Shropshire Community Health NHS Trust

QUALITY ACCOUNT

2017-2018

Contents

About this document

The Trust Board Shropshire Community Health NHS Trusts produce this document as required by the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the NHS Quality accounts Amendment Regulations 2011 and with additional reporting arrangements as per the Regulation schedule for 2017/18. These Regulations are cited as the National Health Service (Quality Accounts) (Amendment) Regulations 2017. These Regulations come into force on 1st November 2017. The Quality Account publication on the NHS Choices website fulfils the Shropshire Community Trust's statutory duty to submit to the account to the Secretary of State

Copies of this document are available from our website at www.shropscommunityhealth.nhs.uk , by email to communications@shropcom.nhs.uk or in writing from: Chief Executive's Office, Shropshire Community Health NHS Trust, William Farr House, Mytton Oak Road, Shrewsbury, SY3 8XL. If you would like this report in a different format, such as large print, or need it in a different language, please contact our Patient Advice and Liaison Service who can arrange that on 0800 032 1107 or email pals@shropcom.nhs.uk

Foreword

Welcome from Steve Gregory, Executive Director of Nursing and Operations

Once again I have the great pleasure of introducing the Shropshire Community Health NHS Trust Quality Account for 2017/18.

The purpose of our Quality Account is our annual report to the public about the quality of healthcare services we deliver and is an opportunity for the Trust to offer its approach to quality up for scrutiny, debate and reflection by the public. We hope that this account provides you and other interested parties with detail relating to the quality of care that we provide to our patients and the way that we support and develop our staff to provide that care safely and effectively.

Each year our Quality Account is both retrospective and forward looking. We look back at the year just passed and present a summary of our key quality improvement achievements and challenges. We look forward and set out our quality priorities for the year ahead, ensuring that we maintain a balanced focus on the three key domains of quality: Patient Safety, Clinical Effectiveness and Patient Experience

Some of the content of the Quality Accounts is mandated by NHS Improvement and /or by The NHS (Quality Accounts) Amendment Regulations 2012, however other parts are determined locally and shaped through the feedback we receive.

The Quality Account is split into three main parts:

Part 1 Provides a statement summarising the Trust's values and the services we provide and how we work with our partners

Part 2 Provides a review of performance against the priorities for improvement as identified in our 2016/17 Quality Account.

Part 3 sets out our quality priorities for this year (2018/19)

Part 4 of the report discusses activities we undertake to put Quality at the heart of the organisation

Part 5 of the report discussed how we use patient experience and feedback to improve services, and our work towards co production.

We have continued to strengthen and develop the processes that underpin our services and therefore the quality of care provision. You will read about the continuing work that has been undertaken in this Quality Account which includes:

- Looking at all aspects of our services and how we can measure our quality and compliance toward our aim to be an outstanding caring, responsive, effective, well led and safe organisation.

- Showing how we have continued to work hard to be a provider of high quality End of life care for Children and Adults during 2017 - 2018 and have met all of the actions that the CQC suggested

- We have developed our acuity and dependency scoring so that we can adjust our staffing to reflect dependency and introduced our internal quality and assurance accreditation scheme

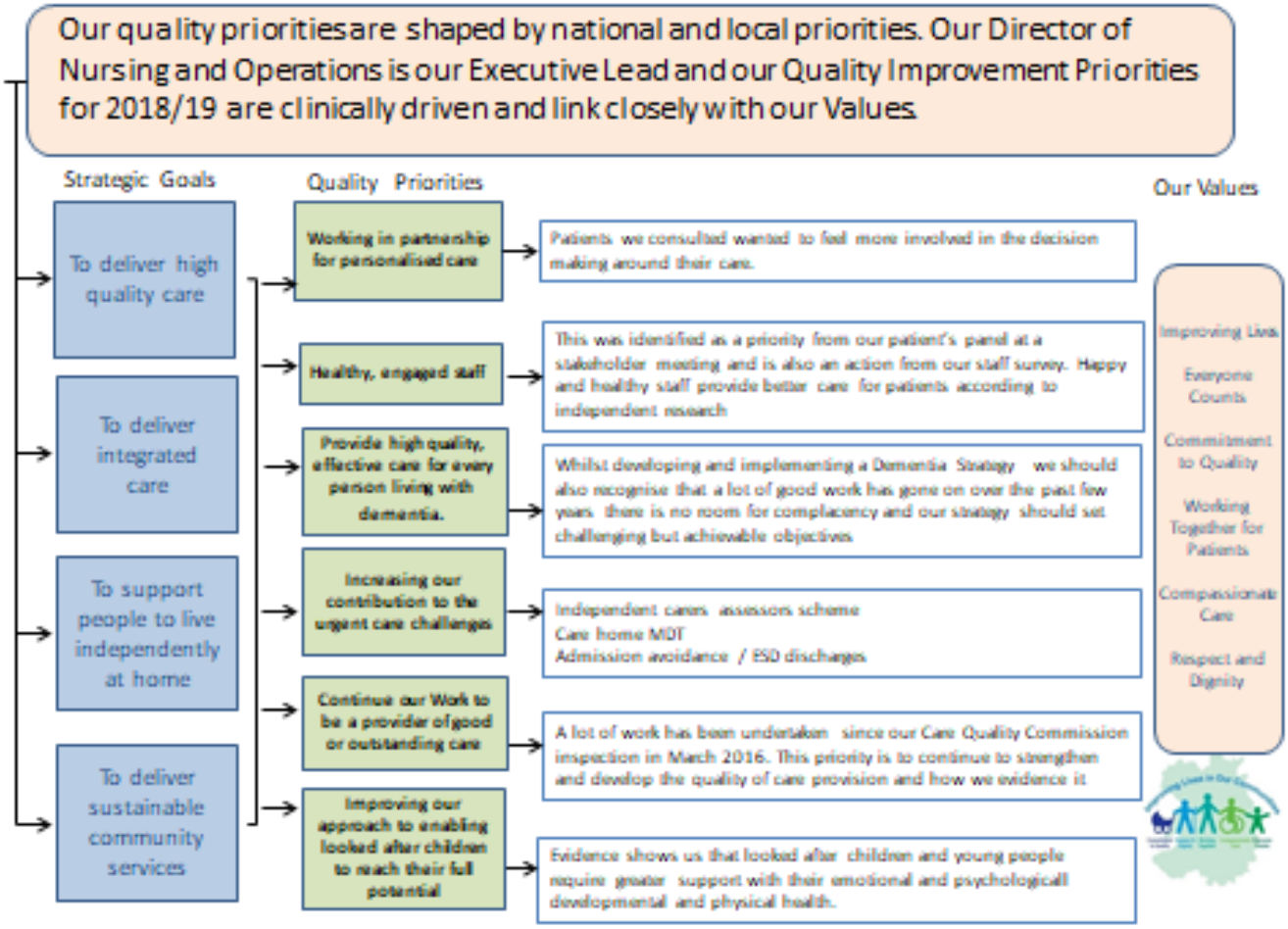
- We have introduced new roles and restructured out operational and quality teams to support our workforce to deliver high quality care.

So, it's been a busy year for us taking our services forward to ensure that people stay as healthy as possible in the places they want to be and we remain as committed as ever to helping them to do so. We have had another busy and challenging year and I would like to take this opportunity to say thank you all our staff and volunteers who have helped us to deliver so many important services to our local population through their hard work and dedication. I hope that you find this Quality Account of interest and that it provides clarity for you on what Community Services are. The priorities that have been identified for 2018-2019 through discussions with a range of people, both internal and external to our organisation and therefore we are confident that they will help us to continue our development.

Steve Gregory
Executive Director of Nursing and Operations

Executive Summary: Our Quality Priorities for 2018/19

Our Quality Priorities for 2018/19 and how we aim to deliver them



Initiative	Timeframe	Target/KPI/Measure of Success
Working in partnership for personalised care we will roll out a patient guide on their consultations what questions should you ask. We will develop a strengthened process for ensuring staff access patient and carer feedback and have responsibility to use it	March 2019	We will have rolled out and sought patients view on this within 6 months using our patient and carer panel. We will have Developed a clear SOP for ensuring staff access patient and carer feedback and have responsibility to use it, We will evidence how we have used feedback as a resource for improvement via team meeting minutes etc.
Healthy, engaged staff: promote a working environment that promotes wellbeing and provides a great working experience.	March 2019	Staff will feedback that they have the opportunity for discussion between themselves and managers identifying 'what matters to me' conversations Training data will be available to demonstrate uptake in conducting

