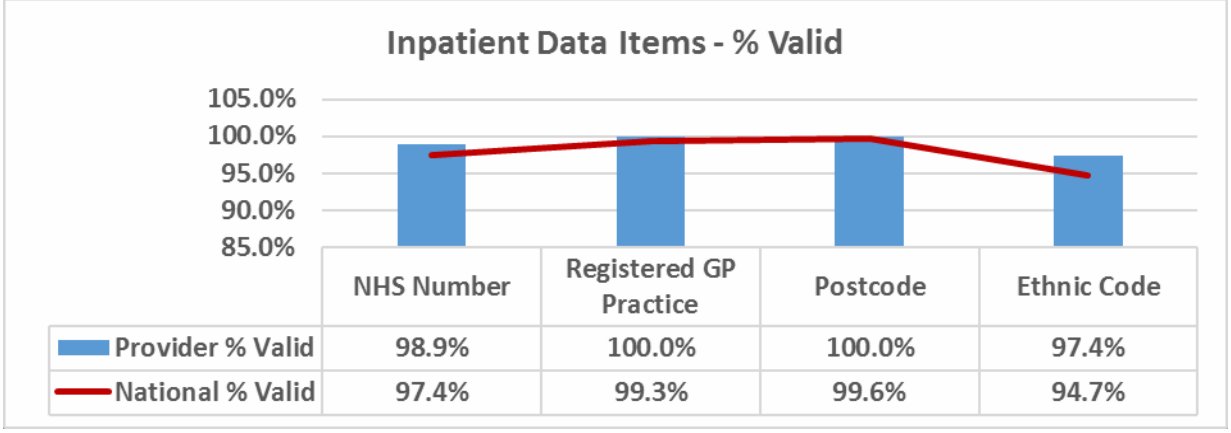
'Key' Information fields taken from Data provided for secondary use resulted in the following scores compared with Nationals 'Validity Scores':





	NHS Number	Registered GP Practice	Postcode	Ethnic Code
Provider % Valid	99.9%	100.0%	100.0%	96.5%
National % Valid	99.6%	99.8%	99.9%	94.2%





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

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

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

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

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

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

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

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

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

Current value streams include:

Respiratory Discharge Value Stream which has implemented over 13 improvements, leading to a two day reduction in the length of stay and an increase in the numbers of patients cared for in our

two respiratory wards. During 2018-2019 the Unscheduled Care Group, now owning this work, will spread the learning across all wards in the Care Group and monitor the impact through measurement.
The **Sepsis Value Stream** Sponsor Team will spread their learning during 2018-2019 to standardise the approach to diagnosing and treating sepsis. Their improvement workshops have demonstrated the potential to significantly reduce the time taken to deliver this life saving treatment, but also the complexity of implementing and sustaining standard work to a disease process that develops very quickly.

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

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

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

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

3.2 Patient Safety

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

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

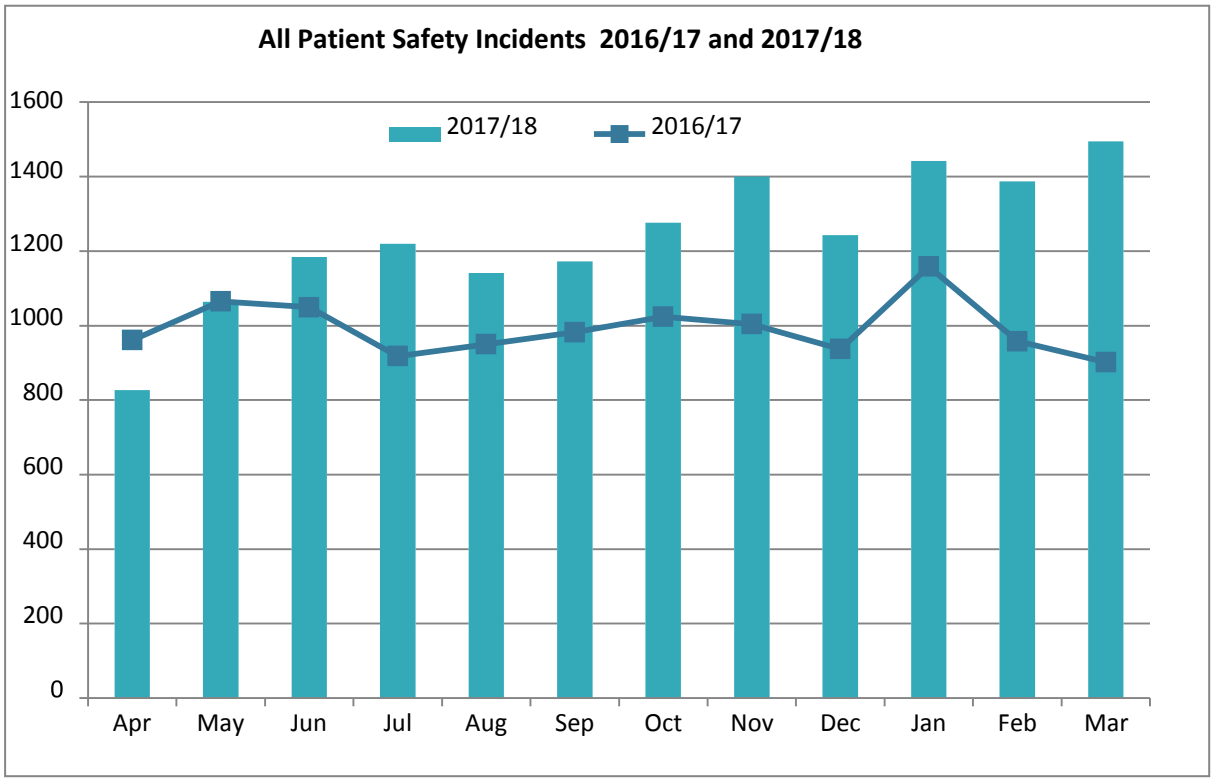
One of these is the Executive Rapid Review – a meeting that is held weekly and which looks at all moderate and severe harm incidents from the previous seven days along with all complaints from the same time period. This ensures that we are identifying trends early, that the right processes are in place,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

The other, mentioned above in the section about the Transforming Care Institute is Value Stream #5 – Patient Safety. This exciting initiative which has been running since December 2017 uses the tried

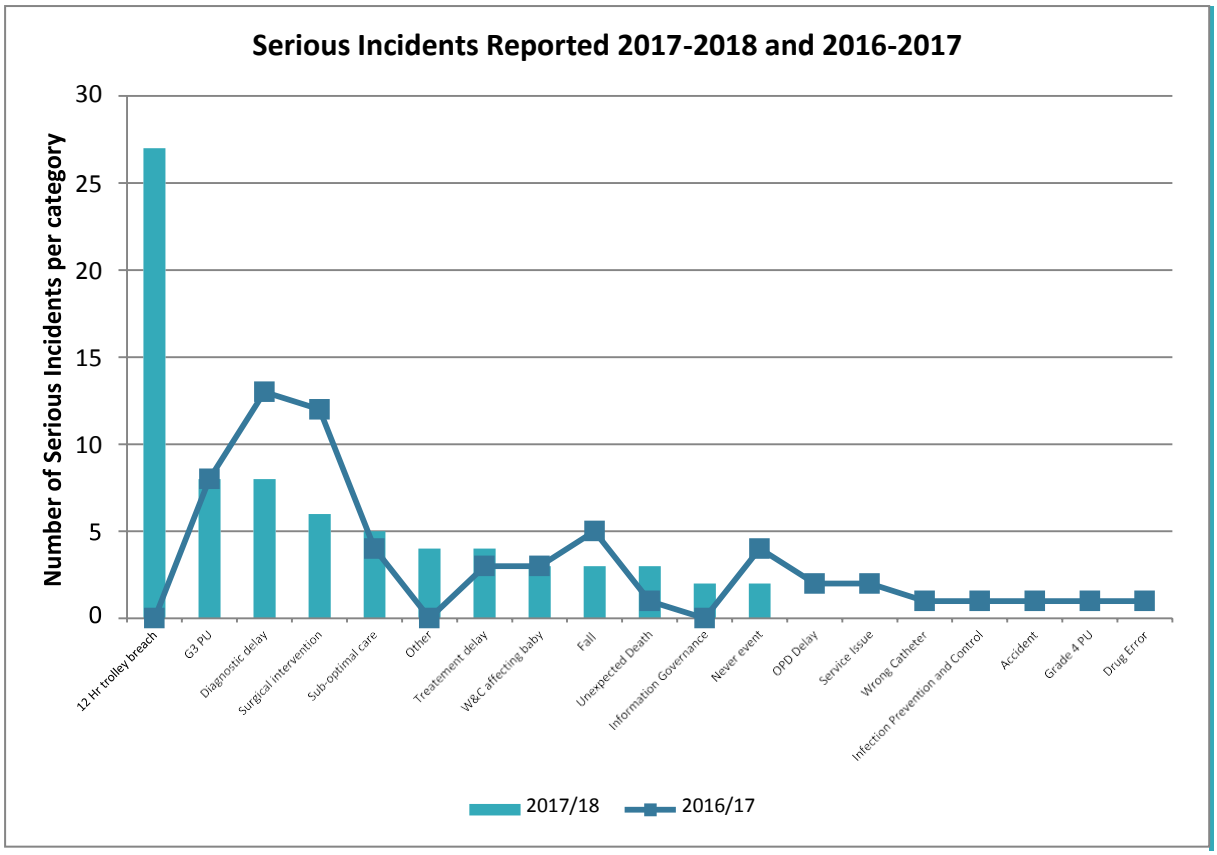
and tested methodology learned from the work with the Virginia Mason Institute to explore in depth specific areas of patient safety – for example, reporting and learning from incidents. This will be rolled out further in 2018-2019 and we look forward to reporting our progress with this work.
The Trust has reported two Never Events (nationally defined) in 2017-2018 one of which occurred in our operating theatres and the other in one of our emergency departments. One was in October 2017 and the other in February 2018. The investigation for the most recent Never Event is in progress at the time of writing this Quality Account and the investigation of the other shows that there are lessons relating to process and procedures that should be learned. An example of this is around the use of software that the Trust uses in such procedures. Completion of actions are monitored by the Care Group Board and through them the Quality and Safety Committee.

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

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



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



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

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

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

Duty of Candour

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

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

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

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

Patient Safety Alerts

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

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

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

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

NHS Safety Thermometer

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

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

Venous Thromboembolism

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

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

Infection Prevention and Control (IPC)

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

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

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

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

At the end of Qtr 4 2017-2018 we had reported 32 cases of CDI with 24 of them being found due to lapses in care. CDI lapse in care common themes included delay in sending samples, lack of evidence relating to antimicrobial stewardship.

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

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

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

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

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

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

Quality Ward Walks

The IPC Nurses undertake a programme of monitoring within wards and departments. The Quality Ward Walk concentrates on four main areas; Cleanliness, Equipment, Isolation & Management of Infected patients and Invasive Devices. The IPC nurses also record any other observations of IPC concern. The audit form is designed to give an overall percentage score so wards can be monitored over time for trends and also so the IPC nurses can identify challenges at both ward and Trust level.

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

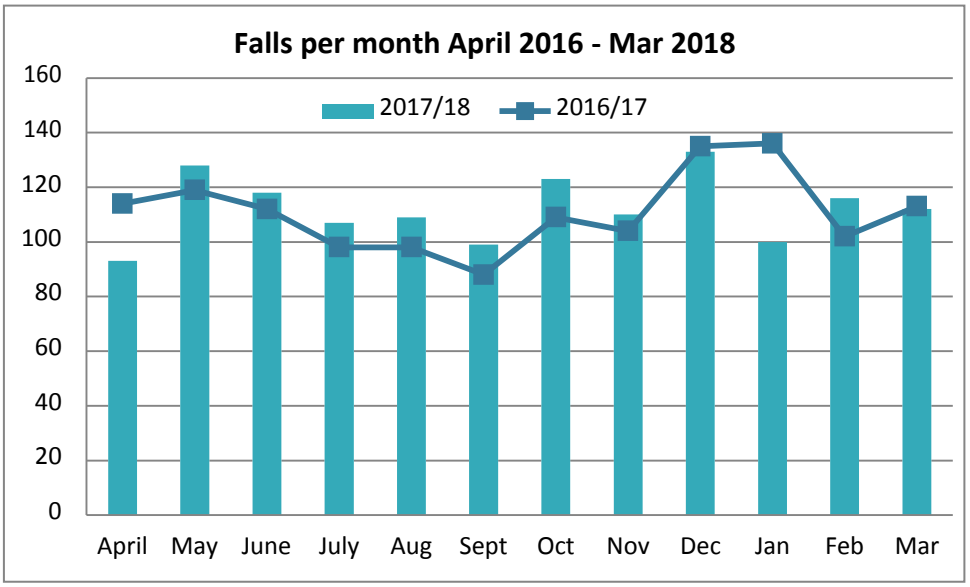
Detailed recommendations form part of the report and the IPC nurses request email feedback to be completed within two weeks. If the compliance score is significantly less than 80%, supported visits are undertaken by IPC team giving opportunity to observe the changes made to improve practice. In addition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

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

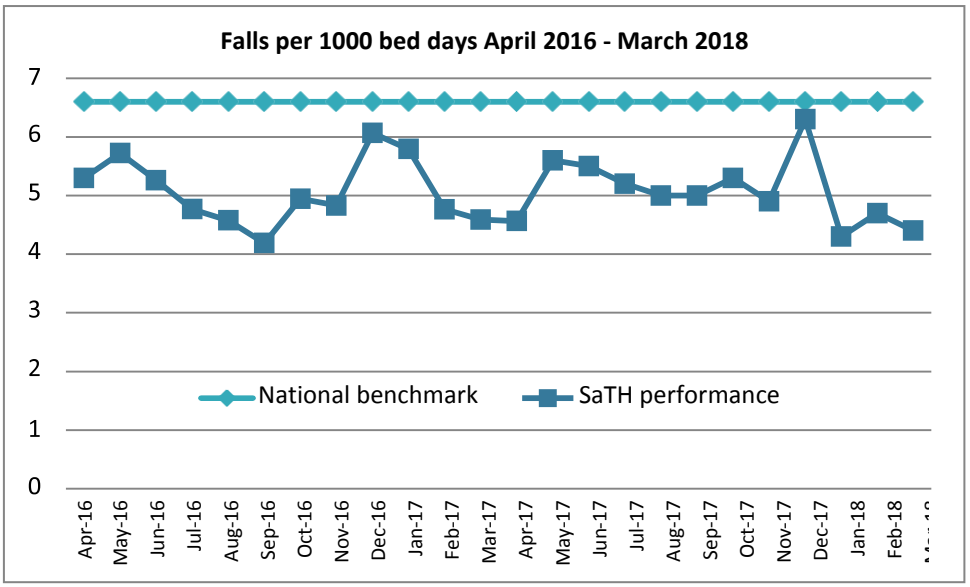
Falls Prevention

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

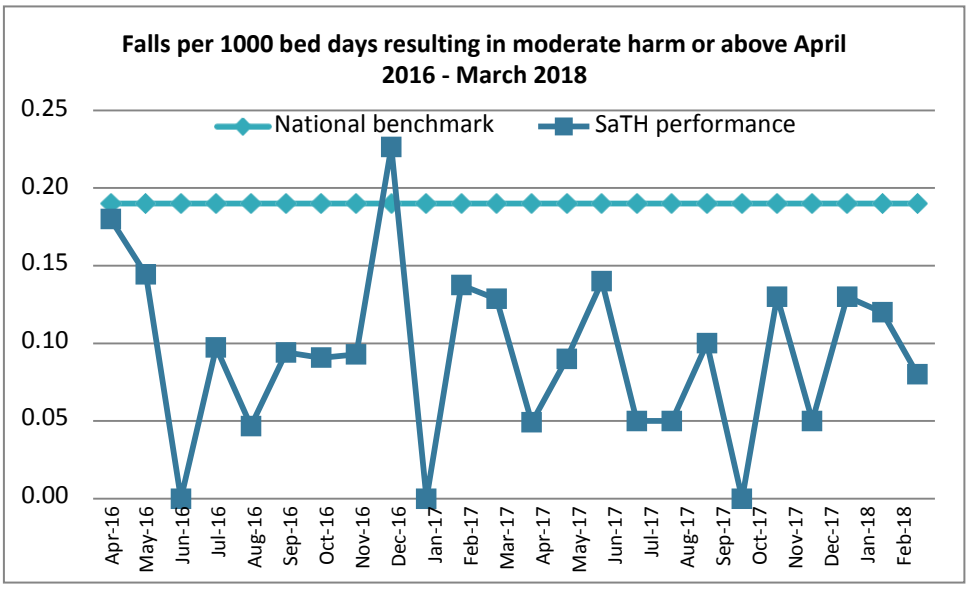
The chart below shows the number of falls recorded in 2017-2018 compared to the previous year:



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



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

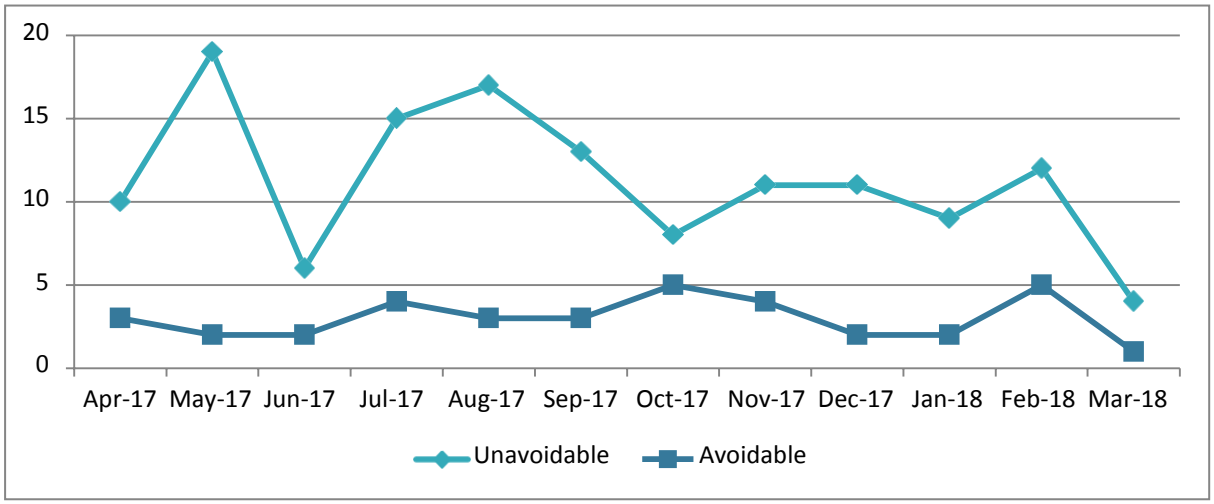


Pressure Ulcers

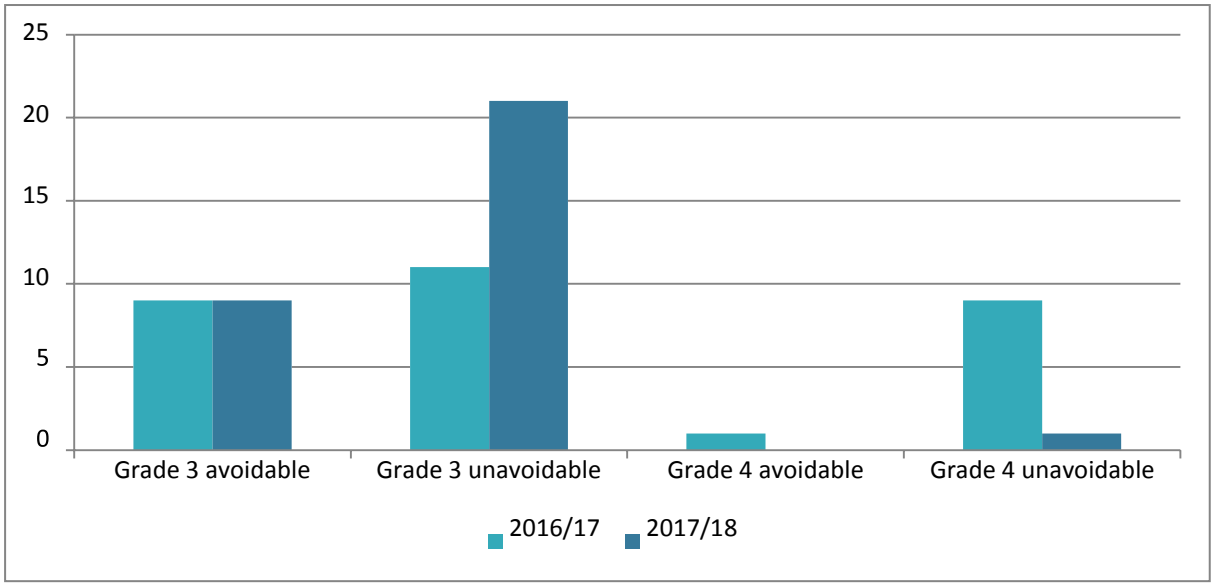
A pressure ulcer - also known as a 'bed sore' or 'pressure sore' - is an ulcerated area of skin caused by irritation and continuous pressure on part of your body. Pressure ulcers are more common over places where your bones are close to your skin such as your heels, the lower part of your back and your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

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

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



Grade three and four pressure ulcers:



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

Safeguarding Vulnerable Adults

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WHAT YOU THINK ABOUT WORKING

Top Ranking Scores

SaTH Score 2017	National 2017 Average	SaTH Score 2016	
9%	12%	9%	% of staff experiencing discrimination at work in the last 12 months
2%	2%	3%	% of staff experiencing physical violence from staff
11%	14%	17%	% of staff experiencing physical violence from patients, relatives or the public
24%	27%	26%	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public
86%	85%	88%	% of staff believing that the organisation provides equal opportunities for career progression or promotion

Our Organisation

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

67%	76%	68%
TRUST SCORE 2017	NATIONAL 2017 AVERAGE	TRUST SCORE 2016

Overall Staff Engagement

63%	73%	65%
TRUST SCORE 2017	NATIONAL 2017 AVERAGE	TRUST SCORE 2016

Staff agreeing that the organisation acts on concerns raised by patients

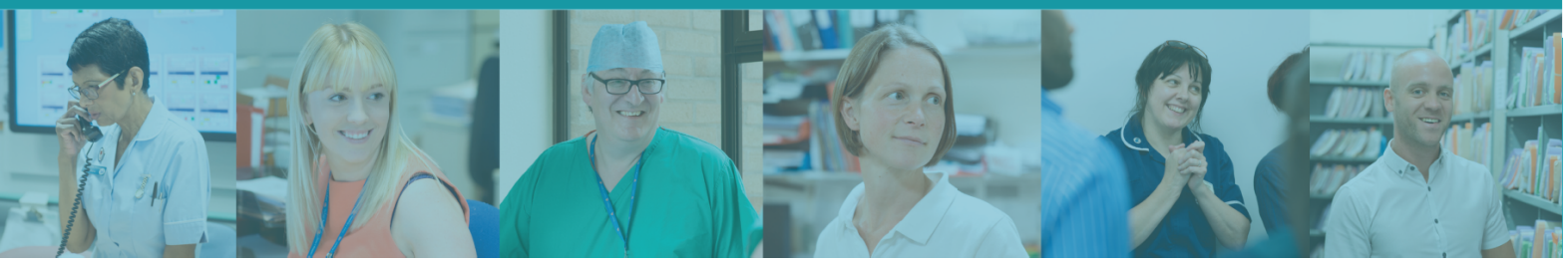
Violence, harassment & bullying

56% TRUST SCORE 2017	67% NATIONAL AVERAGE 2017	67% TRUST SCORE 2016	Staff reporting most recent experience of violence
44% TRUST SCORE 2017	45% NATIONAL AVERAGE 2017	43% TRUST SCORE 2016	Staff reporting most recent experience of harassment or bullying
25% TRUST SCORE 2017	25% NATIONAL AVERAGE 2017	22% TRUST SCORE 2016	Staff experiencing harassment or bullying from staff
56% TRUST SCORE 2017	67% NATIONAL AVERAGE 2017	67% TRUST SCORE 2016	Staff experiencing harassment or bullying from patients

Working patterns

51% TRUST SCORE 2017	51% NATIONAL AVERAGE 2017	48% TRUST SCORE 2016	% of staff satisfied with the opportunities for flexible working patterns
70% TRUST SCORE 2017	71% NATIONAL AVERAGE 2017	69% TRUST SCORE 2016	% of staff working extra hours

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



AT SaTH (2017/18)

NHS
The Shrewsbury and Telford Hospital
NHS Trust

Job Satisfaction

Staff feel able to contribute towards improvements at work:

70% NATIONAL AVERAGE 2017

70% TRUST SCORE 2016

	TRUST SCORE 2017 (OUT OF 5)	NATIONAL AVERAGE 2017 (OUT OF 5)	TRUST SCORE 2016 (OUT OF 5)
Staff recomending the organisation as a place to work or receive treatment	3.56	3.76	3.62
Staff motivation at work	3.90	3.92	3.91
Staff satisfaction with level of responsibility and involvement	3.86	3.90	3.89
Effective team working	3.70	3.71	3.74
Staff satisfaction with resourcing and support	3.23	3.31	3.29

Managers

Recognition and value of staff by managers and the organisation

3.41 /5 TRUST SCORE 2017

3.44 /5 NATIONAL 2017 AVERAGE

3.44 /5 TRUST SCORE 2016

Staff reporting good communication between management and staff

29% TRUST SCORE 2017

33% NATIONAL 2017 AVERAGE

31% TRUST SCORE 2016

Support for immediate managers

3.74 /5 TRUST SCORE 2017

3.74 /5 NATIONAL 2017 AVERAGE

3.73 /5 TRUST SCORE 2016

Appraisals & Support for development

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

Patient care & experience

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

Health and Wellbeing

Staff feeling unwell due to work related stress

Staff feeling pressure to attend work when unwell

3.58 /5 TRUST SCORE 2017

3.62 /5 NATIONAL AVERAGE 2017

3.63 /5 TRUST SCORE 2016

Organisations interest in Health and Wellbeing

Fairness and effectiveness of procedures for reporting errors

3.59 /5 TRUST SCORE 2017

3.73 /5 NATIONAL AVERAGE 2017

3.63 /5 TRUST SCORE 2016

% REPORTING ERRORS, NEAR MISSES OR INCIDENTS IN LAST MONTH

Errors and Incidents

STAFF WITNESSING POTENTIALLY HARMFUL ERRORS

Staff Confidence in reporting unsafe clinical practice

3.51 /5 TRUST SCORE 2017

3.65 /5 NATIONAL AVERAGE 2017

3.56 /5 TRUST SCORE 2016

3.3 Clinical Effectiveness

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

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

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

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

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

Current Position - National 7 Day Service Audits

Clinical Standard 2
Proportion of patients reviewed by a Consultant within 14 hours at admission

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

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

Clinical Standard 6

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

– either on site or via formal network arrangements?'

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

Clinical Standard 8

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

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

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

Progress so Far

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

Next steps

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

Monitoring inpatient care

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

MRSA bacteraemia
C Diff
MRSA screening rates
Number of pressure ulcers
Number of falls
Medication errors
Staffing information
Appraisal rates
Sickness absence rates
Training attendance
Safeguarding referrals
Mixed sex accommodation breaches
Number of complaints

Monitoring mortality

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

	Prescribed Information	Statement
27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure	During 2017-2018, 1917 patients of Shrewsbury and Telford Hospital NHS Trust died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 419 in the first quarter 433 in the second quarter 506 in the third quarter 556 in the fourth quarter
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 09 May 2018, 1206 case record reviews and investigations have been carried out in relation to 100% of the deaths included in item 27.1 In 14 cases* a death was subjected to both a case record review and an investigation. *(This number reflects the number of Serious incident investigations. The Trust is currently developing a process for collating the number of high risk case reviews and less formal investigations performed by, and discussed within the Care Groups) The number of deaths in each quarter for which a case record review was carried out was: 289 in the first quarter 291 in the second quarter 349 in the third quarter 277 in the fourth quarter
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown) with an explanation of the methods used to assess this	2 deaths, representing 0.11% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. These were reported as Serious incidents and a Root cause analysis report undertaken. In relation to each quarter, this consisted of: 1 death representing 0.24% for the first quarter 1 death representing 0.23% for the second quarter 0 representing 0% for the third quarter 0 representing 0% for the fourth quarter The Trust uses the CESDI (Confidential Enquiry

	Prescribed Information	Statement
		into Stillbirths and Deaths in Infants) definitions for scoring the outcomes of reviews: Grade 0 - No sub-optimal care Grade 1 - Sub-optimal care but different management would have made no difference to outcome Grade 2 - Sub-optimal care – different care MIGHT have made a difference to outcome (possible avoidable death) Grade 3 - Sub-optimal care. WOULD REASONABLY BE EXPECTED to have made a difference to outcome (probable avoidable death) The outcomes for the year, by number of deaths and percentages of total reviewed are: CESDI 0 1081 90.38% CESDI 1 97 8.11% CESDI 2 16 1.33% CESDI 3 2 0.16%
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation the deaths identified in item 27.3	Case 1. Delayed diagnosis of a silent perforated duodenal ulcer. The patient did not present with specific recognisable sign and symptoms but a chest x ray taken overnight clearly showed a pneumoperitoneum. It is the opinion of the review that had it been acted on at this point or on the later ward round, then the outcome for the patient would have been consideration for surgery intervention which would most likely have been successful. Learning: For the Urology Team to view radiological images that have been taken over night unless they have been formally reported by the Radiologist. Advice is sought through the appropriate speciality escalation process. Recognition of Pneumoperitoneum on x ray To remind Clinicians of the process for the allocation of Consultants for patients being admitted to the Surgical Assessment Ward Case 2 Delayed diagnosis of an Intracerebral haemorrhage and administration of Coagulation Factor IX in a patient with haemophilia B. Learning: A warning against confirmatory bias and the need to develop a pathway for Haemophiliac patients, when admitted to the Emergency Department, providing a process for contacting the on-call haematologist regardless of reason for attendance.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of	A report is currently being compiled of the main themes from 'Learning from Deaths' 2017-18.