Provide information and opportunity for discussion between staff and managers identifying 'what matters to me' conversations with staff. Staff undertake training staff in conducting and partaking in appraisals to ensure that appraisals meaningful and relevant for staff Ensure our training is relevant and accessible for staff, with access to role specific training if identified by appraisal or as a service need. Supervision Audit in Quarter 4 2018/19 with an improvement compared to the previous audit		and partaking in appraisals ensure that appraisals meaningful and relevant for staff Improvement evident in Trust staff survey scores relating to quality of appraisals Ensure our training is relevant and accessible for staff, with access to role specific training if identified by appraisal or as a service need which will be evidenced by improved compliance An improvement compared to the previous audit on opportunity uptake and participation in staff support and supervision.
Provide high quality, effective care for every person living with dementia We will Involve patients and carers at the outset in developing a strategy and their involvement will be evidenced through minutes of the strategy group	March 2019	We will demonstrate involvement by holding key consultation events on the strategy, and attending relevant interest groups. Involve patients and carers at the outset in developing a strategy and their involvement will be evidenced through minutes of the strategy group. Identify and report key performance indicators and milestones in improving and providing high quality care for every patient with dementia via the dementia strategy group and our Advanced Practitioner in Mental Health We will identify the benefits from our investment in Memory and wellbeing workers via a thematic review of their impact at Quality and Safety committee.
Continue our Work to be a provider of good or outstanding Caring, Responsive, Effective, Well Led and Safe services for patients Roll out our QAAS assurance scheme across all services Develop a standardised competency approach for clinical skills and have standardised and clear competencies for staff to achieve or measure their performance against this year Monitor the implementation of our End of Life Strategy for Adults and Children and continue our governance work in End of life Care and undertake associated clinical audit Continue to reduce reliance an agency staff by working to agreed ward and MIU staffing establishments, exploring new roles, and matching staffing and dependency, measured by our safer staffing reports and agency usage reports in our committees. Improve our processes of learning lessons using DATIX, and alerts.	March 2019	Fully Roll out a Quality Assurance and Accreditation Scheme in all Services by September 2019 We will have available a standardised competency approach for clinical skills and have standardised and clear competencies for staff to achieve or measure their performance against this year. We will be able to evaluate the implementation of our End of Life Strategy for Adults and Children and continue our governance work in End of life Care and undertake associated clinical audit via themed reviews and EOL audits Reduced agency usage and agreed revised establishments in MIU and inpatient wards, with continued monitoring of, complexity and dependency of patient's needs. Ensure we have strong processes to share and embed lessons learned by asking staff about relevant lessons learned in their areas, and reviewing team minutes and observing any key relevant changes in practice
Improving our approach to enabling looked after children (LAC) to reach their full potential through the delivery of high-quality care	March 2019	All healthcare practitioners who come into contact with looked-after children will have the skills, knowledge, values and attitudes that are required for safe and effective practice.

Ensure the child's health assessment and care plan is of high quality and completed within local and statutory timeframes		Monitored via the LAC dashboard and a looked after children's health assessment audit to measure the quality of practitioner assessments.
Take into account the views of looked-after children, their parents and carers, to inform, influence and shape service provision		Feedback from Children, young people, parents and carers evidencing positive engagement. Children, young people, parents and carers will be actively involved in service design, delivery and evaluation.
Looked-after children will be able to participate in decisions about their health care.		The child/young person will influence care planning during their health assessments. Evidence of the voice of the child/young person will be reviewed during the quality audit.
We will support a smooth transition to adulthood so that young people continue to obtain the health advice and services they need.		A transition audit will take place with an action plan developed from the findings

Part 1 Our Vision and Values

Our Vision and Values set out our ambitions and the core set of behaviours and beliefs that guide us in what we say and do

Our Vision:

"We will work closely with our health and social care partners to give patients more control over their own care and find necessary treatments more readily available. We will support people with multiple health conditions, not just single diseases, and deliver care as locally and conveniently as possible for our patients. We will develop our current and future workforce and introduce innovative ways to use technology."

Our Values:

Improving Lives
We make things happen to improve people's lives in our communities

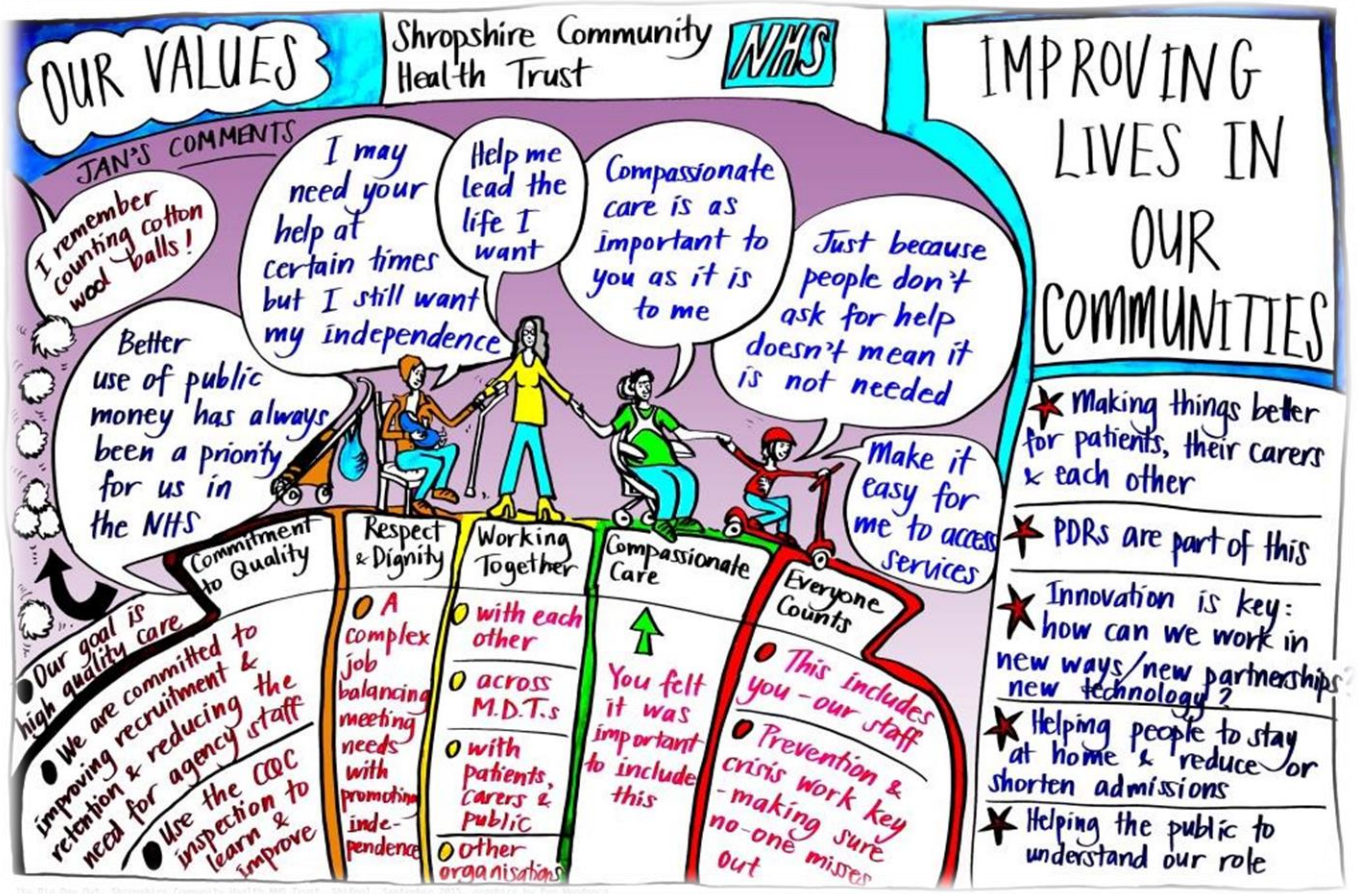
Everyone Counts
We make sure no-one feels excluded or left behind - patients, carers, staff and the whole community

Commitment to Quality
We all strive for excellence and getting it right for patients, carers and staff every time

Working Together for Patients
Patients come first. We work and communicate closely with other teams, services and organisations to make that a reality

Compassionate Care
We put compassionate care at the heart of everything we do

Respect and Dignity
We see the person every time - respecting their values, aspirations and commitments in life – for patients, carers and staff



Who we are and what we do

Shropshire Community Health NHS Trust provides community health services for adults and Children in Shropshire, Telford and Wrekin, and some surrounding areas too.

Community health services cover 'cradle-to-grave' services that many of us take for granted. They provide a wide range of care, from supporting and advising families with young children, to treating those who are seriously ill with complex conditions.

Most community healthcare takes place in people's homes. Teams of nurses and therapists coordinate care, working with other professionals including GPs and

social care. Although less visible than the larger acute hospitals, they deliver an extensive and varied range of services.

Shropshire Community Health NHS Trust provides a wide range of community health services to about 470,000 adults and children in their own homes, local clinics, health centres, GP surgeries, schools and our community hospitals in Bishops Castle, Bridgnorth, Ludlow and Whitchurch.

Our role is especially important in a large geographical area such as ours with increasing numbers of people, including children and young people, with long-term health conditions.

We have nearly one million patient contacts each year, the vast majority of which are with people in their homes, in community centres and clinics. A very small amount of people also receive inpatient care in our community hospitals (1,694 people received inpatient care in 2017 - 2018. In prison healthcare there were 14,171 contacts. We also supplied 291,841 items of equipment or medical products, (nearly 8000 more than the year previous).

Patient Activity Figures 2017/18	
Community contacts	630,409
Outpatient attendances	58,033
Inpatient and day cases	1,011
Inpatient Rehabilitation Episodes	1,694
Radiology examinations	10,753
Minor injuries attendances	27,833
Equipment and products supplied	291,841
Prison healthcare contacts	14,171

Good community health services prevent the need for some patients to be admitted to hospital, including those with chronic conditions such as diabetes, asthma, chest disease, arthritis, hypertension, osteoporosis and stroke.

People have told us that we should help them manage their own condition and stay healthy enough not to have to spend time in hospital, unless they really need to. We have community teams that specifically work with patients who need additional or short-term care and support to help them return home from hospital as quickly as possible, or to avoid being admitted in the first place.

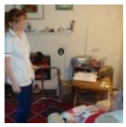
Our Partners in Care

Within the county of Shropshire there are two Clinical Commissioning Groups (or CCGs) which are responsible for buying (known as commissioning) a wide range of health services for the people of Shropshire and Telford and Wrekin. They are our main commissioners and commission the majority of our services such as community nursing, community hospitals and most of our other services such as our specialist community teams.