	Prescribed Information	Statement
	what the provider has learnt during the reporting period	Individual actions undertaken as a result of Serious Incident Investigations and deep dive thematic reviews include: **Fractured neck of femur:** To introduce a single page guideline for the management of hypotension based on NICE guidelines for junior doctors called to see patients with a fractured neck of femur (complete) Extend recovery resource for monitoring post-operatively (complete) Additional physiotherapy support during the winter period (complete) **Other examples:** Guidance has been issued for the process of administering anti-epileptic drugs (AEDs) in patients who are unable to take orally. **Fluids and Electrolytes** Concern was raised about an increase in December 2015, March and April 2016 which may reflect patients being readmitted with fluid and electrolyte disorders at times of high activity. Most patients were admitted with dehydration secondary to sepsis, UTI or pneumonia. Readmission rate within 28 days overall was below peer average. The figures in November 2016 showed variation between observed and expected mortality as stable and within expected control limits. Recommendations following the review were: Continue to monitor this group for a further six months to assess any changes Identify administrative personnel to address the administrative errors. SaTH Medical Director to speak with Shropshire Community Health NHS Trust Medical Director to share conclusions and consider how to reduce number of unnecessary transfers (complete)
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 described above are reviewed at the Mortality Group meetings within the Trust – audits are carried out as planned by each area. The Fluids and Electrolyte review was repeated in July 2017 and co-operative working between Trusts continues.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period	Trust wide data collection commenced in April 2017. There is no 'relevant document' for the previous reporting period 2016-17. Thematic retrospective 'Deep Dive' reviews conducted during 2017-18:

	Prescribed Information	Statement
		39 patients identified from the National Hip Fracture database, who died within 30 days of admission during the calendar year 2015. 61 patient deaths reported to the Trauma Audit and Research Network (TARN) from April 2015-2017
27.8	An estimate of the number of deaths included in 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this	Trust wide data collection commenced in April 2017. There is no 'relevant document' for the previous reporting period 2016-17 Fractured neck of femur review 2015 1 patient died following an in-patient fall. All appropriate cases had been discussed with, or investigated by the Coroner. 1 patient, representing 1.63% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. TARN review 2015-17 No avoidable deaths were identified. 5 cases had already been subject to investigation for sub optimal care. All appropriate cases had been discussed with, or investigated by the Coroner.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8	N/A. Trust wide data collection commenced in April 2017. There is no 'relevant document' for the previous reporting period 2016-17.

Exemplar Programme

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

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

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

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

Exemplar Improvement in Quality Indicators

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

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

Outcomes

- Increased awareness of ward managers, teams and staff in Exemplar quality standards and stakeholder requirements
- Better multi-disciplinary working – Exemplar brings together stakeholders into one main assessment; previously they were all stand-alone assessments/audits. In order to achieve 'Silver' an area needs to achieve the minimum standards across all the areas and not just be good in one.
- CQC assurance – any area that has been through Exemplar has demonstrated compliance with the minimum standards.
- Documentation compliance – raised the importance of good record keeping in-line with NMC and Trust standards.
- Positive stakeholder engagement which has helped stakeholders to raise awareness, support wards and will drive up performance/compliance:
    - Facilities – Cleanliness
    - Education targets – achieving SSU, Medical Devices, Oral Medications compliance/completion targets
    - Appraisal targets – Increased and attainment of compliance
    - Complaints – Increased compliance with adherence to response times
    - Health & Safety – Increased compliance and course attendance
    - Pharmacy – Increased awareness and compliance with pharmacy standards and improvement in performance on controlled drugs and rolling audits
    - Estates – Increase awareness of how to raise and action estates work, increased legionella compliance
    - Resus – Increase in Resus trolley check performance
    - Protected Mealtimes & Food Safety – Exemplar has raised the profile of protected mealtimes and food safety which is helping to improve overall outcomes and improvements in practices.
    - Infection, Prevention and Control – Increased performance in audits and communication between the teams in raising issues and asking for support.
    - Patient Experience – FFT response rates increase

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

Challenge	Action
Patient information books out of date and not always available	Update and refresh of patient information books in progress
RSH – white pharmacy delivery boxes had a broken locks	Profile raised and successful trial of iBins commenced. 5 iBins in situ on each site with more on order.
SSU compliance spreadsheet is not always easy to understand	Profile of education team has been raised and wards have successfully challenged incorrect data and more likely to request help and support from the education team who work with the ward manager to proactively plan and give advice on how to maintain SSU going forwards.
Visibility of pharmacy rolling audit results had stopped	Review of process to ensure pharmacy audit results are received and emailed out regularly
Pharmacy staff did not always check the RN	Reminder to pharmacy staff to always check

who ordered a CD (controlled drug) was the same RN who received a CD	which introduces an additional safety check
Controlled Drug audit compliance was poor with wards failing on similar issues regularly	Pharmacy attends NMF to provide training and updates. Exemplar encourages ward managers to work with pharmacist to improve results and address issues.
IPC Quality Ward Walk (QWW) audits use the same questions across all care groups which can result in a much lower number of applicable questions.	IPC are reviewing their QWW to see if they can tailor the audit to specific areas.
Toilet brushes not always dated which wasn't compliant with policy	Facilities reviewed process and introduced an additional check before released to reduce defect
Insufficient or cancelled H&S courses	Review of courses and additional ones added to the programme
Access to Safer sharps assessment inconsistent	H&S team able to address and improve access for staff
Wards highlighted problems with agency nurses who had worked on different wards 'not knowing how we work here'	Corporate nursing are working on introducing agency flash cards to improve process
Online oral medications module contains out of date information.	Awareness of issue raised and being explored
Food safety awards were different to Exemplar	Awards changed to demonstrate consistent approach and make it easier to understand

3.4 Patient Experience

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

Complaints Service and Patient Advice and Liaison Service (PALS)
In 2017-2018, the Trust received 600 formal complaints; this equates to less than one in every 1000 patients making a complaint (0.69 complaints per 1000 patients). During 2017/18, the Trust has continued to strengthen learning from complaints made by patients and their families. Learning from complaints is shared across the Trust through a variety of meetings and training to ensure that as a Trust we learn from poor patient experience. Response rates within agreed timescales have increased from 30% at the end of 2016-2017 to 74% at the end of 2017-2018, with further improvements planned to increase response rates further. Timescales are agreed with the complainant, but are usually 30 working days, extended to 45 and 60 for complaints that are more complex, for example involve other organisations.

The PALS team continues to support patients and their families with on the spot resolution, and in 2017-2018 assisted 1491 patients and families with their concerns. In addition, the PALS team provides the Trust Bereavement Service, issuing families with the Medical Certificate of Cause of Death and providing them with support in the next steps, as well as facilitating bereavement meetings where families request these. At the end of 2016-2017, an onsite registrar service at the

Royal Shrewsbury Hospital was introduced. This has been developed and increased in 2017-2018 and regularly receives positive feedback from bereaved families.

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

Changes in Practice

- Signage to be put up in A&E advising members of the public that they cannot film there
- Staff to ensure they document all communication with relatives
- Regular audit of hand hygiene in Ophthalmology
- Weekly checks to be carried out by bookings team to review all patients not yet on lists
- Review and strengthening of SOP for dispensing trays
- Nursing staff to ensure that all consent forms, including paediatric forms, are available in each clinic room
- Checks in place to ensure that staff declutter and wipe clean lockers and tables at least twice a day
- Letter to be sent to staff about smoking in non-smoking areas
- Revise guidance on the review of babies after birth whose mothers are suspected of sepsis
- Improve multi-disciplinary working to ensure patients and family members are involved in decision-making processes re discharge
- Housekeeper numbers to be increased in A&E
- Ensure mother's birth wishes are properly communicated to midwives attending birth
- Nursing staff to check omitted medicine in daily huddle and ensure that reasons for omission are clearly documented
- Review in place for flow through Paediatric Assessment Unit

Training

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

New Policies and Processes

- 24 hour ECG results to be sent out daily.
- Single use tape measures to be ordered for A&E
- Mouth care policy for end of life patients implemented
- Introduction of 'plan for the day' sheets to be given to patients following ward rounds
- New head and neck assessment for vulnerable patients with NIV / oxygen therapy / NG tubes.
- Develop link worker role for hearing aids/devices.

- New nursing documentation has a section within it that outlines discharge plans for patients and should be followed.
- ED dementia link nurse role to be introduced

Information for Patients

- Booking staff to advise patients that they may be seen sooner that estimated waiting times
- Staff to ensure they provide up to date waiting times
- Update of endoscopy patient information leaflets to include the role of nurse or operating department practitioner
- Booking team to contact patients by phone when dating patients with less than two weeks' notice
- Update wording on website to clarify when partners can stay with women in labour
- Hysteroscopy leaflet updated with more information on pain

Individual staff are asked to reflect on complaints that they have been involved on, and learning from complaints is also discussed at Care Board meetings, and at ward and departmental meetings.

In 2018-2019, the PALS team will be capturing learning from PALS contacts and will share this learning across the Trust, to ensure that all learning from patient feedback is captured and cascaded to all areas.

Friends and Family Test

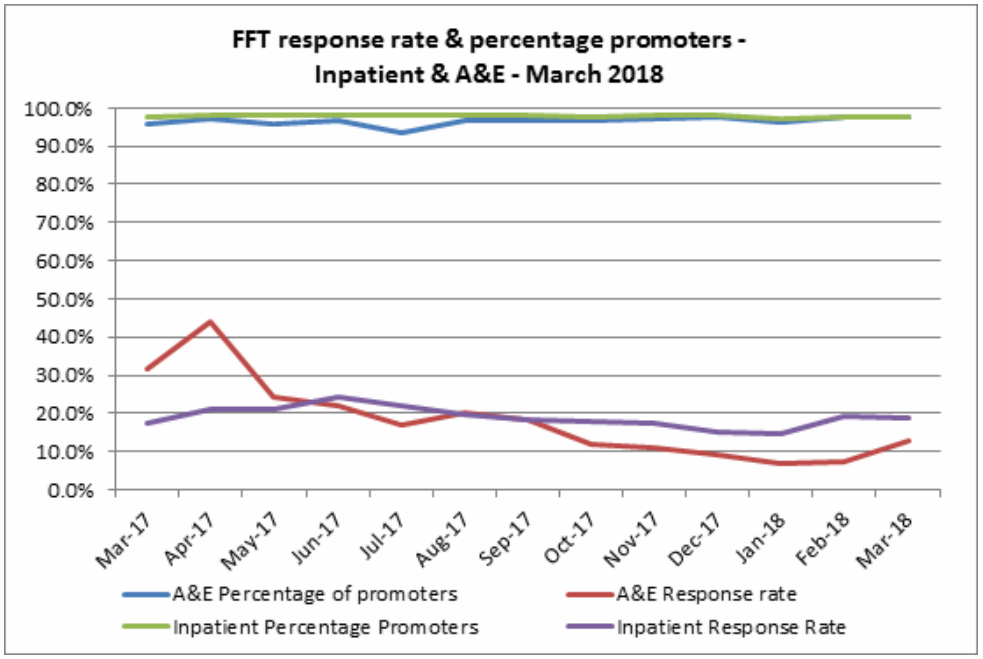
We have taken several approaches to understand and therefore improve the experience that people have of our care at SaTH. One of the approaches that has been used is the Friends and Family Test – a one question measure used across the organisation asking respondents **"Would you recommend the service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

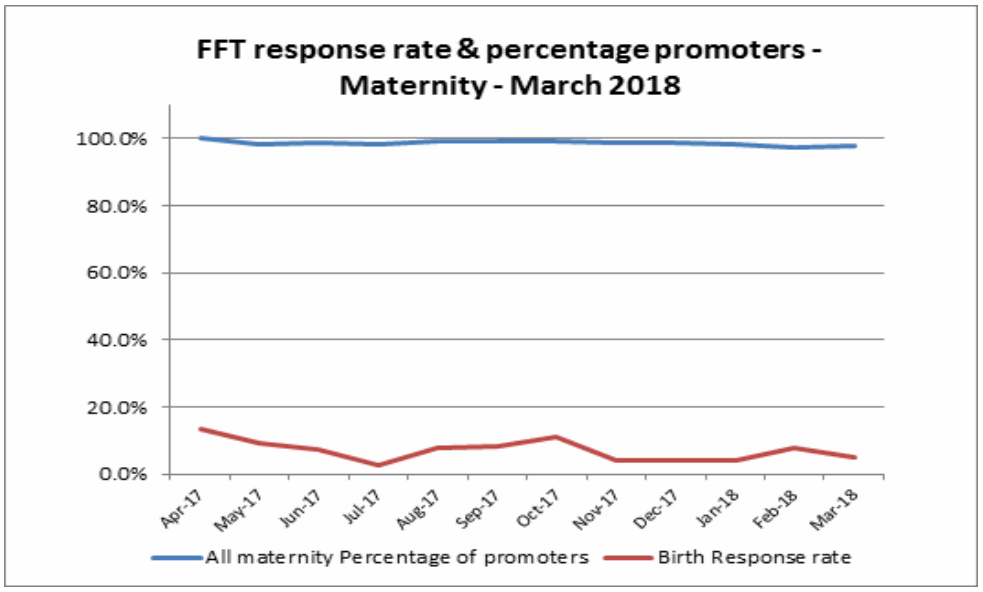
We report monthly to the Quality and Safety Committee the responses made to the survey at a Trust level and also the response rate (the percentage of people that have received treatment) that responded to the question. We believe that there are ways that we can improve this response rate therefore giving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

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

In Patient responses
Emergency Department responses
Maternity responses.

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





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

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

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

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

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

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

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

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

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

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

PLACE scores by site:

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

Sath 2016 Average	99.4	90.5	81.71	93.61	68.99	91.14	58.14	74.1

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

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

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

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

Part four: Statements from external organisations

4.1 Statements from our Partners

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

4.2 Changes made to the Quality Account following receipt of statements

Page	Change Made	Date
4	Amendment to reflect the name of SSSFT to MPFT	14 June 2018
8	Additional detail on how the Board receive updates on progress of actions from patient stories	14 June 2018
12/13/18/21/57/59	Minor formatting to text	14 June 2018
33	Additional tables included as requested – CQC (removed)	14 June 2018
51	Further detail added re Seven Day Services (not requested)	14 June 2018
54	Additional information added 27.6 and27.7 (not requested)	14 June 2018
63	Additional table added - PLACE	
43	Amendment made to statement re CDI following CCG feedback	26 June 2018
Numerous	A number of charts have had to be removed as the file exceeded NHS Choices limit for size	28 June 2018

4.3 Thank you

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

How to give us feedback about this Quality Account

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

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

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

We welcome your feedback on our Quality Account.

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

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

Statement by Directors:

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

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

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

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

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

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

Signature .....

Date 27 June 2018

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

Statement from our Auditors:

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

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

Scope and subject matter

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

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

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

Respective responsibilities of the Directors and the auditor

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

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

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

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

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

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

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

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

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

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

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

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

Assurance work performed

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

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

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

Limitations

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

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

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

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

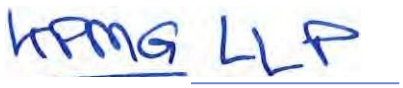
Basis for disclaimer of conclusion on the Friends and Family Indicator (FFT)

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

Conclusion

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

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



KPMG LLP
Chartered Accountants 1 Park
Row Nottingham
NG1 6FQ

28 June 2018

Appendix Two

Glossary of Terms used in this Quality Account

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

Health Research Authority (HRA)	The HRA protects and promotes the interests of patients and the public in health and social care research.
Health and Social Care Information Centre (HSCIC)	HSCIC (now called NHS Digital) provides national information, data and IT systems for health and care services.
Healthcare Quality Improvement Partnership (HQIP)	HQIP is an independent organisation lead by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices. It was established in April 2008 to promote quality in healthcare and in particular to increase the impact that clinical audit has on healthcare quality improvement.

Learning Disability Mortality Review (LeDeR)	LeDeR was set up as a result of one of the key recommendations of the Confidential Inquiry into premature deaths of people with a Learning Disability (CIPOLD). It aims to make improvements in the quality of health and social care for people with learning disability and to reduce premature deaths in this population.
Learning from Deaths	Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and their families, and identify where they could do more. A CQC review in December 2016, 'Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England opens in a new window found that some providers were not giving learning from deaths sufficient priority and so were missing valuable opportunities to identify and make improvements in quality of care. In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care.
Methicillin-resistant Staphylococcus Aureus (MRSA)	MRSA is a bacterium responsible for several difficult-to-treat infections.
National Clinical Audit and Patient Outcomes Programme (NCEPOP)	This programme consists of more than 30 national audits related to some of the most commonly occurring conditions. These collect and analyse data supplied by local clinicians to provide a national picture of care standards for that specific condition. On a local level, the audits provide trusts with individual benchmarked reports on their compliance and performance, feeding back comparative findings to help participants identify necessary improvement for patients.
National Institute for Health and Care Excellence (NICE)	NICE provides national guidance and advice to improve health and social care.
National Institute for Health Research (NIHR)	NIHR is funded by the Department of Health to improve the health and wealth of the nation through research.
National Mortality Case Record Review (NMCRR)	NMCRR aims to improve understanding and learning about problems and processes in healthcare associated with mortality and also to share best practice.
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHS Outcomes Framework	The NHS Outcomes Framework sets out the indicators that will be used to hold NHS England to account for improvements in health outcomes

Nurse Associate Role	The Nursing Associate role is a new support role that will sit alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. Following huge interest some 2,000 people are now in training with providers across England. (https://hee.nhs.uk/our-work/developing-our-workforce/nursing/nursing-associate-new-support-role-nursing)
Pressure Ulcers	Pressure ulcers are also known as pressure sores, or bed sores. They occur when the skin and underlying tissue becomes damaged. In very serious cases, the underlying muscle and bone can also be damaged. See www.nhs.uk/conditions/pressure-ulcers
Red to Green (R2G)	The R2G approach is a visual management system to assist in the identification of wasted time in a patient's journey. It can be used in wards in both acute and community settings as part of the Safer Care Bundle (https://improvement.nhs.uk/resources/safer-patient-flow-bundle/)
Workforce Race Equality Scheme	Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS provider organisations. The NHS Equality and Diversity Council announced on 31 July 2014 that it had agreed action to ensure employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

Appendix 2

Annual Accounts (Financial Statements)

Shrewsbury and Telford Hospital NHS Trust

Annual accounts for the year ended 31 March 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	331,474	314,664
Other operating income	4	27,567	35,580
Operating expenses	6, 8	(378,637)	(351,406)
Operating deficit from continuing operations		**(19,596)**	**(1,162)**
Finance income	11	31	22
Finance expenses	12	(521)	(310)
PDC dividends payable		(3,713)	(4,259)
Net finance costs		**(4,203)**	**(4,547)**
Other gains / (losses)	13	(82)	-
Deficit for the year from continuing operations		**(23,881)**	**(5,709)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations		**-**	**-**
Deficit for the year		**(23,881)**	**(5,709)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(6,163)	(1,711)
Revaluations	17	1,132	5,482
Total comprehensive income / (expense) for the period		**(28,912)**	**(1,938)**
Financial performance for the year			
Retained deficit for the year		**(23,881)**	(5,709)
Impairments	7	**6,586**	483
Adjustments in respect of donated asset reserve elimination		**(105)**	(405)
Adjusted retained deficit		**(17,400)**	**(5,631)**

A trust's reported NHS financial performance position is derived from its retained surplus/(deficit) and adjusted for the following:-
Impairments to Fixed Assets - an impairment charge is not considered part of the organisation’s operating position.
Adjustments relating to donated asset reserves which have now been eliminated.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	14	3,118	2,977
Property, plant and equipment	15	154,334	164,219
Investment property	18	-	-
Investments in associates and joint ventures	19	-	-
Other investments / financial assets	20	-	-
Trade and other receivables	23	1,370	1,464
Other assets	24	-	-
Total non-current assets		**158,822**	**168,660**
Current assets			
Inventories	22	7,769	7,860
Trade and other receivables	23	18,610	14,582
Other investments / financial assets	20	-	-
Other assets	24	-	-
Cash and cash equivalents	26	1,700	5,682
Total current assets		**28,079**	**28,124**
Current liabilities			
Trade and other payables	27	(28,183)	(25,695)
Borrowings	30	(15,200)	-
Other financial liabilities	28	-	-
Provisions	32	(532)	(601)
Other liabilities	29	(1,166)	(1,169)
Total current liabilities		**(45,081)**	**(27,465)**
Total assets less current liabilities		**141,820**	**169,319**
Non-current liabilities			
Trade and other payables	27	-	-
Borrowings	30	(24,209)	(24,507)
Other financial liabilities	28	-	-
Provisions	32	(159)	(214)
Other liabilities	29	-	-
Total non-current liabilities		**(24,368)**	**(24,721)**
Total assets employed		**117,452**	**144,598**
Financed by			
Public dividend capital		201,372	199,606
Revaluation reserve		27,723	32,754
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(111,643)	(87,762)
Total taxpayers' equity		**117,452**	**144,598**

The notes on pages 8 to 49 form part of these accounts.

Name Simon Wright
Position Chief Executive
Date **25 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**199,606**	**32,754**	**(87,762)**	**144,598**
Surplus/(deficit) for the year	-	-	(23,881)	**(23,881)**
Transfers by absorption: transfers between reserves	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	**-**
Other transfers between reserves	-	-	-	**-**
Impairments	-	(6,163)	-	**(6,163)**
Revaluations	-	1,132	-	**1,132**
Transfer to retained earnings on disposal of assets	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	**-**
Other recognised gains and losses	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	**-**
Public dividend capital received	1,766	-	-	**1,766**
Public dividend capital repaid	-	-	-	**-**
Public dividend capital written off	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	**-**
Other reserve movements	-	-	-	**-**
Taxpayers' equity at 31 March 2018	**201,372**	**27,723**	**(111,643)**	**117,452**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**197,106**	**28,983**	**(82,053)**	**144,036**
Prior period adjustment	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**197,106**	**28,983**	**(82,053)**	**144,036**
Surplus/(deficit) for the year	-	-	(5,709)	**(5,709)**
Transfers by absorption: transfers between reserves	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	**-**
Other transfers between reserves	-	-	-	**-**
Impairments	-	(1,711)	-	**(1,711)**
Revaluations	-	5,482	-	**5,482**
Transfer to retained earnings on disposal of assets	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	**-**
Fair value gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Recycling gains/(losses) on available-for-sale financial investments	-	-	-	**-**
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	**-**
Other recognised gains and losses		-	-	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	**-**
Public dividend capital received	2,500	-	-	**2,500**
Public dividend capital repaid	-	-	-	**-**
Public dividend capital written off	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	**-**
Other reserve movements	-	-	-	**-**
Taxpayers' equity at 31 March 2017	**199,606**	**32,754**	**(87,762)**	**144,598**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(19,596)	(1,162)
Non-cash income and expense:			
Depreciation and amortisation	6.1	10,795	10,497
Net impairments	7	6,586	483
Income recognised in respect of capital donations	4	(1,016)	(1,397)
Non-cash movements in on-SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(3,730)	(5,901)
(Increase) / decrease in inventories		91	15
Increase / (decrease) in payables and other liabilties		3,759	(2,205)
Increase / (decrease) in provisions		(159)	55
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		**(3,270)**	**385**
Cash flows from investing activities			
Interest received		30	22
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(1,242)	(700)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(12,978)	(7,489)
Sales of property, plant, equipment and investment property		102	-
Receipt of cash donations to purchase capital assets		1,016	1,397
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions/disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		**(13,072)**	**(6,770)**
Cash flows from financing activities			
Public dividend capital received		1,766	2,500
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		14,902	11,807
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		-	-
Interest paid on finance lease liabilities		-	-
Other interest paid		(392)	(276)
PDC dividend (paid) / refunded		(3,916)	(3,664)
Financing cash flows of discontinued operations		-	-
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		**12,360**	**10,367**
Increase / (decrease) in cash and cash equivalents		**(3,982)**	**3,982**
Cash and cash equivalents at 1 April - brought forward		**5,682**	**1,700**
Prior period adjustments			**-**
Cash and cash equivalents at 1 April - restated		**5,682**	**1,700**
Cash and cash equivalents transferred under absorption accounting	42	**-**	**-**
Unrealised gains / (losses) on foreign exchange		**-**	**-**
Cash and cash equivalents at 31 March	26.1	**1,700**	**5,682**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.The Board of Directors has concluded that the trust is able to demonstrate that it is a going concern on the following basis:

- The Department of Health and Social Care and NHS Improvement have confirmed the trust's arrangements for accessing cash financing for organisations that have submitted a deficit plan for 2018/19. The NHS Improvement Accountability Framework sets out the process where an NHS Trust will be assisted to develop and agreement of a formal recovery plan to address deficit positions.
- Arrangements are in place for the delivery of cost improvement plans through Executive Director meetings.
- The trust is working with NHSI to obtain STF funding for the continued operations of the trust.

Note 1.2 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Charitable Funds: Following Treasury's agreement to apply IAS 27 (Consolidation and Separate Financial Statements) to NHS Charities from 1 April 2013, the Shrewsbury and Telford Hospital NHS Trust has established that as the trust is the Corporate Trustee of the linked NHS Charity, it effectively has the power to exercise control so as to obtain economic benefits so therefore may have needed to consolidate its NHS Charity Accounts into its NHS Trust Accounts. The trust has considered the income, expenditure, assets and liabilities of the NHS Charity to be immaterial in the context of the accounts of the NHS Trust and have not consolidated these into the trust's accounts.

Revaluation: The trust commissioned Deloitte Real Estate to undertake revaluations of the trust's estate as at 30 September 2017 and 31 March 2018. Residential Land and Dwellings are valued at Market Value in existing use. Specialised buildings are valued at Depreciated Replacement Cost defined as Modern Equivalent Asset. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Note 1.2.1 Sources of estimation uncertainty

In the application of the NHS trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Provisions: Provisions have been made for probable legal and constructive obligations of uncertain timings and amount as at the reporting date. These are based on estimates using relevant and reliable information as is available at the time the financial statements are prepared, These provisions are estimates of the actual costs of future cash flows and are dependent on future events. Any difference between expectations and the actual future liability will be accounted for in the period when such determination is made.

Income: The trust has estimated income by calculating over and under performance of contracts with NHS commissioners based on forecast outturns with relevant income adjustments made. Discussions are held with commissioners on a regular basis regarding activity levels against their contracts, particularly towards and immediately after the year-end.

Note 1.3 Interests in other entities

Associates

There are no associate entities over which the trust has the power to exercise a significant influence. Associate entities are recognised in the trust's financial statement using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the trust's share of the entity's profit or loss or other gains and losses (eg revaluation gains on the entity's property, plant and equipment) following acquisition. It is also reduced when any distribution, eg, share dividends are received by the trust from the associate.

Joint ventures

There are no joint ventures in which the trust participates in with one or more other parties.

Joint operations

There are no joint operations in which the trust participates in with one or more other parties.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Residential Land and Dwellings are valued at Market Value in existing use. Specialised buildings are valued at Depreciated Replacement Cost defined as Modern Equivalent Asset. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments
In accordance with the *GAM* , impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
The trust has no PFI or LIFT agreements.

Note 1.7.6 Useful Economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	1	81
Dwellings	16	58
Plant & machinery	4	30
Transport equipment	7	10
Information technology	3	10
Furniture & fittings	5	23

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	5	5
Development expenditure	-	-
Websites	-	-
Software licences	-	-
Licences & trademarks	3	7
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.9 Inventories
Inventories are valued at the lower of cost and net realisable value using the replacement cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 Investment properties
The trust does not hold any assets which are held solely to generate a commercial return.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

Note 1.13 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases.

All other financial assets and financial liabilities are recognised when the trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as fair value through income and expenditure.

Financial liabilities are classified as fair value through income and expenditure.

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other' receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets
Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the trust intends to dispose of them within 12 months of the Statement of Financial Position date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "finance costs" in the Statement of Comprehensive Income.

Financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced.

Note 1.14 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 32 but is not recognised in the trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 33 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 33, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax

The trust has no corporation tax liability.

Note 1.20 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items (other than financial instruments measured at “fair value through income and expenditure”) are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s *FReM*.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Transfers of functions to/from other NHS bodies/local government bodies

There have been no functions that have been transferred to the trust from other NHS/local government bodies.

Note 1.25 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted
IFRS 9 Financial Instruments
IFRS 15 Revenue from Contracts with Customers
IFRS 16 Lease Accounting
IFRS 17 Insurance Contracts.

Note 2 Operating Segments

The trust operates in one material segment which is the provision of heathcare services with the Trust Board as it's chief operating decision maker deciding how to allocate resources and assessing performance.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	**2017/18 £000**	**2016/17 £000**
Acute services		
Elective income	46,748	46,738
Non elective income	118,034	104,701
First outpatient income	25,446	26,491
Follow up outpatient income	22,787	27,027
A & E income	14,551	12,758
High cost drugs income from commissioners (excluding pass-through costs)	31,283	30,079
Other NHS clinical income	69,709	63,962
Community Services		
Income from other sources (Local Authorities)	87	87
All services		
Private patient income	1,235	1,331
Other clinical income	1,594	1,490
Total income from activities	**331,474**	**314,664**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2017/18 £000**	**2016/17 £000**
NHS England	56,811	53,103
Clinical commissioning groups	242,067	229,245
Department of Health and Social Care	-	-
Other NHS providers	1,192	1,444
NHS other	129	68
Local authorities	86	88
Non-NHS: private patients	1,237	1,331
Non-NHS: overseas patients (chargeable to patient)	190	69
NHS injury scheme*	1,370	1,464
Non NHS: other**	28,392	27,852
Total income from activities	**331,474**	**314,664**
Of which:		
Related to continuing operations	331,474	314,664

* Injury cost recovery income is subject to a provision for impairment of receivables of 22.84% (previously 22.94% to November 2017) to reflect expected rates of collection.