We have other commissioners that buy services from us including Telford and Wrekin Local Authority and Shropshire Local Authority who commission us to provide Public Health Nursing services (Health Visiting, Family Nurse Partnership & School Nursing) for children and families. NHS England buys Dental Services and our Offender Health services in HMP/YOI Stoke Heath.

We are known as a provider Trust in that we provide services in the same way that our Shropshire and Telford & Wrekin Healthcare colleagues at Shrewsbury and Telford Hospital NHS Trust, Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust and South Staffordshire and Shropshire Healthcare NHS Foundation Trust are, and we work closely with them and other NHS Trusts. We continually seek ways to work in collaboration with patient and service user groups and the voluntary sector to provide care that people need at different times.

The table below shows how we organise our clinical services into two Service Delivery Groups (SDGs). Supporting the SDGs are our Corporate and Support Services which include functions such as finance, human resources, information technology and many others.



Adult SDG

- Community Hospitals
- Minor Injury Units
- Integrated Community Services
- Inter-Disciplinary Teams
- Long-Term Conditions & Frail Elderly
- Diabetes
- Tissue Viability
- Continence Services
- Shropshire Wheelchair Service
- Rheumatology
- Physiotherapy
- Podiatry
- Advanced Primary Care Services
- Prison Healthcare
- DAART

Children and Families SDG

- Community Children's Nurses
- Child Development Centres
- Safeguarding Chldren
- Community Paediatrics
- Immunisation and Vaccination
- Dental Services
- 0-19 Public health Nusing Service
- Looked after Children

Corporate/Support Services

- Finance
- Workforce/HR
- Organisational Development
- IT and Informatics
- Hotel Services
- Administration Support
- Business Development
- Performance
- Complaints and PALS
- Emergency Planning
- Patient Experience and Involvement
- Assurance (non-clinical)
- Communications and Marketing

If you would like to find out more about all our services please visit our website: **www.shropscommunityhealth.nhs.uk**

Part 2: Reviewing the quality of care: Looking back at 2017 -2018

Last year we set the following priorities for us to concentrate on over the year. This section of the Quality Account will show how we have done against the specific actions we identified.

Priority One : Continue our Work to be a provider of good or outstanding Caring, Responsive, Effective, Well Led and Safe services for patients using Quality Accreditation and Assurance Tools
Following our Care Quality Commission inspection in March 2016 the inspectors felt that there were some areas that required improvement and challenged us to submit action plans about how we would go about this. Our priority is to achieve all of the actions we set out to do and continue to strengthen and develop the processes that underpin our services and therefore the quality of care provision.

We have introduced and are rolling out a Quality Assurance and Accreditation Scheme (QAAS) in all Services. Currently it is being used in Inpatient Wards and Community Interdisciplinary teams. The QAAS is based on the Care Quality Commissions key lines of enquiry and asks clear and unambiguous questions on the quality of individual services. The services self-assess and 'rate' themselves as Amber, Silver, Gold or Platinum; this is followed up by a formal inspection from a team including Quality Leads and Senior Clinicians. Below is an example from a service rated as Silver.

Safe - Score & Domain Rating	Effective - Score & Domain Rating	Caring - Score & Domain Rating	Responsive - Score & Domain Rating	Well-Led - Score & Domain Rating
42	25	49	20	41
Overall Score & Rating				
177				

The way we manage the clinical workload is by the following methodology; Planned Actual & Variance tool (PAV) is in use now within the IDT teams allowing better work planning, and appropriate scheduling. Shared leaning is now part of all Q&S

meetings, using complains, incidents, FFT and Observe and Act patient and staff stories as tools that used for shared learning

A clinical education forum had been set up to revise all competencies across adults and children services with a standardised competency framework and including the developing a competency resource library.

We have implemented our End of Life Strategy and have formed The End of Life Strategy Implementation group to monitor its implementation which is a sub-group of the Adult Quality and Safety Delivery Group. The aim of the group is:

- Through a project management process to oversee and monitor the implementation of the Palliative and End of life care in the last years of life. A strategy for adults 2017-2020. To map and prioritise the actions and outcomes from the Strategy's operational delivery plan.

- Address the gaps in current practice identified in the Strategy. A significant shift in practice to commence end of life care further 'upstream' as opposed to current practice which often commences in the last week or days of life.

- To use the Lewin's Change Management Model and a Case study approach as a framework for implementation.

- To be the reporting group for work-streams/ task and finish groups that emerge from the implementation process. Monitoring progress, risks and milestones within the time frame.

- To make connections between the local health economy Palliative/End of Life group and Shropshire Community Health NHS Trust (SCHT) throughout the implementation process, bringing to the attention of the group areas for partnership working in order to achieve outcomes

- Develop links with Informatics and resource searching and reporting from other parts of the system, Care Homes, Hospice, social care, Voluntary sector, patients and carers

- To also monitor and provide assurance to the Board that the implementation work is aligned to the Trust values as set out in the Strategy

- Identify and develop key clinical outcome indicators for our Inter disciplinary teams (Community Nurses and Therapists)
- Demonstrate clear understanding and analysis relating to patient experience, patient and staff satisfaction, our staffing and quality indicators

Priority Two : Improving the Discharge from Hospital Experience
This was identified as a priority from our patient's panel at a stakeholder meeting and is also a priority for the local health economy and should be considered as a system wide process.

The Shropshire Community Health NHS Trust considers that this data is as described for the following reasons: As part of our monitoring the effectiveness and safety of our discharge processes we monitor re admission rates. A requirement in this report is also to report the percentage of patients aged:
(i) 0 to 14 and
(ii) 15 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital. All of our inpatient facilities are for over 18 year old Adult patients only. We record all admissions on our electronic patient administration system.

Community Hospitals - Emergency Re-admissions within 28 Days of Discharge April 2017 to March 2018

	2017									2018			Total
	April	May	June	July	August	September	October	November	December	January	February	March	
Bishops Castle	1	2	1	1				4	4	5	1	2	**21**
Bridgnorth	3	5		1	3	3	3	4	1	4	2	5	**34**
Ludlow	5	2	4	7	5	3	6	4	4	5		3	**48**
Whitchurch	3	4	6	5	12	4	10	4	5	7	3	3	**66**
Total	**12**	**13**	**11**	**14**	**20**	**10**	**19**	**16**	**14**	**21**	**6**	**13**	**169**

(Bishops Castle was closed for new flooring August September and October)

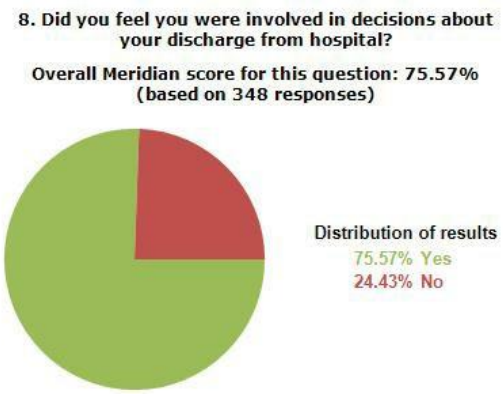
The Shropshire Community health NHS Trust has taken the following actions to improve our discharge from hospital experience

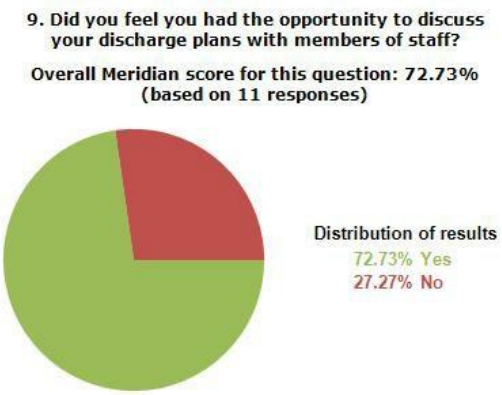
- Handover in Community Hospitals is now at the bedside – shift times have been changed to facilitate this which allows the patient interaction with the oncoming staff and key issues agreed in regard to discharge planning

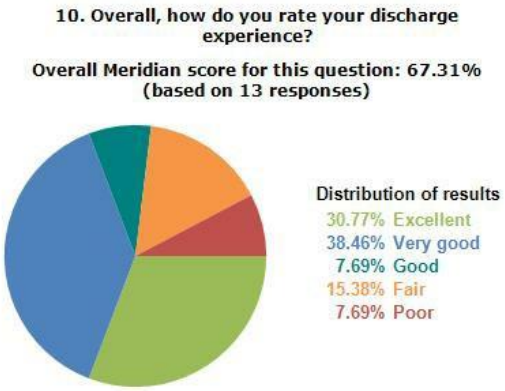
We have implemented a dedicated ward co coordinator who works with patients in driving discharges and implement the 'What matters to me' conversations with patients. Provide information and opportunity for discussion with patients and carers in relation to discharge, such as timings, transport, and self-care and Improve our clarity of message re discharge dates, patient and family responsibilities. We have Measurable through our specific Friends & Family Test (FFT) questions around discharge and communication

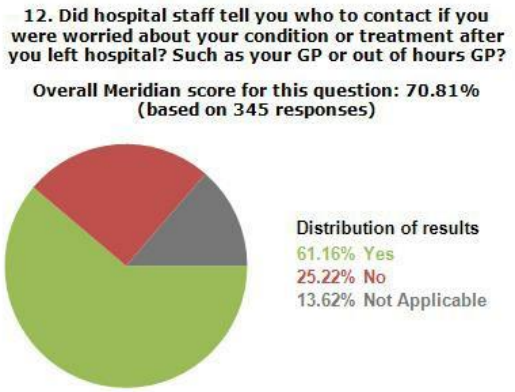
Goal setting – By co locating services and Locality Management We have improved collaborative working between nursing and therapy teams on wards, improve the inpatient nursing / therapy handover process and strengthen liaison between inpatient and community based teams, with demonstrable clear milestones agreed between the patient, and the teams.