** Non-NHS-Other includes income of £28.3m from Welsh bodies (2016-17: £27.8m).

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	190	69
Cash payments received in-year	130	32
Amounts added to provision for impairment of receivables	62	22
Amounts written off in-year	-	-

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	193	415
Education and training	12,342	12,464
Receipt of capital grants and donations	1,016	1,397
Non-patient care services to other bodies	1,908	2,604
Sustainability and transformation fund income	3,932	10,767
Other income*	8,176	7,933
Total other operating income	**27,567**	**35,580**
Of which:		
Related to continuing operations	27,567	35,580
Related to discontinued operations	-	-

*The majority of 'Other Income' is for car parking, radiology, cardiorespiratory, dietetics, speech therapists, maternity pathways and staffing and room rental for the TEMS service.

Note 5 Fees and charges

The Trust undertakes income generation schemes with an aim of achieving profit, which is then used in patient care. The Trust has no income generation activities whose full cost exceeded £1m.

Note 6.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	826	533
Staff and executive directors costs	244,971	234,620
Remuneration of non-executive directors	78	73
Supplies and services - clinical (excluding drugs costs)	28,754	27,959
Supplies and services - general	5,506	5,006
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	38,061	35,956
Inventories written down	152	280
Consultancy costs	897	146
Establishment	4,017	3,965
Premises	14,631	10,549
Transport (including patient travel)	668	680
Depreciation on property, plant and equipment	9,944	9,821
Amortisation on intangible assets	851	676
Net impairments	6,586	483
Increase/(decrease) in provision for impairment of receivables	344	463
Increase/(decrease) in other provisions	357	474
Change in provisions discount rate(s)	1	18
Audit fees payable to the external auditor		
audit services- statutory audit*	79	92
other auditor remuneration (external auditor only)**	10	13
Internal audit costs	148	125
Clinical negligence	13,864	12,604
Legal fees	420	263
Insurance	4	5
Education and training	924	1,013
Rentals under operating leases	5,026	4,894
Car parking & security	361	330
Hospitality	-	1
Losses, ex gratia & special payments	466	7
Other	691	357
Total	**378,637**	**351,406**
Of which:		
Related to continued operations	378,637	351,406
Related to discontinued operations	-	-

*audit services- statutory audit of £66,180 plus £13,236 of VAT

**other auditor remuneration (external auditor only) of £8,520 plus £1,704 of VAT

Note 6.2 Other auditor remuneration

	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services of £8,520 plus £1,704 of VAT	10	13
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**10**	**13**

Note 6.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £5m (2016/17: £2m).

Note 7 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	6,553	483
Other	33	-
Total net impairments charged to operating surplus / deficit	**6,586**	**483**
Impairments charged to the revaluation reserve	6,163	1,711
Total net impairments	**12,749**	**2,194**

The trust commissioned Deloitte Real Estate to undertake revaluations of the Trust's Estate as at 30 September 2017 and 31 March 2018. The valuation has been prepared by David Cooney MA, MRICS under the supervision of Edwin Bray MRICS, a Partner at Deloittte LLP. The valuations have been undertaken having regard to International Financial Reporting Standards ("IFRS") as applied to the United Kingdom public sector and in accordance with HM Treasury Guidance, International Valuation Standards ("IVS") and the requirements of the RICS Valuation – Professional Standards (UK Edition and Global) (Informally "Red Book") as revised in April 2015 and July 2017 (Global), section VPGA1. Cost of rebuilding the asset are based on BCIS (Index 318) as at the Valuation Date. As a result of these revaluations the Net Book Value of the Estate was valued downwards by £11,583,020 as follows: Revaluation Reserve – total £5,030,410 charged, representing a Revaluation upwards of £1,132,153 and net decrease of £6,162,563. The decrease results from Impairments charged of £7,762,022 and Reversal of Impairments of £1,599,459.
Impairments charged to SoCI of £6,552,610.
In addition, impairments in respect of equipment to the value of £33,470 have been charged to SoCI, giving a total impairment charge of £6,586,080 to SoCI.

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	172,042	173,214
Social security costs	17,436	16,839
Apprenticeship levy	929	-
Employer's contributions to NHS pensions	22,201	21,719
Temporary staff (bank)	14,645	9,043
Temporary staff (agency)	18,742	14,915
Total gross staff costs	**245,995**	**235,730**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**245,995**	**235,730**
Of which		
Costs capitalised as part of assets	1,024	1,110

Note 8.1 Retirements due to ill-health

During 2017/18 there were 3 early retirements from the trust agreed on the grounds of ill-health (10 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £182k (£545k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 10 Operating leases

as a Lessor

There are no operating lease agreements where the Shrewsbury and Telford Hospital NHS Trust is the lessor.

as a Lessee

This note discloses costs and commitments incurred in operating lease arrangements where the Shrewsbury and Telford Hospital NHS Trust is the lessee.

The trust has a contract for computerised digital imaging and archiving service contracts within Radiology. The term of the contract, which covers the Royal Shrewsbury Hospital and the Princess Royal Hospital, is 10 years and commenced on 1 January 2016.

The trust has an operating lease relating to an investment in replacing the boiler plant at the Royal Shrewsbury Hospital, the term of the lease is 15 years and commenced 1 April 2007.

The trust has a lease for printing services for both hospitals. The lease commenced 1 July 2017 for 5 years.

The trust has two property leases for off site office accommodation and an off site sterile services facility. A new lease for the off site office accommodation commenced on 21 July 2015 for 10 years. The lease for the off site sterile services facility is for 20 years commencing 1 April 2010.

The trust has entered into leases for the provision of staff and office accommodation facilities at the Royal Shrewsbury Hospital.

The trust has several managed service contracts for the provision of services within the Pathology and Radiology departments.

The Trust also leases cars and adhoc medical equipment.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	5,026	4,894
Contingent rents	-	-
Less sublease payments received	-	-
Total	**5,026**	**4,894**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	4,737	4,835
- later than one year and not later than five years;	16,885	16,752
- later than five years.	7,981	10,395
Total	**29,603**	**31,982**
Future minimum sublease payments to be received	-	-

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	31	22
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total	**31**	**22**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	448	286
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	38	-
Total interest expense	**486**	**286**
Unwinding of discount on provisions	35	24
Other finance costs	-	-
Total finance costs	**521**	**310**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims made under this legislation	38	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 13 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	102	-
Losses on disposal of assets	(184)	-
Total gains / (losses) on disposal of assets	(82)	-
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available-for-sale financial investments	-	-
Total other gains / (losses)	**(82)**	**-**

Note 14.1 Intangible assets - 2017/18

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**410**	**5,438**	**-**	**5,848**
Transfers by absorption	-	-	-	**-**
Additions	-	861	45	**906**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	84	2	**86**
Transfers to/ from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Gross cost at 31 March 2018	**410**	**6,383**	**47**	**6,840**
Amortisation at 1 April 2017 - brought forward	**210**	**2,661**	**-**	**2,871**
Transfers by absorption	**-**	**-**	**-**	**-**
Provided during the year	66	785	-	**851**
Impairments	**-**	**-**	**-**	**-**
Reversals of impairments	**-**	**-**	**-**	**-**
Revaluations	**-**	**-**	**-**	**-**
Reclassifications	**-**	**-**	**-**	**-**
Transfers to / from assets held for sale	**-**	**-**	**-**	**-**
Disposals / derecognition	**-**	**-**	**-**	**-**
Amortisation at 31 March 2018	**276**	**3,446**	**-**	**3,722**
Net book value at 31 March 2018	**134**	**2,937**	**47**	**3,118**
Net book value at 1 April 2017	**200**	**2,777**	**-**	**2,977**

Note 14.2 Intangible assets - 2016/17

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**379**	**4,083**	**-**	**4,462**
Prior period adjustments	**-**	**-**	**-**	**-**
Valuation / gross cost at 1 April 2016 - restated	**379**	**4,083**	**-**	**4,462**
Transfers by absorption	-	-	-	**-**
Additions	31	1,333	-	**1,364**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	22	-	**22**
Transfers to/ from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Valuation / gross cost at 31 March 2017	**410**	**5,438**	**-**	**5,848**
Amortisation at 1 April 2016 - as previously stated	**136**	**2,059**	**-**	**2,195**
Prior period adjustments	**-**	**-**	**-**	**-**
Amortisation at 1 April 2016 - restated	**136**	**2,059**	**-**	**2,195**
Transfers by absorption	**-**	**-**	**-**	**-**
Provided during the year	**74**	**602**	**-**	**676**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2017	**210**	**2,661**	**-**	**2,871**
Net book value at 31 March 2017	**200**	**2,777**	**-**	**2,977**
Net book value at 1 April 2016	**243**	**2,024**	**-**	**2,267**

Note 15.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**13,157**	**118,056**	**491**	**5,113**	**45,829**	**375**	**15,750**	**5,726**	**204,497**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	5,479	-	4,191	1,026	26	1,125	99	**11,946**
Impairments	-	(19,613)	-	-	-	-	-	-	**(19,613)**
Reversals of impairments	-	2,373	(5)	-	(120)	-	-	-	**2,248**
Revaluations	-	646	-	-	-	-	-	-	**646**
Reclassifications	-	1,497	-	(4,263)	6,143	(1)	46	(3,509)	**(87)**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(6,753)	(25)	(5,721)	-	**(12,499)**
Valuation/gross cost at 31 March 2018	**13,157**	**108,438**	**486**	**5,041**	**46,125**	**375**	**11,200**	**2,316**	**187,138**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**121**	**-**	**-**	**26,247**	**226**	**10,159**	**3,525**	**40,278**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**5,051**	**16**	**-**	**3,333**	**35**	**1,275**	**234**	**9,944**
Impairments	-	(4,097)	-	-	-	-	-	-	**(4,097)**
Reversals of impairments	-	(417)	(16)	-	(86)	-	-	-	**(519)**
Revaluations	-	(486)	-	-	-	-	-	-	**(486)**
Reclassifications	-	(2)	-	-	2,212	(1)	-	(2,210)	**(1)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(6,569)	(25)	(5,721)	-	**(12,315)**
Accumulated depreciation at 31 March 2018	**-**	**170**	**-**	**-**	**25,137**	**235**	**5,713**	**1,549**	**32,804**
Net book value at 31 March 2018	**13,157**	**108,268**	**486**	**5,041**	**20,988**	**140**	**5,487**	**767**	**154,334**
Net book value at 1 April 2017	**13,157**	**117,935**	**491**	**5,113**	**19,582**	**149**	**5,591**	**2,201**	**164,219**

Note 15.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**13,156**	**116,429**	**479**	**594**	**46,042**	**375**	**14,070**	**5,318**	**196,463**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**13,156**	**116,429**	**479**	**594**	**46,042**	**375**	**14,070**	**5,318**	**196,463**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions	-	3,614	-	4,807	1,761	-	1,680	436	**12,298**
Impairments	-	(5,101)	-	-	(539)	-	-	(18)	**(5,658)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	2,875	12	-	-	-	-	-	**2,887**
Reclassifications	1	239	-	(288)	28	-	-	(2)	**(22)**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	(1,463)	-	-	(8)	**(1,471)**
Valuation/gross cost at 31 March 2017	**13,157**	**118,056**	**491**	**5,113**	**45,829**	**375**	**15,750**	**5,726**	**204,497**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**1,046**	**-**	**-**	**24,430**	**191**	**9,067**	**3,253**	**37,987**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**-**	**1,046**	**-**	**-**	**24,430**	**191**	**9,067**	**3,253**	**37,987**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**-**	**4,950**	**8**	**-**	**3,446**	**35**	**1,092**	**290**	**9,821**
Impairments	-	(3,288)	-	-	(166)	-	-	(10)	**(3,464)**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(2,587)	(8)	-	-	-	-	-	**(2,595)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	(1,463)	-	-	(8)	**(1,471)**
Accumulated depreciation at 31 March 2017	**-**	**121**	**-**	**-**	**26,247**	**226**	**10,159**	**3,525**	**40,278**
Net book value at 31 March 2017	**13,157**	**117,935**	**491**	**5,113**	**19,582**	**149**	**5,591**	**2,201**	**164,219**
Net book value at 1 April 2016	**13,156**	**115,383**	**479**	**594**	**21,612**	**184**	**5,003**	**2,065**	**158,476**

Note 15.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	13,157	104,472	486	4,165	17,097	140	5,420	652	**145,589**
Finance leased	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	3,796	-	876	3,891	-	67	115	**8,745**
NBV total at 31 March 2018	**13,157**	**108,268**	**486**	**5,041**	**20,988**	**140**	**5,487**	**767**	**154,334**

Note 15.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	13,157	113,277	491	4,197	16,157	149	5,498	1,967	**154,893**
Finance leased	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	4,658	-	916	3,425	-	93	234	**9,326**
NBV total at 31 March 2017	**13,157**	**117,935**	**491**	**5,113**	**19,582**	**149**	**5,591**	**2,201**	**164,219**

Note 16 Donations of property, plant and equipment

During 2017/18 various pieces of medical equipment have been donated by Royal Shrewsbury Hospital League of Friends; The Shrewsbury and Telford Hospital NHS Trust Charitable Funds and Lingen Davies Cancer Fund, including an additional MRI Scanner donated by RSH League of Friends.

Note 17 Revaluations of property, plant and equipment

The trust commissioned Deloitte Real Estate to undertake revaluations of the Trust's Estate as at 30 September 2017 and 31 March 2018. The valuation has been prepared by David Cooney MA, MRICS under the supervision of Edwin Bray MRICS, a Partner at Deloittte LLP. The valuations have been undertaken having regard to International Financial Reporting Standards ("IFRS") as applied to the United Kingdom public sector and in accordance with HM Treasury Guidance, International Valuation Standards ("IVS") and the requirements of the RICS Valuation – Professional Standards (UK Edition and Global) (Informally "Red Book") as revised in April 2015 and July 2017 (Global), section VPGA1. Cost of rebuilding the asset are based on BCIS (Index 318) as at the Valuation Date. As a result of these revaluations the Net Book Value of the Estate was valued downwards by £11,583,020 as follows:
Revaluation Reserve – total £5,030,410 charged, representing a Revaluation upwards of £1,132,153 and net decrease of £6,162,563. The decrease results from Impairments charged of £7,762,022 and Reversal of Impairments of £1,599,459.
Impairments charged to SoCI of £6,552,610.
In addition, impairments in respect of equipment to the value of £33,470 have been charged to SoCI, giving a total impairment charge of £6,586,080 to SoCI.

Note 18 Investment Property

The trust has no investment property that requires disclosure within this note.

Note 19 Investments in associates and joint ventures

The trust has no investments in associates or joint ventures.

Note 20 Other investments / financial assets

The trust has no other current or non-current investments or financial assets.

Note 21 Disclosure of interests in other entities

The trust has no interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated structured entities that require disclosures within this note.

Note 22 Inventories

	31 March 2018	31 March 2017
	£000	£000
Drugs	1,929	2,033
Work In progress	-	-
Consumables	5,687	5,670
Energy	153	157
Other	-	-
Total inventories	**7,769**	**7,860**

Inventories recognised in expenses for the year were £69,807k (2016/17: £65,123k). Write-down of inventories recognised as expenses for the year were £152k (2016/17: £280k).