The new measures identified in FFT discharge questions show that there is more work to do and whilst our processes around discharge have improved, e.g. Red to green', daily board rounds and collaborative working with community based services, the patient's own perception of their experience needs further action.









The comments from patients alongside this data have a theme of lack of advanced planning, last minute... or short notice. The Shropshire Community Health NHS Trust will take develop actions to continue in our aim improve our discharge from hospital experience which will include:

Identify a clear visual aid to both the patient and staff in regard to prompting early on daily discussions about discharge plans.

Identify a 'discharge champion' on each ward to promote early and daily discharge planning and communication.

Discuss with our patient and carers panel these findings and what a good discharge would look like for them

Priority Three: Transition of Care – Ensuring patients transfer from one service to another, safely, easily and without disruption or gaps in service provision
Key priority for all children and young people (CYP) across all services including mental health and those with complex and long term health conditions such as diabetes and asthma. Three main strands to this: • Early preparation for transition within children and young people services • The transition process – ensuring effective communication with young people, their family/carers and other health and social care professionals involved in their care. • Post transition – ensuring positive outcomes and experience for young people and their families/carers that transition to adult services.

We have the Parent and Carer Council (PACC) and Parents Opening Doors (PODS) as a key stakeholder in our transition focus group which has met on a regular basis along with children's professionals from different services to identify the local challenges.

A baseline audit has been undertaken with children and young people's services across out Trust with the aim of seeking to understand the current process whilst identifying areas of good practice and where improvements are required.

Conclusions:
Eight of our children and families services where transition occurs responded to the audit - 60% of respondents said that planning for transition by school year 9 or immediately if they enter children's services after year 9 in their service, however, 35% of respondents reported that young people had a keyworker or to coordinate care and support before, during and after transfer and only 15% of respondents said local arrangements were in place to ensure that young people who move from children's to adult services meet a practitioner from each adult service they will move to before they transfer.

We recognised that there was room for improvement to enable young people to reach their potential before, during and after transition to adult services. Transition is a complex area involving many services and professionals and needs to be tailored to the individual child. As a result we decided to focus on improving transition for young people with life limiting and complex health needs. A partnership between children and adult community nursing services, adult and paediatric doctors, young people, parents and carers has been formed to apply for a grant to enable us to develop a transition team to lead a transition pathway for young people with complex and life limiting conditions which will include care planning, respite services to support transition and essential training for primary and secondary care. We expect to find out the outcome in summer 2018.

We wanted to undertake a prospective audit, using NICE Quality Standard, of young people who transition during the month of May, June & July 2018. Sample criteria will be established for each service area. The prospective audit proposal and audit tool has been completed – the audit is due to commence this spring.

We had an aim to develop young person/parent/carer satisfaction survey for distribution during autumn 2018. This will be undertaken following the prospective audit.

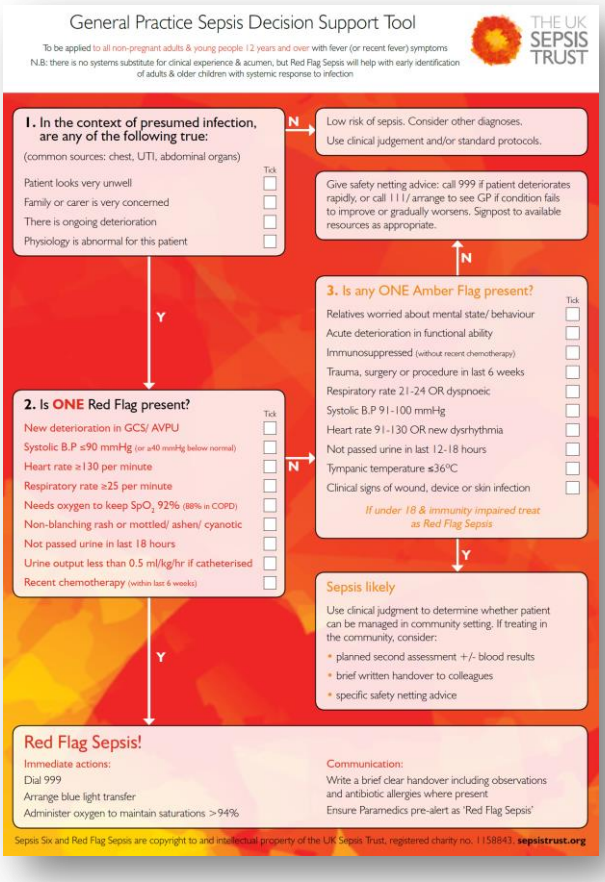
One ambition was to involve acute, primary care, Local Authority and education to improve transition across Shropshire, Telford & Wrekin. We have involved primary care within our transition focus group and bid submission whilst consulting with Local Authority and education when gathering information to support improvement.

Improving transition continues to be a key priority within our Trust – partnership working between children's and adult services will support improved health outcomes for young people transitioning to adult services.

Priority Four: Sign up to Safety: Putting Safety First. Safer care of the deteriorating patient. Recognising and responding to deterioration and promoting successful recovery from an ill health
Patients of all ages are known to suffer harm if deterioration in their condition is not detected or acted upon in a timely or effective manner. This is a clinical issue contributing to death and severe harm. Research has shown that 26% of preventable deaths were related to failures in clinical monitoring. These included failure to set up systems, failure to respond to deterioration and failure to act on test results (Hogan et al, 2012).1 In 2015 around 7% of patient safety incidents reported to the National Reporting and Learning System (NRLS) as death or severe harm were related to a failure to recognise or act on deterioration. Deteriorating Patient.

We have been running a training programme for ward and MIU staff on using the National Early Warning Score and appropriately responding to the National Early Warning Score (NEWS). Recognition of the deterioration adult has been a focus of our intermediate life support training for registered ward staff this year.

WE are using the Royal College of GPS sepsis decision support tool for our wards and Minor Injury Units. Currently we are conducting a clinical audit of all patients who have scored 3 or more on the NEWS or triggered a 'red flag' criteria in the Sepsis tool to identify any further learning or actions we a required to take to ensure all our staff are familiar and using these essential patient safety guides.



As discussed in more detail later in the report, in relation to this priority from last year, the Trust has implemented recommendations from the CQC's Learning, Candour and Accountability report (2016) and the National Learning Disability Mortality Review programme (LeDeR) and continues to monitor national guidance learning from deaths. The Trust undertakes reviews of all deaths and provides a regular report to the Quality and Safety Committee and the Trust Board as part of the assurance around management of risk within the Trust.

Priority Five: Service redesign and change & Optimising the use of technology
This is reflective of the Community trusts three key strategic priorities. **Getting to 'Good' and Beyond** Safe, Caring, Effective, Responsive, Well-Led **Building our 5 Year Plan** Sustainability and Transformation Plans (STP) **Implementing Electronic Patient Record** Optimising the use of technology This priority focuses on Implementing Electronic Patient Record, and our 5 year plan for Sustainability and Transformation, and
Activities we will undertake in 2017-2018
Implement our Electronic Patient Record system and monitor its impact on teams and the quality of services provided to patients
Audit the impact of the changes we have implemented following recommendations for productivity and service redesign : How did our services respond to a big service change and did it have an impact our service to patients and on quality indicators

Implementation of the full EPR involves and includes the full range of services serving the geographical area of Shropshire and Telford and Wrekin (and some bordering counties into mid Wales) amounting to a population of approximately 456,000 residents and includes all in-patient, outpatient and community based services for children and adults.

Where legitimate access is appropriate, EPR provides opportunities for all employees of SCHT approximately 1300 whole time equivalent. Clinical staff are the largest group of Trust employees.

The business case was underpinned by the following high level objectives providing the overarching framework for benefits realisation:-

- To improve the experience of patients at all stages of care from initial contact,
- through referrals, to scheduled treatment and back home

- 5.2 To improve the quality of care by enabling standards (National Institute of Clinical excellence, Care Quality Commission etc..) to be implemented across the NHS and Clinical and Social Care networks

- To enable effective access to clinical and administrative information across care providers and locations to support the NHS clinical priorities and to help ensure safer care

- To reduce the fragmentation of care through improved consistency and coherence of systems and records, thereby helping to maintain high quality care

- To improve Health policy development and Health research through increased availability, improved quality and speed of retrieval to data

Within the business case, the granular benefits behind the high level objectives are described under the following three categories:-

• Quality and Safety
• A single, secure collection point and repository for clinical information of service users • An integrated single source of key clinical information that is available 24/7 from all the Trust's operating bases – including mobile working • A system that is able to better support the clinical and risk management of service users who often have complex conditions, multiple records and engage with different parts of the service • The basis for more consistent multi-agency and collaborative working to support service users • Reduction of repeat assessments - Improved patient experience • Opportunities to simplify, standardise and improve existing clinical processes leading to improved patient experience and patient care • Allow for the greater use of mobile working increasing greater access to health care professionals for patient/service users

- Clinical Efficiencies

  - A framework for standardisation and service re-design of clinical and administrative processes across the Trust
  - Opportunities for a technical solution to intergrate/interwork with other clinical systems both within the Trust and across the Local Health economy (other Trusts, GP Practices, Social Care etc..)
  - Bed Management and associated basic patient management functions
  - Caseload management, including discharges
  - Clinical records management; including coding, tracking and searching
  - Minor Injuries functionality both clinical and reporting
  - Mobile working -improved staff efficiency (and possibly time savings) through reduced administration and quicker access to clinical records/information – enabling clinical staff to spend more time with patients
  - Introduce new support functions enabling – for example - improved referral management, case note tracking and bed management
  - Improved information and performance management support – through more integrated records and systems that are better able to support clinical services
  - The ability to provide patients with secure access to their clinical records
  - Improved flow of clinical information between partner organisations

-

- Financial Efficiencies (appendix A)

  - These efficiencies were identified as a result of the time released due to the increased opportunity for mobile working through the reduced requirement for clinicians to attend work base during the working day to access patient records and caseload diaries.