Note 23.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	9,777	3,948
Capital receivables	-	-
Accrued income	6,054	7,730
Provision for impaired receivables	(739)	(661)
Deposits and advances	-	-
Prepayments	1,776	1,986
Interest receivable	3	2
Finance lease receivables	-	-
PDC dividend receivable	235	32
VAT receivable	517	668
Other receivables	987	877
Total current trade and other receivables	**18,610**	**14,582**
Non-current		
Trade receivables	-	-
Capital receivables	-	-
Accrued income	-	-
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Other receivables	1,370	1,464
Total non-current trade and other receivables	**1,370**	**1,464**
Of which receivables from NHS and DHSC group bodies:		
Current	11,421	9,247
Non-current	-	-

Note 23.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**661**	**588**
Increase in provision	431	428
Amounts utilised	(266)	(390)
Unused amounts reversed	(87)	35
At 31 March	**739**	**661**

Injury cost recovery income is subject to a provision for impairment of receivables of 22.84% (previously 22.94% to November 2017) to reflect expected rates of collection.

Invoices raised to overseas visitors are provided for immediately as a high number of these invoices are not collected.

Specific provisions are made against any invoices that are outstanding and deemed to be non-collectable including those that have been sent to the trust's debt collection agency.

Note 23.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	£000	£000	£000	£000
0 - 30 days	8,604	-	2,310	-
30-60 Days	344	-	561	-
60-90 days	212	-	165	-
90- 180 days	218	-	555	-
Over 180 days	399	-	357	-
Total	**9,777**	**-**	**3,948**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	-	-	-	-
Total	**-**	**-**	**-**	**-**

Note 24 Other assets

The trust has no other assets that require disclosure within this note.

Note 25 Non-current assets held for sale and assets in disposal groups

The trust has no non-current assets held for sale or assets in disposal groups that require disclosure within this note.

Note 26.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**5,682**	**1,700**
Net change in year	(3,982)	3,982
At 31 March	**1,700**	**5,682**
Broken down into:		
Cash at commercial banks and in hand	30	32
Cash with the Government Banking Service	1,670	5,650
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**1,700**	**5,682**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**1,700**	**5,682**

Note 26.2 Third party assets held by the trust

The trust held cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2018	31 March 2017
	£000	£000
Bank balances	4	4
Monies on deposit	-	-
Total third party assets	**4**	**4**

Note 27.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	7,443	8,186
Capital payables	6,422	7,790
Accruals	11,013	6,617
Receipts in advance (including payments on account)	8	14
Social security costs	-	-
VAT payables	-	-
Other taxes payable	77	4
PDC dividend payable	-	-
Accrued interest on loans	127	33
Other payables	3,093	3,051
Total current trade and other payables	**28,183**	**25,695**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	2,369	1,376
Non-current	-	-

The payables note above includes amounts in 'Other payables' as set out below:

	31 March 2018 £000	31 March 2017 £000
Outstanding pension contributions	3,014	2,974

Note 28 Other financial liabilities

The trust has no other financial liabilities that require disclosure within this note.

Note 29 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,166	1,169
Deferred grants	-	-
Lease incentives	-	-
Total other current liabilities	**1,166**	**1,169**
Non-current		
Deferred income	-	-
Deferred grants	-	-
Lease incentives	-	-
Total other non-current liabilities	**-**	**-**

Note 30 Borrowings

	31 March 2018 £000	31 March 2017 £000
Current		
Bank overdrafts	-	-
Drawdown in committed facility	-	-
Loans from the Department of Health and Social Care	15,200	-
Other loans	-	-
Obligations under finance leases	-	-
Total current borrowings	**15,200**	**-**
Non-current		
Loans from the Department of Health and Social Care	24,209	24,507
Other loans	-	-
Obligations under finance leases	-	-
Total non-current borrowings	**24,209**	**24,507**

Note 31 Finance leases

The Shrewsbury and Telford Hospital NHS Trust have no finance leases where the trust is the lesser or lessor.

Note 32 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**52**	**218**	**545**	**815**
Change in the discount rate	-	-	1	**1**
Arising during the year	25	114	266	**405**
Utilised during the year	(42)	(145)	(330)	**(517)**
Reclassified to liabilities held in disposal groups	-	-	-	**-**
Reversed unused	-	(38)	(10)	**(48)**
Unwinding of discount	8	-	27	**35**
At 31 March 2018	**43**	**149**	**499**	**691**
Expected timing of cash flows:				
- not later than one year;	43	149	340	**532**
- later than one year and not later than five years;	-	-	62	**62**
- later than five years.	-	-	97	**97**
Total	**43**	**149**	**499**	**691**

Early departure costs relate to a provision for future payments payable to the NHS Pensions Agency in respect of former employees who took early retirement.

Legal claims relate to NHS Resolution non clinical cases with employees and members of the general public.

Other provision relates to Injury Benefits relating to former staff and contains provisions payable to former employees forced to retire due to injury suffered in the workplace (£239k) and the CRC scheme (£260k).

Note 32.1 Clinical negligence liabilities

At 31 March 2018, £286,307k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Shrewsbury and Telford Hospital NHS Trust (31 March 2017: £174,609k).

Note 33 Contingent assets and liabilities

	31 March 2018	31 March 2017
	£000	£000
Value of contingent liabilities		
NHS Resolution legal claims	(91)	(113)
Employment tribunal and other employee related litigation	-	-
Redundancy	-	-
Gross value of contingent liabilities	**(91)**	**(113)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(91)**	**(113)**
Net value of contingent assets	-	-

The contingent liabilities represent the difference between the expected values of provisions for legal claims carried at note 32 and the maximum potential liability that could arise from these claims.

Note 34 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	71	1,189
Intangible assets	-	-
Total	**71**	**1,189**

Note 35 Other financial commitments

The trust is not committed to making any payments under non-cancellable contracts which are not leases, PFI contracts or other service concession arrangements.

Note 36 Defined benefit pension schemes

The trust has no defined benefit pension schemes.

Note 37 On-SoFP PFI, LIFT or other service concession arrangements

The trust does not have any PFI schemes, LIFT schemes or other service concession recognised on-SoFP.

Note 38 Financial instruments

Note 38.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with commissioners and the way those commissioners are financed, the trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the board of directors. The trust's treasury activity is subject to review by the trust's internal auditors.

Currency risk

The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

The trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken.

The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

Note 38.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Financial Instruments - Assets as at 31 March 2018					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	18,710	-	-	-	**18,710**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	1,700	-	-	-	**1,700**
Total at 31 March 2018	**20,410**	**-**	**-**	**-**	**20,410**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Financial Instruments - Assets as at 31 March 2017					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	13,764	-	-	-	**13,764**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	5,682	-	-	-	**5,682**
Total at 31 March 2017	**19,446**	**-**	**-**	**-**	**19,446**

Note 38.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Financial Instruments - Liabilities as at 31 March 2018			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	39,409	-	**39,409**
Obligations under finance leases	-	-	**-**
Trade and other payables excluding non financial liabilities	28,176	-	**28,176**
Other financial liabilities	-	-	**-**
Provisions under contract	149	-	**149**
Total at 31 March 2018	**67,734**	**-**	**67,734**

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Financial Instruments - Liabilities as at 31 March 2017			
Embedded derivatives	-	-	**-**
Borrowings excluding finance lease and PFI liabilities	24,507	-	**24,507**
Obligations under finance leases	-	-	**-**
Trade and other payables excluding non financial liabilities	25,680	-	**25,680**
Other financial liabilities	-	-	**-**
Provisions under contract	218	-	**218**
Total at 31 March 2017	**50,405**	**-**	**50,405**

Note 38.4 Fair values of financial assets and liabilities

The book value (carrying value) is a reasonable approximation of fair value for the Trust's financial assets and liabilities.

Note 38.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	43,525	25,898
In more than one year but not more than two years	3,690	15,200
In more than two years but not more than five years	20,519	9,307
In more than five years	-	-
Total	**67,734**	**50,405**

Note 39 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	2	0
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	565	264	335	463
Stores losses and damage to property	27	152	26	279
Total losses	**592**	**416**	**363**	**742**
Special payments				
Compensation under court order or legally binding arbitration award	1	460	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	53	151	28	66
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**54**	**611**	**28**	**66**
Total losses and special payments	**646**	**1,027**	**391**	**808**
Compensation payments received		-		-

Details of cases individually over £300k:

A falls claim from HSE for £460k has been accrued to 'Compensation under court order or legally binding arbitration award'.

£145k of the ex-gratia payments are included in legal claims in Note 32 Provisions for liabilities and charges analysis rather than Note 6.1 Operating expenses.

Note 40 Gifts

The total value of gifts did not exceed £300,000 so no further disclosure is required.

Note 41 Related parties

The Department of Health and Social Care is regarded as the parent department. The main entities within the public sector that the trust has had dealings with during the year are:
NHS Shropshire CCG
NHS Telford and Wrekin CCG
NHS South East Staffs And Seisdon Peninsular CCG
NHS Stafford And Surrounds CCG
NHS England
Health Education England
NHS Resolution
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT
Mid Cheshire Hospitals NHS FT
Shropshire Community Health NHS Trust
The Royal Wolverhampton NHS Trust
Betsi Cadwaladr University Local Health Board
Cwm Taf Local Health Board
Powys Local Health Board
Welsh Assembly Government
National Health Service Pension Scheme
NHS Pension Scheme
HM Revenue and Customs

The trust is linked to the Shrewsbury and Telford Hospital NHS Charity. The Annual Report and Accounts for the Shrewsbury and Telford Hospital NHS Charity are submitted separately to the Charity Commission and are not consolidated into the trust's Accounts.

The trust is also linked to Royal Shrewsbury Hospital League of Friends, Friends of Princess Royal Hospital and Lingen Davies Cancer Fund who donate various pieces of medical equipment to the trust.

Note 42 Transfers by absorption

There were no transfers by absorption in the year where the trust has been either the receiving or divesting party.

Note 43 Prior period adjustments

The trust has made no prior period adjustments where comparative information has been restated due to either a change in accounting policy or material prior period error.

Note 44 Events after the reporting date

There are no events after the reporting date that require disclosure within this note.

Note 45 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	109,064	132,940	93,881	113,516
Total non-NHS trade invoices paid within target	35,467	50,195	46,940	68,821
Percentage of non-NHS trade invoices paid within target	**32.52%**	**37.76%**	50.00%	60.63%
NHS Payables				
Total NHS trade invoices paid in the year	2,732	7,446	2,822	7,345
Total NHS trade invoices paid within target	2,340	5,763	1,837	4,390
Percentage of NHS trade invoices paid within target	**85.65%**	**77.40%**	65.10%	59.77%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 46 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	**20,650**	**10,325**
Finance leases taken out in year	**-**	**-**
Other capital receipts	**-**	**-**
External financing requirement	**20,650**	**10,325**
External financing limit (EFL)	20,650	10,325
Under / (over) spend against EFL	0	0

Note 47 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	12,852	13,663
Less: Disposals	(184)	-
Less: Donated and granted capital additions	(1,016)	(1,397)
Plus: Loss on disposal of donated/granted assets	-	-
Charge against Capital Resource Limit	11,652	12,266
Capital Resource Limit	12,830	13,228
Under / (over) spend against CRL	1,178	962

The underspend mainly results from the trust's cash position not enabling it to invest in capital expenditure relating to internally generated capital from donated asset depreciation.

Note 48 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) - control total basis	(17,400)
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	(17,400)

Note 49 Breakeven duty rolling assessment

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
		£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		712	26	59	81	65	(12,130)	(14,649)	(5,631)	(17,400)
Breakeven duty cumulative position	(22,891)	(22,179)	(22,153)	(22,094)	(22,013)	(21,948)	(34,078)	(48,727)	(54,358)	(71,758)
Operating income		262,882	277,980	299,850	309,362	314,106	316,794	326,477	350,244	359,041
Cumulative breakeven position as a percentage of operating income		-8.44%	-7.97%	-7.37%	-7.12%	-6.99%	-10.76%	-14.93%	-15.52%	-19.99%

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of The Shrewsbury and Telford Hospital NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 40, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 39 the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects The Shrewsbury and Telford Hospital NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

In considering the Trust's arrangements for securing sustainable resource deployment, we identified that the Trust had reported a deficit of £17.4 million in 2017/18 and had failed to deliver a number of operational targets for the year. In particular the Trust failed to meet its Accident and Emergency targets.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 39, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

We are required to report to you if we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency;

On 22 May 2018 we referred a matter to the Secretary of State under section 30 (1)(b) of the 2014 Act in relation to the breach of the Trust's breakeven duty due to the reported deficit of £17.4 million in 2017/18, and the cumulative deficit of £71.8 million at 31 March 2018.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of the Shrewsbury and Telford Hospital NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

KPMG

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of The Shrewsbury and Telford Hospital NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

John Cornett
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
31 Park Row
Nottingham
NG1 6FQ

25 May 2018

Appendix 3

Annual Governance Statement

Shrewsbury and Telford Hospital NHS Trust **Organisation Code: RXW**

Annual Governance Statement – 2017/18

1 Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of The Shrewsbury and Telford Hospital NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Shrewsbury and Telford Hospital NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Shrewsbury and Telford Hospital NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3 Capacity to handle risk

The Chief Executive is the Accountable Officer for the Trust and for ensuring the Trust meets its statutory and legal requirements. The Chief Executive is supported by the Director of Corporate Governance who is the lead director for risk management and fulfils the role of Board Secretary. The Director develops corporate risk management strategies and policies interpreting national guidance to fit the local context and the Board Assurance Framework in conjunction with the entire Trust Board. All the Directors have delegated authority for specific areas of risk.

The Non-Executives are accountable to the Secretary of State. They are expected to hold the Executive to account and to use their skills and experience to make sure that the interests of patients, staff and Trust as a whole, remain paramount. They have a significant responsibility for scrutinising the business of the Trust particularly in relation to risk and assurance.

The organisation provides annual mandatory and statutory training for different levels of staff depending on their responsibilities as detailed in the Risk Management Training Policy. This includes risk awareness training which is provided to all staff as part of their mandatory corporate induction programme. Risk management awareness training was provided throughout 2017/18 at all levels of the organisation. The Trust seeks to learn from good practice as described in our Quality Improvement Strategy and particularly through our partnership with the Virginia Mason Institute; from other areas by benchmarking practice against national standards and reports; reviews of incidents, complaints and claims; and the ward exemplar programme.

4 The risk and control framework

The Trust's Risk Management Strategy is updated and approved by the Trust Board. The strategy describes an integrated approach to ensure that all risks to the achievement of the Trust's objectives, are identified, evaluated, monitored, and managed appropriately. It defines how risks are linked to one or more of the Trust's strategic or operational objectives, and clearly defines the risk management structures, accountabilities, and responsibilities throughout the Trust.

Risk assessment is a key feature of all normal management processes. All areas of the Trust have an on-going programme of risk assessments, which inform the local risk registers. This process was audited by the Trust's Internal Audit who found there was substantial assurance around the processes in place for the sixth successive year. Risks are evaluated using the Trust risk matrix which feeds into the decision making process about whether a risk is considered acceptable. Unacceptable risks require control measures and action plans to reduce them to an acceptable level. The risk registers are reviewed regularly and if a risk cannot be resolved at a local level, the risk is escalated through the operational management structure,

ultimately to the Trust Board. Each risk and related action has an identified owner who is responsible for monitoring and reporting on the risk to the appropriate committee and for implementing changes to mitigate the risk in a specified timeframe.