  - Potential greater scope with reduction in estates costs due to co- location of services. Reduction in administrative and no non pay costs due to co-location of services

Additional Quality Activities we have undertaken in 2017-2018

The Trust identified the following four priorities to concentrate on as part of the Sign Up to Safety:

- Reduce Medication Errors and improved medicines procedures for covert administration
- Improve Transition between paediatric and adult services (also priority 3 from last year)
- Handover and Discharge
- Reduce the number of people absent from work through sickness

The Trust aimed to have demonstrable improvement against these by the end of 2017 -18 in order to contribute to the national campaign's aspiration of reducing avoidable harm in the NHS by 50% over three years. Below is an update under each heading – plan with dates and timescales being developed to map over the three year period and will be completed and distributed when all detail entered.

Reduced Medication Errors

The ethos of reporting all medicines incidents including near misses is promoted in SCHT. This leads to improved intelligence about process failures and trend analysis allowing a lessons learnt culture to thrive.

Medicines incidents are reported via a standard electronic incident reporting system and scrutinised by a multidisciplinary team. Any incidents that meet the criteria in the medicines incidents policy are discussed at a specific group including the team that reported, and lessons learnt are decided.

Information on lessons learnt are disseminated to the wider workforce by various means e.g. "Spotlight on….." bulletins, workbooks (scenario based) and guidance documents.

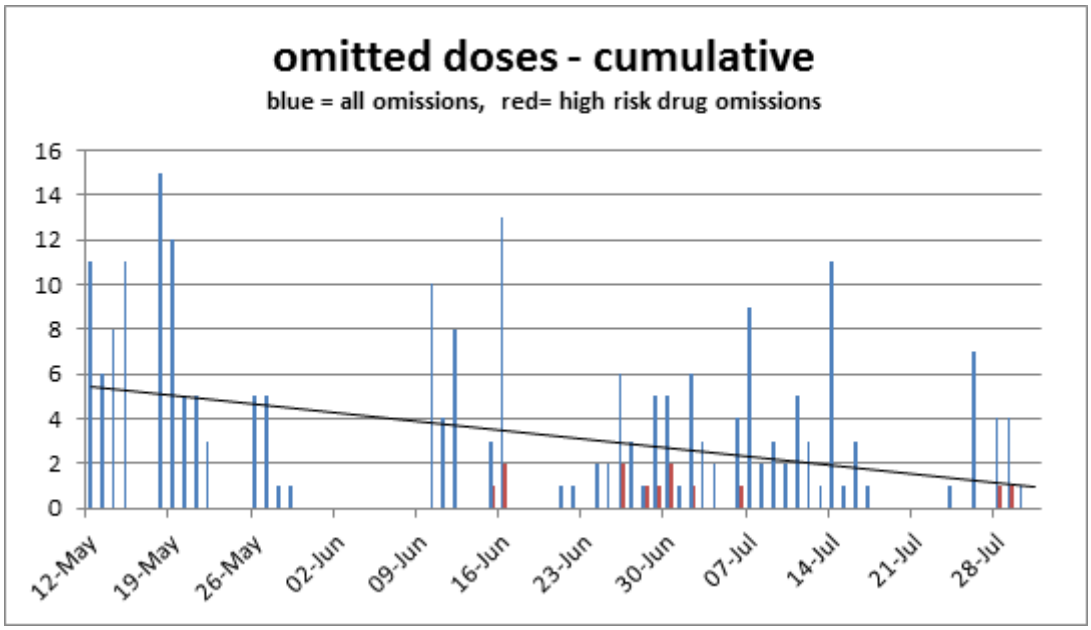
Clinically unjustified omissions of medicines doses are discussed as they are usually process failures and often involve human factors such as communication difficulties.

An insulin focus group was convened to improve safety controls around insulin prescribing and administration. This work has improved the access to training and

competency assessment and information on the safe use of different forms of insulin.

Safety huddles at handover on wards have proved invaluable to highlight any particular themes at that time. Medicines are a specific subject in these meetings. Any high risk or unusual drugs are highlighted to the incoming staff.

The future implementation of Electronic Prescribing and Medicines Administration (ePMA) system will highlight in real time any omissions so that immediate action can be taken and provides vital safety controls to promote medicines safety.



The rates of omission of medicines in community hospitals are periodically monitored by pharmacy staff, and have been reported to remain at low levels. A Root Cause Analysis is done for any omissions of high risk drugs that present a potential patient safety issue. They are discussed at the Medicines Incident Review meeting chaired by the Medicines Safety Officer and lessons learnt are shared amongst clinical teams.

Are aim of course is ultimately to have zero omitted medicines. The introduction of Electronic Prescribing and Medicines Administration (EPMA) system will highlight in real time any omissions so that immediate action can be taken. The various commercial products available all have the capacity to give a dashboard style report that the ward sister can view at any time and the pharmacy team are currently reviewing the different systems. .

Her Majesty's Prison (HMP) Stoke Heath has made significant progress with reduced omissions –monitored via another IT system; System One. The numbers of unjustified omitted doses (where there is no System One record of administration) remains very low. In March 2017 there were in excess of 16500 doses of drug administered with only 11 being unjustified omissions.

There were a number of omissions due to refusals or failure to attend and initiatives are being put into place to provide these patients with medication reviews to explore alternative treatment regimens.

Covert Medicines Standard Operating Procedure

As a recognised process in national bodies e.g. Care Quality commission, Shropshire Community Trusts inpatient wards continue to care for increasing patients who are unable, due to their mental capacity, to understand the importance of taking medicines to treat significant conditions and where the omission of such medicines may lead to deterioration. E.g. Epilepsy, high blood pressure, heart conditions. The development of our procedure also ensures our medicines given to patients without capacity to consent to have them, is subject to scrutiny and a multi disciplinary decision to administer, (including the patients advocate), and regular review and scrutiny by a multi-disciplinary team, to encourage alternative strategies other than the use of medicines to manage challenging behaviour. Any patient receiving covert medicines for a period of more than 7 days is reviewed and notified to the Trusts Director of nursing or Medical Director.

Covert administration of medication occurs when medicines are administered in a disguised format without the knowledge or consent of the person receiving them, for example, crushed and mixed with food or drink. Covert administration of medication can only be necessary and justified in exceptional circumstances when legal requirements have been satisfied. Medicines are never administered covertly to patients who have capacity to make their own decisions.

Improving Transition

Transition is identified as a key priority for all children and young people (CYP) across all services including mental health and those with complex and long term health conditions such as diabetes and asthma**.**

- Three main strands to this that we explored in 2016 - 2017:
- Early preparation for transition within children and young people services
- The transition process – ensuring effective communication with young people, their family/carers and other health and social care professionals involved in their care.
- Post transition – ensuring positive outcomes and experience for young people and their families/carers that transition to adult services.
- The first meeting has been held to consider the National Institute for Clinical Effectiveness (NICE) Guidance NG43 – Transition from children's to adult service for young people using health or social care services. Second date being planned
- Individual services have been mapping compliance against the guidance to establish baseline to inform actions going forward.

Handover and Discharge

- Handover in Community Hospitals is now at the bedside – shift times have been changed to facilitate this. Bedside handover is a key positive factor, improving communication and highlighting key issues for the shift. And can be used in conjunction with safety huddles which are brief meetings of hospital leaders & key team members at the beginning of the day or shift to ensure common understanding of the patients who are at risk of deterioration, or recent incidents on the ward. The huddle identifies focus and priorities for the day

- Enabling time for Handovers in Community Teams has been part of the productivity work we have undertaken. There is now a standardised format for this handover and clinical review meetings are now operationalised across Interdisciplinary Teams (IDT's). These are routinely scheduled to take place 5 times a week with a minimum occurrence of 3 times a week. In addition all new patients onto caseload have an expected date of discharge set from the service. This new process is being monitored weekly at present and documented using a standardised template as a record of the meetings for all staff to review the clinical discussion //key points if they miss a scheduled handover. We have also standardised the process of message taking across teams.

Reduce the number of people absent from work through sickness

The Health and Wellbeing Strategy is in place with the aim of creating a work environment which is beneficial to the health and wellbeing of our staff and to inspire them to take a greater interest in their own health and wellbeing.

The National Commissioning for Quality and Innovation (CQUIN) about Health and Wellbeing – will continue as part of Five Year Forward plan

There has been a sustained focus throughout 2017/18 to implement the operational plan for our Health and Wellbeing Strategy and develop further interventions that will make the most difference to our workforce based on the most common causes of sickness absence, for example musculo-skeletal issues and stress. Our plan for the next three years includes:

Work with our health and social care partners to support the health and wellbeing of our workforce.

We will continue to raise the profile of the health and wellbeing of our staff in line with our values.

Introduce a range of physical activity schemes for our staff, and develop our network of Health and Wellbeing champions around the county as they promote health and wellbeing for our people.

Support staff to remain at work whilst it is beneficial for their health and wellbeing.

Improve access to therapy services for staff.

Develop a range of mental health initiatives for staff, including access to counselling services, improving skills development for managers and leaders in recognising, managing and preventing stress.

Promote staff resilience through Schwartz rounds, clinical supervision, coaching and mentoring.

Provide proactive support to leaders and managers to ensure the maintenance of a healthy working environment recognising the impact of the physical environment on productivity and wellbeing.

Actively support staff and leaders through periods of ill-health through excellent Occupational Health and Counselling provision, benchmarking and reviewing our services and developing, refining and publicising Occupational Health management pathways.

Monitor progress using health and wellbeing metrics from a range of sources

Provide timely and relevant management information to enable the development of a value-adding approach to health and wellbeing.

During 2017/18

- To ensure that our staff understand our focus on their health and wellbeing from the start of their employment with us, our Staff Induction Handbook, which is issued to all new starters in the Trust, contains a health and wellbeing section. During 2017/18 a rebrand was undertaken, a new logo developed, and Twitter account launched. From early 2018 Health and Wellbeing has been included in Clinical Corporate Induction.

- Physical Activity and Healthy Lifestyle

We continue to promote healthy travel to work through our Cycle to Work Scheme which is open year-round to all eligible staff. This is publicised at Corporate Induction, and through regular communications to staff (such as computer desk-top

banners). The Cycle to Work scheme is offered alongside other salary sacrifice benefits which enable staff to purchase IT equipment and mobile phones.

- Health and Wellbeing days were held across the county with over 200 staff attending staff were able to access advice on staff benefits, have health checks (Body Mass index, cholesterol, and blood pressure), access advice on a healthy lifestyle and experience a massage to aid musculoskeletal issues and promote relaxation plus access to advice on pensions and wills. We have recruited staff Health and Wellbeing Champions and continue to grow the network. Champions are key in helping us to develop Health and Wellbeing campaigns and have encouraged colleagues to become more active and to focus on healthy eating. Champion-led activities have included; standing meetings, walking meetings and one to one supervision, and a support group for weight management.

- A 'Mind, Body and Soul' Challenge was undertaken by staff in early 2018 with the aim of encouraging a holistic approach to wellbeing which all staff could undertake.

We continued to offer and promote fast track physiotherapy service for all staff, and this scheme has been successful in keeping people in work that may otherwise have gone off sick

- Supporting Positive Mental Health

We continue to provide a confidential counselling service through Network of Staff Support (NOSS) to staff that require this. During 2017 and early 2018 we trained Resilience Facilitators and held a resilience week where staff could access development based around Positive Psychology theory to help maintain and increase resilience. We will deliver further sessions throughout 2018.

- During 2017/18 the supervision offer to staff has been strengthened and Schwartz Rounds successfully rolled-out across the Trust.

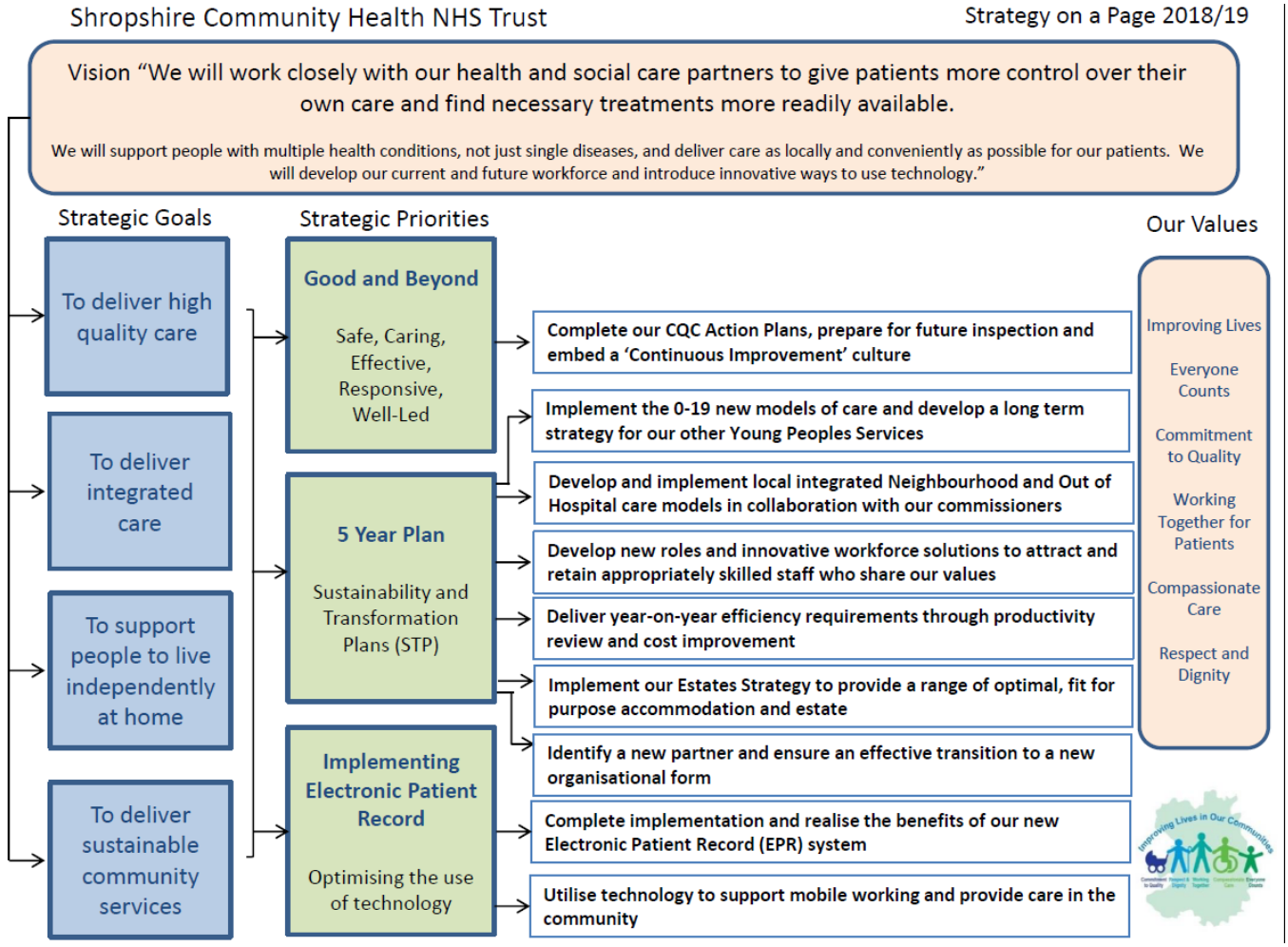
Part 3: Our Commitment to Quality - Looking forward to our Quality Priorities for 2018 -2019

Our identified priorities for 2018-2019 are shown below and have been discussed and agreed with members of our Patient and Carer Panel and other local organisations including our partners in the CCGs, Healthwatch Shropshire, Healthwatch Telford and Wrekin and as well as our staff and our Board.

The priorities are clinically and patient driven and link closely with our strategic priorities and our values. Crucially they support the quality domains of safe, caring, responsive and effective services that are well led.

As an overarching theme our stakeholders wanted to explore how we can improve our collaborative working with patients and be clear how we can allow the patient to be in control of their own health/life. Also work towards developing a happier, more engaged workforce. Happy staff – Happy patients!

The priorities are reflective of the Community trusts three key strategic priorities.



Priority One : Working in partnership for personalised care

Patients we consulted wanted to feel more involved in the decision making around their care. Patients want feel more like part of the team, be able to have more of a say in what's going on in their care, be better informed.

Activities we will undertake in 2018-2019:

Introduce and Roll out a patient guide on their consultations – What questions should you ask?

We will review the effectiveness and patients view on this within 6 months using our patient and carer panel

Develop a strengthened process for ensuring staff access patient and carer feedback and have responsibility to use it, evidence how we have used feedback as a resource for improvement. We will be asking as part of our Quality Assurance and Accreditation Scheme (QAAS) assessment, and will be asking staff how they get and use patient feedback. The QASS outcomes are fed back throughout Quality and Safety meetings.

Improve the patient knowledge by allowing patients to freely communicate with one another and seek mutual support e.g. by improving waiting rooms settings, using volunteers as experts.

We will review all of the waiting rooms that we control for appropriate seating arrangements and access, as well as relevant access to patient information within 6 months. This will be reported through patient and carer panel.

Priority Two: Healthy, engaged staff: promote a working environment that promotes wellbeing and provides a great working experience.

This was identified as a priority from our patient's panel at a stakeholder meeting and is also an action from our staff survey. Happy and healthy staff provide better care for patients according to independent research.

Activities we will undertake in 2018-2019:

Provide information and opportunity for discussion between staff and managers identifying 'what matters to me' conversations with staff.
We will ask staff on quality visits if they have those opportunities for discussion.

Encourage staff to '*take a break'* and recharge themselves to ensure they can support patients, colleagues and ultimately their self safely.

Improve our appraisal techniques, making appraisals meaningful and relevant for staff by training staff in conducting and partaking in appraisals.
Ensuring our training is relevant and accessible for staff, with access to role specific training if identified by appraisal or as a service need. We will monitor appraisal rates and ask staff if they found their appraisal relevant and useful.