The organisation's current overall risk appetite has been described by the Board as 'open' as the Trust is prepared to consider all delivery options and select those with the highest probability of productive outcomes, even where there are elevated levels of associated risk.

The Director of Nursing and Quality has delegated responsibility for Quality and Safety. The performance of Quality has been monitored closely by the Board with detailed, monthly performance reviews. Scrutiny of this aspect is also part of the role of the Quality and Safety Committee. The Trust has worked with clinical staff to establish Key Performance Indicators to monitor quality from the ward to Board.

The Trust Board and our other senior leaders gain assurance that the performance information that they are being provided with is current, accurate and reliable and has been validated to ensure that it is robust; this is done through a process of triangulation. This provides a picture of the organisation as a whole and can helps to validate feedback from patients and staff and enables appropriate actions and decisions to be taken.

The different elements of Quality Governance are brought together in the overarching Quality Improvement Plan which is updated by Corporate Nursing and collates the evidence that we have completed all must do and should do actions for the CQC and that we are compliant with the CQC requirements.

All serious incidents are reported to Commissioners and to other bodies in line with current reporting requirements. Root cause analysis is undertaken with monitored action plans.

The annual clinical audit plan is linked to the Trust priorities and risks and is monitored by the Clinical Audit Committee, which reports to the Quality and Safety Committee. A patient panel was established in 2013 which enables suitably trained patients and members of the public to undertake clinical audits. The patient panel has been recognised nationally as an area of good practice.

Following a serious case in maternity in 2009 and a number of external reviews, the Secretary of State for Health commissioned an independent review of the investigation of maternity serious incidents in February 2017. The review has continued throughout the year and the report is due to be published in 2018/19.

The Finance Director is the nominated Senior Information Risk Officer (SIRO) who is responsible along with the Medical Director as Caldicott Guardian, for ensuring there is a control system in place to maintain the security of information. The result of the Information Governance Toolkit Assessment provides assurance that this is being managed. The overall result for SaTH was 70% (Satisfactory). The Trust attained at least level 2 compliance in all 45 requirements

The BAF enables the Board to undertake focused management of the Trust's major risks. There is a schedule of associated action plans for each key risk which identifies the date and Committee of last presentation. Progress against mitigating these risks is proactively monitored and reported to Trust Board. The BAF risks during the year were:

- **If we do not work with our partners to reduce the numbers of patients who are medically fit for discharge and delayed transfers of care, alongside streamlining our own internal processes, we will not reduce length of stay or increase the number of simple and complex discharges to reduce the bed occupancy levels to 92%.** At times, there have been over 140 patients in hospital beds who are fit to be discharged from acute care although the length of time individual patients are waiting has decreased. Routinely these patients have occupied 15% of bed capacity. This risk impacts on many of the other risks the Trust is facing. The three main reasons for delays are domiciliary care provision and nursing/residential home placements and an increase in further non-acute care including rehabilitation. Although the Trust has worked with partner agencies to improve the situation; and there has been an increase in funded care packages, this has not been sufficient to improve the situation. Given the over-riding responsibility of the Board for patient safety and experience, this remains a source of difficulty.

- **If we do not have the patients in the right place, by removing medical outliers, patient experience will be affected**. The Trust continues to experience exceptional levels of demand and concerns of capacity both in our inpatient and emergency areas. This has led to patients being escalated and occupying spaces that are sub-optimal in terms of our ability to care for them safely or with dignity and respect. The risks assessed and incidents such as from Datix, complaints, infection prevention control, safeguarding, staffing and legal claims are triangulated by the corporate nursing team to gain assurance that where possible risks are lessened

- **If there is a lack of system support for winter planning then this would have major impacts on the Trust's ability to deliver safe, effective and efficient care to patients** An internal winter planning group was established early in the year and a winter plan agreed. A number of actions were implemented including SaTH2Home scheme (facilitated discharge with clinical support); bed realignment; increasing the number of medical staff in medicine to support discharge, clinical staff to support A&E departments and additional bed capacity. The level of expenditure incurred in response to the winter demands this year (£5.0m) has been higher than in any previous financial year. Funding levels have been provided by Commissioners and NHSI (£4.9m) to support the majority of the predicted levels of spend. Nevertheless, even with all these elements in place, winter has been challenging with high levels of escalation leading to additional patients on wards, with all the concurrent risks associated with this.

- **If the maternity service does not evidence a robust approach to learning and quality improvement, there will be a lack of public confidence and reputational damage.** This new risk was added to the BAF in April 2017 in light of incidents which have caused significant harm and the intense scrutiny that the Trust is under. The Secretary of State commissioned a review which was due to report in early 2018; however, the publication of the report has been delayed until later in 2018. The Trust is working with a wide range of organisations to deliver the Maternity Transformation Programme which aims to achieve the vision set out in 'Better Births'. The Maternity Service has made significant progress in improving systems and processes to embed learning and the latest clinical quality metrics show good clinical outcomes compared with the national average. However, until the Secretary of State review is published, and the Trust can demonstrate that learning has been embedded, then this will remain a risk.

- **If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning then we will fail the national quality and performance standards** The A&E performance has not been achieved and the Trust has consistently underperformed on both the original TDA trajectory and the revised trajectory with a performance of 76.6% Other reasons for the failure to meet the target include due to the high demand for services and the numbers of patients who are fit-to-transfer, but occupying a hospital bed. A number of actions have been taken to improve performance including the opening of a Clinical Decision Unit at RSH, and a second unit opening at PRH in April 2018. The Trust has put in place a 'fit to sit' model to help with the process, this prevents patients from taking up a cubicle for the duration of their time in the A&E, and ED patient flow coordinators focusing on the minors stream commenced in March.

  The Trust maintained performance for the cancer waiting times targets where the Trust is performing above the national average. The Trust achieved the standards in relation to Referral-to-Treatment target from September 2017 although performance deteriorated in March due to severe operational pressures as capacity was substantially impacted by winter pressure.

- **If we are unable to implement our clinical service vision in a timely way then we will not deliver the best services to patients** The Trust has a clear clinical service vision, but has been unable to progress the plans due to external constraints. Many services are fragile, due to staff shortages. Although a significant amount of work has taken place the public consultation on NHS Future Fit was delayed. A decision was taken in March 2018 to proceed to public consultation in May 2018. Once the outcome of the consultation is known, then the Trust will be in a position to implement our clinical service vision however this will remain a risk throughout 2018/19.

- **Risk to sustainability of clinical services due to shortages of key clinical staff** This risk continues to be a significant issue for the Trust and relates to risks of staffing gaps in key clinical areas for which

the longer term plan is being developed through NHS Future Fit. One of the key drivers for NHS Future Fit is the difficulty in attracting staff to a split site service with onerous on-call commitments which, unless changes are made, is likely to struggle in future to meet key national standards and guidance. Further delays in the Future Fit process resulted in more resignations of staff from key clinical areas due to the uncertainty engendered. There are a number of challenged services including the Emergency Departments where there are three Substantive Consultants for both Emergency Departments at RSH and PRH and three Locum Consultants as well as insufficient middle grade doctors. There is also a shortage of permanent nursing staff in some areas. Other services in the spotlight include dermatology (a single consultant), and neurology (two consultants instead of the required six). Until the outcome of Future Fit is implemented, this will remain a risk.

- **If we do not get good levels of staff engagement to get a culture of continuous improvement then staff morale & patient outcomes may not improve** Work has started to further develop leaders in our organisation and the Leadership Academy was launched in June 2017. Values based recruitment is used to inform recruitment decisions at all levels of the organisation. The results of the latest national staff survey show deterioration and so robust action will be needed to be taken.

- **If we do not develop real engagement with our staff and our community we will fail to support an improvement in health outcomes and deliver our service vision.** The Trust appointed a Community Engagement Facilitator in August 2017 who is now delivering the People's Academy which is an interactive and educational programme for our local communities. The Academy has been developed with input from a range of public representatives with their input around what topics the academy should cover. In addition we have over 10,000 public members and 900 volunteers. Our trust has been highlighted as an area of good practice for our young volunteer scheme as well as our induction and training for volunteers.

  The Trust continues to work with the Virginia Mason Institute (VMI) who transformed its systems to become widely regarded as one of the safest hospitals in the world. Virginia Mason are providing training and coaching to draw inspiration and develop new ways of working. Many of the workstreams now involve patients as well as staff

- **If we are unable to resolve the structural imbalance in the Trust's Income & Expenditure position then we will not be able to fulfil our financial duties & address the modernisation of our ageing estate & equipment** The 2017/18 financial year has been challenging for the Trust. The Trust agreed a planned in year deficit for 2017/18 as a control total with NHS Improvement of £6.1 million, subject to the receipt of Sustainability and Transformation Funding (STF) monies of £9.3 million. The effect of workforce challenges has led to increased spending in respect of Agency staffing and an inability to secure the full level of cost improvement savings. This combined with reduced Income has resulted in the Trust overspending in the year by £12 million. Significantly, in failing to limit the overspend to the level agreed with NHSI the Trust has then been unable to secure the full level of available STF monies. The level of STF monies withdrawn has amounted to £5.4 million and as a consequence the Trust will end the year with a deficit of £17.4 million.

- **If we do not deliver our CIPs and budgetary control totals then we will be unable to invest in services to meet the needs of our patients** The Trust has been set a Control Total target by NHSI to achieve a deficit in the 2018/19 year of £8.615m. In order to achieve this level of deficit it is necessary for the Trust to generate cost improvement savings equivalent to 2.2 per cent of Trust expenditure budgets, amounting to savings of circa £8.2 million. Schemes have been identified to deliver this level of saving however considerable levels of risk presently exist in respect of a number of these schemes. A waste reduction working group has been established chaired by the Chief Operating Officer and attended by senior members of the operational teams along with Finance and Workforce. This group will oversee the production and monitoring of the detailed plans for each scheme along with all quality impact assessments.

The Well-Led Framework combines the Board Governance Assurance Framework and the Quality Governance Framework. The work on the Well–Led framework has been led by the Corporate Nursing Team. An enhanced Board Development Programme is in place and the senior Board Committees (Workforce, Performance, Quality and Safety and Audit Committee) are chaired by Non-Executive Directors.

The Trust has included the requirement for members of Trust Board to make a declaration against the Fit and Proper Persons Test has robust arrangements in place for new appointments to the Board (whether non-executive or executive). The Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability. The Chair and Non-Executive Directors have a broad base of skills and experience and each Non-Executive Director also brings individual skills and personal experience of their community and the NHS to guide the work of the Trust, including financial, commercial, community engagement, and health care.

Directors are required to adhere to the highest standard of conduct in the performance of their duties. In respect of their interaction with others, the Trust Board operates under an explicit Code of Conduct, which is compliant with the NHS Code of Governance. The Board of Directors of the Trust are required to agree and adhere to the commitments set out in the Code of Conduct, which includes the principles set out by the Nolan Committee on Standards in Public Life. Once appointed, Board Members are required to sign a declaration to confirm that they will comply with the Code in all respects.

All new Non-Executive Directors have a detailed induction programme tailored to individual requirements and Board responsibilities. The Chair is subject to an annual assessment of performance by NHSI. The Trust Board undertakes on-going Board development, using external expertise where required. The Chief Executive is subject to formal review by the Chair. Executive Directors are subject to annual appraisals by the Chief Executive, and Non-Executive Directors are subject to annual appraisal by the Chair, both of which inform individual development plans for all Board members.

Continuous professional development of clinical staff, including medical staff, supports the delivery of high quality clinical services. The Trust has policies, processes and procedures in place to ensure all medical practitioners providing care on behalf of the Trust have met the relevant registration and re-validation requirements. All appointments to senior management positions are subject to rigorous and transparent recruitment processes including values based interviews. Senior managers have objectives linked to the delivery of the strategic objectives and operational plan. The Chair and Chief Executive continue to review the capacity of senior managers within the Trust to ensure there is the required and necessary balance to deliver and maintain high quality and safe services during a time of unprecedented transformational change within the organisation.

The Trust also has a leadership academy for leaders at all levels of the organisation, which aligns effort and resources to shared organisational goals, ensures all effort and initiatives link together to create added value, ensures behaviours and actions are aligned to the organisational vision, values and goals, and ensures behaviours help produce performance, assurance and improvement at individual, team and organisational level.

The risk of not having suitably qualified individuals at all levels of the organisation is mitigated by our robust recruitment and selection processes for staff at all levels. The Trust Board is assured on a monthly basis that we continue to demonstrate compliance with relevant governance requirements at all times.

Performance of the formal sub-committees of the Board are periodically reviewed to ensure the structure is fit-for-purpose; with clear focus on key strategic imperatives, assurance of systems, the reduction of duplication and delivery against robust plans. The new Trust Chair is reviewing the Committee structure to ensure it is fit for purpose. During the year NHSI undertook a review of the Trust's governance structures. A report was received in March 2018 and the recommendations will be considered and actions implemented over 2018/19.

Membership of the Board of Directors is made up of the Trust Chair, six independent Non-Executive Directors, and five Executive Directors (including the Chief Executive). There have been a number of changes to the Board during the year. The Chair of the Trust stepped down at the end of his term of office in December 2017 with a new Chair taking up post in February 2018. In April 2017, a new Director of Nursing, Midwifery and Quality commenced in post. The Chief Operating Officer retired in December 2017 and an interim was in post until the permanent replacement took up their role in February 2018. .One of the non-executives stepped down in January 2018 and the Trust is currently recruiting additional non-executive directors. Each Director has delegated authority for the delivery of specific objectives as outlined below:

- Chief Executive - statutory accountable officer, overall management of the Trust and its performance
- Finance Director – Finance, fraud prevention, performance and contracts, information governance, information and IT and estates
- Chief Operating Officer – Operational delivery including business continuity and major incident planning
- Director of Nursing, Midwifery and Quality – Nursing and midwifery practice, patient safety and experience
- Medical Director – medical practice and education, Caldicott Guardian, Research and Development
- Director of Corporate Governance – Trust Board Secretary, corporate governance, and communications and community engagement (non-voting)
- Workforce Director – Human resources, training and development and organisational development (non-voting)

The Trust Board has overall responsibility for the activity, integrity, and strategy of the Trust and is accountable, through its Chair, to the NHSI. The role of the Board is largely supervisory and strategic, and it also has the following key functions:

- To set strategic direction, define Trust objectives and agree Trust operating plans
- To monitor performance and ensure corrective action is taken where required
- To ensure financial stewardship
- To ensure high standards of corporate and clinical governance
- To appoint, appraise and remunerate directors
- To ensure dialogue with external stakeholders

The Board approves an annual schedule of business and a regular update which identifies the key reports to be presented in the coming quarter. The Trust Board met a total of eight times in public during the year including the AGM; and Board papers are published on the Trust website.