The previous supervision audit showed several areas to improve upon. We looked at the percentages of staff attending different types of supervision. Significant numbers (around 25%) do not attend 1:1 management meetings, and around 42% don't attend formal clinical supervision. About a third don't have regular access to a management meeting or supervision. Most staff (between 84 to 98 percent) uses informal discussion with colleagues or senior staff, often external to the Trust (53%). If we agree that clinical supervision is a standard we need to achieve for staff, these are low numbers.
We will repeat this audit in Quarter 4 2018/19 expect an improvement in these figures.

Supervision was a topic at a recent staff away day and we asked how many staff were receiving supervision, demonstrated in the picture below.

Priority Three: Provide high quality, effective care for every person living with dementia.

Whilst developing and implementing a Dementia Strategy we should also recognise that a lot of good work has gone on over the past few years there is no room for complacency and our strategy should set challenging but achievable objectives

Activities we will undertake in 2018-2019:

Involve patients and carers at the outset in developing a strategy and their involvement will be evidenced through minutes of the strategy group.

Identify and report key performance indicators and milestones in improving and providing high quality care for every patient with dementia via the dementia strategy group and our Advanced Practitioner in Mental Health

We will identify the benefits from our investment in Memory and wellbeing workers via a thematic review of their impact at Quality and Safety committee.

Priority Four: Increasing our contribution to the urgent care challenges

Independent carers assessors scheme
Care home MDT

Admission avoidance / ESD discharges

Activities we will undertake in 2018-2019

Review how we promote and manage our ICS / IDT admission avoidance work to prevent people having to attend A&E departments, with an aim to focus greater attention on admission avoidance opportunities to achieve at least 31 admissions avoided each month.

We will review how if red to green patient experience and flow initiative is applied and monitor via our reduced length of stay and delayed transfers of care / discharges.

Priority Five: Continue our Work to be a provider of good or outstanding Caring, Responsive, Effective, Well Led and Safe services for patients

A lot of work has been undertaken since our Care Quality Commission inspection in March 2016. This priority is to continue to strengthen and develop the quality of care provision and how we evidence it.

Activities we will undertake in 2018-2019:

Fully Roll out a Quality Assurance and Accreditation Scheme in all Services within 3 months

Develop a standardised competency approach for clinical skills and have standardised and clear competencies for staff to achieve or measure their performance against this year.

Monitor the implementation of our End of Life Strategy for Adults and Children and continue our governance work in End of life Care and undertake associated clinical audit

Continue to reduce reliance an agency staff by working to agreed ward and MIU staffing establishments, exploring new roles, and matching staffing and dependency, measured by our safer staffing reports and agency usage reports in our committees.

Ensure we have strong processes to share and embed lessons learned by asking staff about relevant lessons learned in their areas, and reviewing team minutes.

Priority Six: Improving our approach to enabling looked after children to reach their full potential through the delivery of high-quality care

Evidence shows us that looked after children and young people require greater support with their emotional and psychological developmental and physical health.

Activities we will undertake in 2018-2019:

All healthcare practitioners who come into contact with looked-after children will have the skills, knowledge, values and attitudes that are required for safe and effective practice.

Ensure the child's health assessment and care plan is of high quality and completed within local and statutory timeframes.

Take into account the views of looked-after children, their parents and carers, to inform, influence and shape service provision.

Looked-after children will be able to participate in decisions about their health care.

We will support a smooth transition to adulthood so that young people continue to obtain the health advice and services they need.

Part 4:

Quality at the Heart of the Organisation

This section of the Quality Account will show how we measure our day to day work in order to meet the requirements and standards that are set for us and how we evaluate that the care we provide is of the highest standard. Much of the wording of the statements in this section of the Quality Account is mandated by the NHS (Quality Accounts) Regulations.

The income generated by the NHS services reviewed between 1 April 2015 and 31 March 2016 represents 100% of the total income generated from the provision of relevant health services by the Trust during 2016 - 2017.

During the year 01 April 2016 to 31 March 2017, the Trust provided and/or subcontracted 50 relevant health services across three divisions of Community Services, Community Hospitals and Outpatients and Children's and Family Services. The Trust has reviewed all of the data available to it on the quality of care in 100% of these relevant health services.

Participation in Audit and Research

The Trust is committed to a process of continuous quality improvement in the services we provide to our patients and recognises clinical audit as a validated and reliable means of achieving this. In order to improve our processes further, an internal audit inspection was commissioned in the autumn of 2017 using the Healthcare Quality Improvement Partnership's (HQIP) 'Clinical Audit 10 simple rules for NHS Boards' as the standards against which to audit our arrangements. The results of the inspection have been reviewed by the Trust, and a comprehensive action plan produced in response to the key findings. This includes development of a clinical audit strategy as well as revision of the existing clinical audit policy, closer alignment of the clinical audit plan with key Trust objectives and risks, measures to improve Board and sub-Board committee involvement in and scrutiny of the clinical audit programme and improvements to our standard audit proposal and reporting templates. The process for drawing up the forward audit plan has been formalised and the key stages involved outlined in a process map contained within the Trust clinical audit policy. Key objectives include striving to ensure the participation of all clinical services within the Trust in the audit programme and increasing the level of patient and public involvement in clinical audit activity generally. Implementation of the internal audit inspection action plan will be closely monitored at both Quality and Safety Group and Committee level.

National Clinical Audit and the Patient Outcome Programme (NCAPOP)

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

During 2017/18 the Trust participated in two national clinical audits. Details of these are listed below:

Falls and fragility fractures audit programme (inpatient falls). The Trust scored highly and above the national average on the vast majority of measures
National COPD audit (pulmonary rehab). Again, the Trust's performance was in line with, or above, the national average

Local Clinical Audit

Each year, service areas agree a programme of planned clinical audit and quality improvement activity for the forthcoming financial year based on considerations such as Trust quality objectives, National Audits, commissioning priorities, national guidance and local clinical priorities. The structure of the programme is based on best practice guidance produced by HQIP on developing a clinical audit programme. Projects not listed on the forward plan at the start of the year are accepted onto the programme on an *ad hoc* basis as the year progresses.

The forward plan is approved at Service Delivery Group (SDG) Quality and Safety meetings initially and then at Quality and Safety Delivery Group and Quality and Safety Committee. Progress against the plan is monitored closely at SDG level. A quarterly report on progress is also provided to the Quality and Safety Delivery Group and any problems not resolved there escalated to the Quality and Safety Committee.

A total of 61 clinical audits were included on the 2017/18 programme of which 42 were new projects and 16 carried over from the previous year. Three projects were undertaken on a continuous or on-going basis. As at 31 March, 30 projects had been completed, 24 were still in progress, and four had not started.

A major focus of clinical audit activity this year has been around the process of transition of young people from children's to adult services. Three audits are being carried out against NICE quality standard QS140, one looking at the arrangements in place in Trust services from where young people transition, another asking young people about their experience of the process, and a third looking at transition by undertaking a case note review. The findings and recommendations of all three projects will be made available during 2018/19.

Completed clinical audit reports continue to be reviewed at SDG Quality and Safety group meetings and by way of response, the Trust has identified actions to take to improve healthcare. Some examples of the projects we have carried out during the year are included below:

A review of patients requiring insulin administration by community nursing teams.
Key findings: patients are not always receiving adequate assessment of their diabetes needs, more training is required among community nursing teams and

particularly among care home staff in relation to diabetes management; more diabetes mentors are required. *Key recommendations/learning points:* training of staff in diabetes management and insulin administration is to be increased and improved; a review of community nursing practice in relation to diabetes assessment is to be undertaken.

Audit of NICE guidance NG68 on sexually transmitted infections. *Key findings*: the issue of consent and understanding of consent, as well as the availability of emergency contraception is not always undertaken at consultation with young people. *Key recommendations/learning points:* school nurses must ensure that consent and emergency contraception use and availability are discussed at every consultation.

Audit of CQUIN on preventing ill health by risky behaviours – alcohol and tobacco. *Key finding*: a sustained increase in the proportion of inpatients being screened for alcohol and tobacco use at our community hospitals has been identified, as well in the proportion of patients given very brief advice. *Key recommendations/learning points:* staff working in community hospitals need training in how to ask questions about patients' alcohol and tobacco use; the documentation for recording this information needs to be improved.

Participation in Clinical Research

Health services provided or sub-contracted by Shropshire Community Health NHS Trust in 2017-2018 have participated in research activity this year and projects that we are involved with or considering in participating in include 'exploring how children and/or young people (CYP) diagnosed with Selective Mutism (SM) construct their speaking and non-speaking selves '

Mobility and Quality of Life: Developing a patient reported outcome measure for mobility-related quality of life.