Trust Board Attendance	**Year ending 31st Mar 18**
Name and Title	**Attendance**
Professor Peter Latchford – Chair - until Dec 2017	6/6
Ben Reid – Chair - from Feb 2018	1/2
Harmesh Darbhanga – Non-Executive Director	6/8
Brian Newman – Non-Executive Director	7/8
Clive Deadman – Non Executive Director	6/8
David Lee – Non-Executive Director – from Dec 16	8/8
Chris Weiner – Non-Executive Director – from Dec 16	7/8
Paul Cronin – Non-Executive Director – until Jan 2018	5/6
Simon Wright – CEO	8/8
Neil Nisbet – Finance Director	7/8
Debbie Kadum – Chief Operating Officer – until Dec 2017	5/6
Sara Biffen – Acting Chief Operating Officer – Jan 2018	1/1
Nigel Lee – Chief Operating Officer – from Feb 2018	1/1
Edwin Borman – Medical Director	8/8
Deidre Fowler – Director of Nursing, Midwifery & Quality - from Apr 2017	8/8

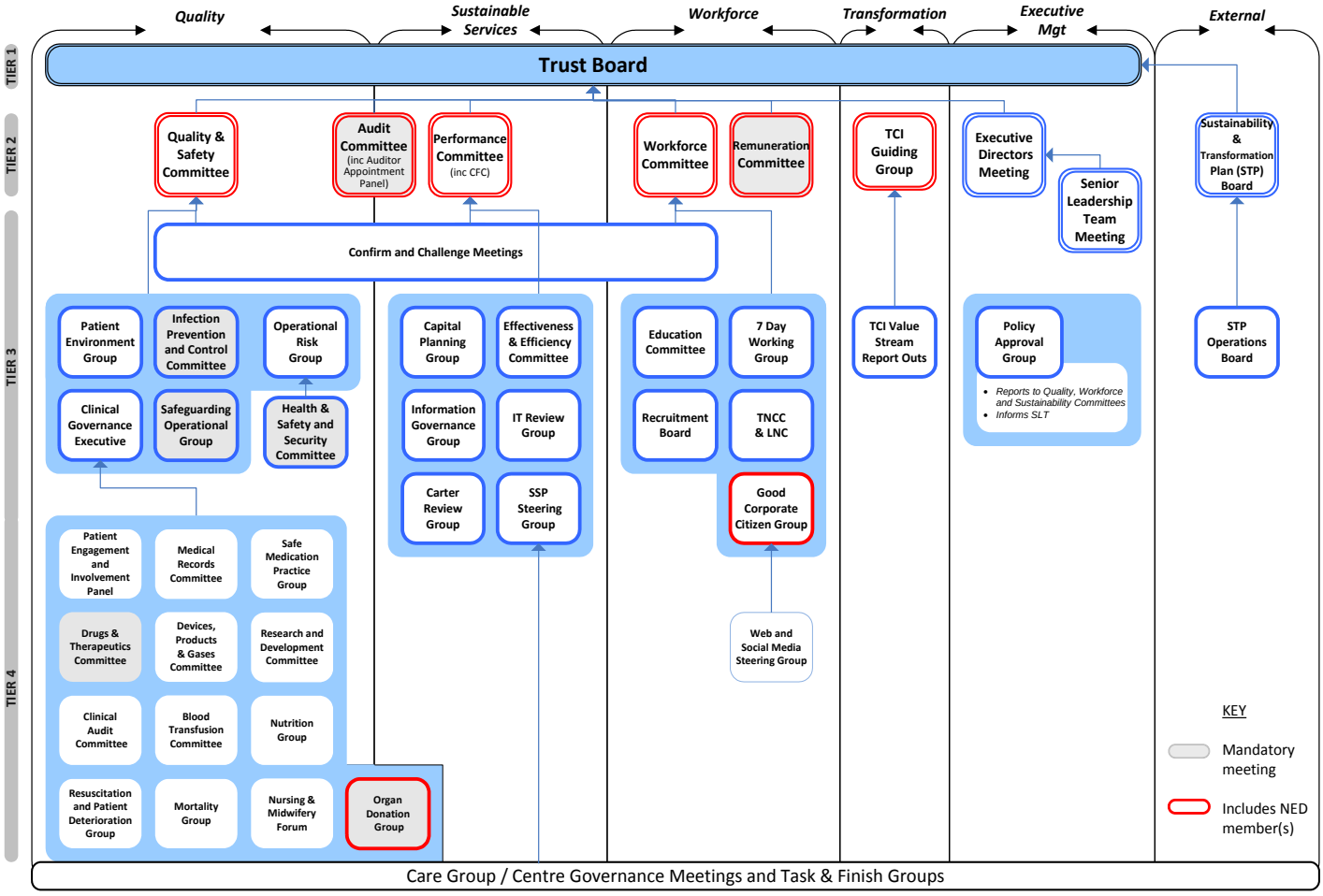
The Board has overall responsibility for the effectiveness of the governance framework and requires that each of its sub-committees has agreed terms of reference which describes the duties, responsibilities and accountabilities, and describes the process for assessing and monitoring effectiveness.

Exception reports to the Board ensure that the Board considers the key issues and makes the most effective use of its time.

The Board operates with the support of five Tier 2 committees accountable to the Trust Board; the TCI Guiding Group and the Executive Directors meeting. All the Tier 2 committees have at least one Non-executive Director member. The chairs of each of the sub-committees routinely present written and verbal reports to the Board highlighting key issues and decisions at their meetings. Approved minutes of each sub-committee area also presented at public Board meetings.

Two of the Tier 2 Committees are Non-Executive Committees (Audit, Remuneration). Although these Committees have a membership consisting of only Non-Executive Directors, other Directors will attend as required. The other three Committees are chaired by a Non-Executive Director, (Performance, Quality and Safety, and Workforce). Minutes of these meetings demonstrate that Non-Executive Directors oversee progress and provide challenge to the Directors. The Chairs of Performance Committee and Quality and Safety Committee are also members of the Audit Committee. The Transforming Care Institute (TCI) Guiding Group is executive in nature, but has a Non-Executive member.

SaTH Committee Structure – May-18



The Audit Committee is the senior board committee responsible for oversight and scrutiny of the Trust's systems of internal control and risk management. It ensures that there are effective internal audit arrangements in place that meet mandatory NHS Internal Audit Standards and provides independent assurance to the Board. The Committee reviews the work and findings of External Audit and maintains oversight of the Trust's Counter Fraud arrangements. Attendance through the year was in line with the requirements of the Terms of Reference. The Audit Committee met 6 times during 2016/17. It was chaired by a Non-Executive Director, who submits a regular report to the Trust Board.

The Trust's Standing Orders, Standing Financial Instructions and Reservation and Delegation of Powers were updated in June 2017 to take account of changes to the Trust's governance arrangements and legislation. The Standing Orders were adhered to throughout the year and no suspensions were recorded.

The Trust's policy on Managing Conflicts of Interest in the NHS was revised in 2017 to take account of new requirements following the publication of revised national guidance. This recommendation has been implemented to include all permanent medical staff; all staff at band 8 and above; specialist nurses; and all procurement and stores staff. The Board's Register of Interests was kept updated during the year.

The Annual Plan is agreed by the Trust Board and reported to the NHSI. This includes objectives, milestones, and action owners and is revised by the board quarterly.

Risk Management is embedded within the organisation in a variety of ways including policies which require staff to report incidents via the web-based reporting system. All papers to Trust Board and Tier 2 Committees are required to consider risks and assurance; and to have an Equality Impact Assessment carried out and this forms part of the cover sheet for each paper. All new and revised policies are required to have an Equality Impact Assessment undertaken prior to approval and ratification.

Incident reporting is in place across the Trust via a web-based reporting system supplemented by paper forms. A network of safety advisers encourage reporting and the Trust supports an open culture. A weekly rapid review meeting of moderate and severe harm incidents was established, which demonstrates better learning from complaints and incidents as well as assurance around duty of candour.

Through its governance arrangements and the reviews undertaken by Deloitte and the construction of the Board Governance Memorandum, I am assured that the Trust complies with the HM Treasury/Cabinet Office Corporate Governance Code and does not have any significant departures from the Code.

The trust is fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5 Review of economy, efficiency and effectiveness of the use of resources

The Head of Internal Audit provides an opinion on the overall arrangements for gaining assurance through the BAF, and on the controls reviewed as part of Internal Audit's risk-based annual plan. Internal Audit's review of the Trust's Assurance Framework gave substantial assurance and made one medium and three low priority recommendations mainly relating to reporting within the electronic risk register system.

During the year, Internal Audit reported on seven core audits. Internal Audit issued substantial assurance ratings for three core audits; moderate assurance ratings for three core audits and limited assurance for one core audit. The moderate assurance ratings relate to cash management (no high priority recommendations); income and debtors (one high priority recommendation); and computer-based IT controls (three high priority recommendations). The limited assurance rating relates to budgetary controls with two high priority recommendations. Actions to rectify these weaknesses are being implemented. Based on the assurances given for the core reports issued, and the current financial position of the Trust, Internal Audit issued an overall opinion for the year of Moderate.

As part of their annual internal audit plan, Internal Audit also deliver a number of risk based advisory and performance reviews. In discussion with the Trust, these are focussed on areas identified as offering the greatest scope for improvement to maximise the benefit and learning to the Trust. Three performance reviews took place during 2017/18.

The Trust has a Local Counter Fraud Specialist (LCFS) whose work is directed by an annual workplan agreed by the Audit Committee. As well as investigating potential frauds, notified to the LCFS by the Trust, there have been proactive exercises to detect potential fraud. These have included examining the anti-fraud controls within the Estates Department; and looking at staff absence, clinic duration, and private practice.

The LCFS has worked with the Trust to further enhance the system in place for declarations of interest and auditing disclosures made in comparison to those on Disclosures UK.

Formal actions plans have been agreed to address the significant control weaknesses in all areas. Implementation of the recommendations has been tracked with two overdue actions at year-end. There have been no common weaknesses identified through Internal Audit reviews.

6 Information governance

Information Governance incidents are reported via the Trust's incident reporting system. There were three data lapses in the year which were reported to the Information Commissioner. These cases were

1. A patient received a letter that was put into a 'window' envelope and was folded inappropriately which resulted in 'sensitive' data being visible **Actions**: Full investigation (RCA) Remedial Action taken and Shared Learning.
2. Nine individual patient letters were accidently put into an envelope addressed to one other patient. **Actions**: Full investigation (RCA) Remedial Action taken and Shared Learning. Provision of additional training for respective staff/department. Implementation of electronic communications with GP surgeries
3. A handover book containing information relating to >150 patients was missing from a secure office on ITU PRH. The book was used for the Out-reach team management of patients. **Actions**: A thorough search was made throughout the hospital on several occasions. It is felt that the book may turn up in time as it has probably been picked up with other patient notes/documents. A full RCA was performed and an action plan implemented to mitigate further risks

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7 Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The 2017/18 Quality Account is currently in preparation and the content and two of the indicators will be reviewed by External Audit to provide assurance on the accuracy of the account. The draft Quality Account is shared with partner organisations who are asked to provide a commentary on the account and to check the accuracy. These commentaries are included as part of the Quality Account.

The Trust has a robust system in place to assure the quality and accuracy of performance information. The Trust has in place a system to validate and audit its elective waiting time data on a weekly and monthly basis with random specialty audits being carried out to quality assure the validation process. The process has been audited by Internal Audit, and implementation of recommendations monitored.

8 Significant Issues

8.1 Progress on 2016/17 significant Issues

In the 2016/17 Annual Governance Statement, the Trust disclosed two significant issues. Progress on these issues is outlined below.

Cash Flow

The 2017/18 year was difficult for cash, with significant in year pressures, as a result of the Trust's failure to deliver the required control total. The cash shortfall was accommodated in the short term by the slippage in delivery of the capital programme and extension of payment terms to revenue creditor suppliers, before securing authorisation from NHSI to secure cash support to underpin the increased level of in year deficit.

Faced with a sizeable 2018/19 Income and Expenditure deficit, the Trust will, in order to ensure that sufficient cash resources exist, need to again secure authorisation from NHSI to underpin the deficit with an equivalent level of cash support. The Trust has been informed that access to revenue financing during 2018/19 will be subject to increased challenge and scrutiny and will only be provided in exceptional circumstances

Fragility of services

The Trust has a number of risks relating to the services under the spotlight. This was particularly difficult for the Accident and Emergency Department (AED) and the situation remains precarious with further resignations of consultants but the business continuity plan has not been invoked as locums have been

secured to sustain the service. There has been progress with other services, particularly neurology, dermatology, ophthalmology and spinal surgery where a range of options to provide these services have been developed.

8.2 2017/18 significant issues

Medium Term Financial Plan
The Trust's financial difficulties in the 2018/19 year can be traced to an inability to achieve the required level of cost improvement savings in the 2017/18 year and also growing levels of Agency spending. This has meant that the Trust instead of taking forward into the 2018/19 year a recurrent deficit of £12 million is carrying forward a deficit of £20.5 million. The recurrent financial position of the Trust is critical. A review of the Trust's Medium Term Financial Plan has demonstrated that the deterioration in the Trust's recurrent position will need to be addressed in order for the Trust to be able to take forward its plans to reconfigure clinical services and address severe backlog estate and equipment issues.

Emergency Department staffing
The staffing of the Emergency Department was extremely fragile throughout the year with a significant risk that the Trust may have to enact its business continuity plan resulting in overnight closures of the Princess Royal Hospital Emergency Department. Although the plan was not enacted, safely staffing the Emergency Departments was challenging. One of the key drivers for NHS Future Fit is the difficulty in attracting staff to a split site service with onerous on-call commitments which, unless changes are made, is likely to struggle in future to meet key national standards and guidance.

Patient Flow
The A&E performance has not been achieved and the Trust has consistently underperformed on both the original TDA trajectory and the revised trajectory. The Trust has been working hard with partner organisations to increase flow, and reduce the numbers of 'stranded' and 'superstranded'. The aim is to reduce bed occupancy levels to the nationally accepted safe levels of 92%. At times, bed occupancy has been over 100% with additional patients on wards.

9 Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust Board is responsible for ensuring that the Trust follows the principles of sound governance and this responsibility rests unequivocally with the Board. The Board is required to produce statements of assurance that it is doing its "reasonable best" to ensure the Trust meets its objectives and protect patients, staff, the public and other stakeholders against risks of all kinds. The Trust Board is able to demonstrate:

- That they have been informed through assurances about all risks not just financial.
- That they have arrived at their conclusions on the totality of risk based on all the evidence presented to them.

The Trust's ability to handle risk is further enhanced through the Governance and Committee/Group structure. Each Committee/Group has terms of reference that clearly define their role and responsibilities with clearly stated deputies.

The Trust Board has received assurance on the effectiveness of the controls within the organisation through the following means:

- Reports from Committees set up by the Trust Board, particularly the Audit Committee,
- Reports from Executive Directors and key managers

- External Reviews
- Board Assurance Framework.
- Clinical Audit
- Internal Audit provide the Board, through the Audit Committee, and the Accounting Officer with an independent and objective opinion on risk management, control and governance and their effectiveness in achieving the organisation's agreed objectives. This moderate assurance opinion forms part of the framework of assurances that the Board receives. The annual Internal Audit Plan is aligned to the Trust's Assurance Framework and Risk Register.

10 Conclusion

Three significant control issues have been identified for the year 2017/18:

- Medium Term Financial Plan
- Emergency Department Staffing
- Patient Flow

The system of internal control has been in place at the Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

Accountable Officer: Simon Wright

Organisation: The Shrewsbury and Telford Hospital NHS Trust

Signed

Chief Executive
Date 25th May 2018

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TRANSFORMING CARE INSTITUTE

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