Decision-making strategies employed by Independent/Supplementary Nurse prescribers

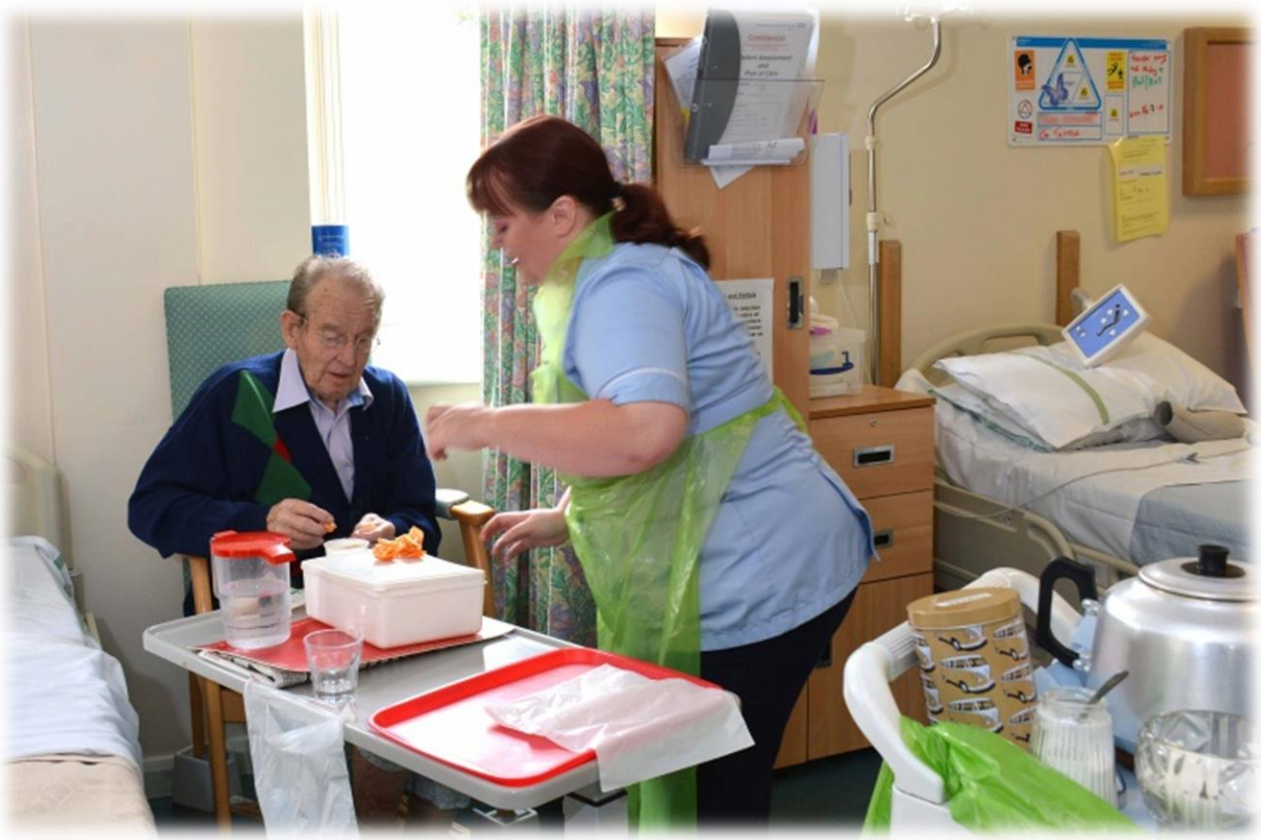
Investigation into mental health interventions and support available within prison settings and during reintegration into the community following release from prison

A multi-perspective qualitative study to understand the experience and impact of the Child and Young Person's Advance Care Plan (CYPACP) is under consideration by our Children's Community Nursing team

In addition to the studies that our patients were recruited onto, several clinicians have carried out research projects as part of post graduate level study and this year we are supporting Doctoral level study with a research project planned for next year

Shropshire community Health are engaged with the Clinical Research Network and have requested to be included as part of the Research Operational Group (ROG), and we have access to addition support for our staff who wish to undertake research with their engagement with the Early Contact and Engagement with Researchers (ERCER) service

Commissioning for Quality and Improvement (CQUIN)



Our CQUINs for 2017/18 were based on national priorities and best practice and applied across our commissioners in Telford and Shropshire. The CQUINS cover a two year period from April 1st 2017 – March 31st 2019

The CQUINS were SCHT are undertaking over the two year period are

Health and Wellbeing of Staff (staff survey improvement)

Healthy Food Options for Staff Patients and Visitors

Uptake of Flu Vaccinations

Alcohol and Tobacco cessation - offering support

Effective discharge

Wound Care

Management of Long Term Conditions

NHS England (Prison Healthcare)

• The proposed CQUIN Scheme for 2017/2018 agreed for HMPYOI Stoke Heath were:

- To improve the primary care of patients with diagnosed personality disorder. This is for the patient group that are not managed by secondary mental health services, but require regular input from primary care and safeguarding services due to complex care needs. This patient group are often jointly managed between primary care and the prison service, and can present many challenges for those staff working with them.
- All primary care staff to attend training and awareness of the safe management of patients with diagnosed personality disorders within primary care services including medical and primary care general staff. To share this learning with prison service colleagues, and to enhance current care planning.
- Through increased knowledge and training, primary care staff to have increased confidence in managing this patient group. To develop specific supervision sessions jointly with prison service colleagues for those working with challenging patients, to allow shared learning, reflective practise and to aid staff wellbeing.

1st August 2017 till 31st December 2017.

- GP and nursing staff to commence training programmes for the care of patients with personality disorders.

- To liaise with prison service colleagues to commence development of local systems to introduce joint clinical supervision between prison service colleagues and primary care staff.

- Development of training materials that can be shared with prison service colleagues to share learning and awareness of patients with personality disorders within primary care services.

- Introduction of shared care professionals meetings for patient group identified. This will include the formulation of joint care plans.

1st January 2018 – 31st March 2018

- By 31st March 2018 all GP and nursing staff to complete training programmes for the care of patients with personality disorders.

- Joint clinical supervision sessions will be in place between prison colleagues and primary care teams by the February 2018.

- Training materials will be disseminated to prison colleagues, with in house training sessions on offer within the healthcare centre, open to prison and primary care clinicians.

- Shared care professionals meetings in place as required for patient group identified. This will include the formulation of joint care plans.

February 2018

- Primary care staff survey to evaluate staff opinions and wellbeing factors following completion of the personality disorder awareness training.

Our Commitment to Data Quality

We operate several different administrative systems to manage our work across services. The requirement to ensure high standards of data quality is taken seriously and a lot of work has taken place over the last year to improve our data systems.

Shropshire Community Health NHS Trust submitted records during 2017 –2018 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. Following implementation of Rio, our

Electronic Patient Record, we are now submitting the Community Services Dataset covering our community services

The percentages of records in the submitted data which included the patient's valid NHS number were:

- 100% for admitted care
- 100% for outpatient care
- 99.6% for accident and emergency care
- 99.9% for community services dataset

The percentages of records in the submitted data which included the patients valid General Medical Practice Code was:

- 99.9% for admitted care
- 99.5% for outpatient care
- 100% for accident and emergency care
- 98.17% for community services dataset

Shropshire Community Health NHS Trust recognises the importance of reliable information as a fundamental requirement for the speedy and effective treatment of patients.

Data quality is crucial and the availability of complete, accurate and timely data is important in supporting patient care, clinical governance and management and service agreements for healthcare planning and accountability. We are taking the following actions to improve our data quality:

Processes and procedures implemented to support delivery of high quality include:

- Scheduled (Daily/ Weekly) data quality checks using a wide spectrum of measures and indicators, which ensure that data is meaningful and fit for purpose
- Data Quality/Validation exercises are being undertaken with our services in support of the electronic patient record RiO implementation and data migration.
- Functionality within RiO allows services to monitor and manage certain data quality items real time and manage waiting lists and Referral to Treatment via the front end

Measures and indicators used to monitor data quality include:

- Completeness checks
- Accuracy checks
- Relevancy checks
- Accessibility checks – the Trust has a process in place that is aligned to the national guidance for the Registration Authority (issuing Smartcards) which ensures that access is assigned to users based on the job that they do in the Trust e.g. Position Based Access Controls (PBAC). Access to clinical systems will be reviewed as part of the Electronic Patient Record (EPR) implementation and audited as part of the Data Security and Protection Toolkit requirements.
- Timeliness checks
- Annual accuracy audit of Trust Clinical Information Systems in line with information governance guidance – data quality audits will be completed in line with the Data Security and Protection Toolkit requirements which is also aligned to the Data Protection Bill and General Data Protection Regulation (GDPR).
- Ensuring the Trust Information Systems and any associated procedures are updated in line with national requirements for example, as currently notified by Information Standards Board (ISB)
- Ensuring that the Trust policies and procedures are updated in line with any national changes in legislation and the Data Security and Protection Toolkit requirements.
- Ensuring that the Trust's key information systems have a documented data quality procedure which describes how data quality is maintained monitored and improved.
- There are a number of different roles and groups which have some responsibility for data quality in the Trust. The Trust Board has overall responsibility for monitoring data quality; they monitor data quality via key performance indicators (KPIs) included in the performance report. All staff who record information, whether on paper or by electronic means, have a responsibility to take care to ensure that the data is accurate and as complete as possible. Individual staff members are responsible for the data they enter onto any system.

Information Governance

Shropshire Community Health NHS Trust score for 2017-2018 for Information Quality and Records Management was assessed using the Information Governance Toolkit.

The Trust achieved a final score of 66% against a target of 66% meaning it achieved Level 2 compliance on all requirements. This score remains the same from the previous year; however, there is an action plan in place for the Information Governance Training requirement. The Trust also has an action plan in place for the General Data Protection Regulation (GDPR) compliance.

The Shropshire Community Health NHS Trust considers that this data is as described due to compliance in Information Governance (IG) training. The Trust has taken the following actions to improve this percentage and so the quality of its services, by Individual level reminders regarding IG training requirements with a deadline for the end of March 2018 for compliance. These actions will remain in place to ensure compliance is sustained.

Incident Reporting

Incident Reporting

The Trust monitors all incidents reported on our electronic incident reporting system (Datix) closely. Managers are required to detail any action taken. All incidents are copied to relevant subject experts and to service quality leads, who make immediate and long term recommendations as appropriate The Trust identifies which are reported at all levels of the organisation Thorough investigations into serious incidents are carried out using Root Cause Analysis techniques and are reviewed by the Incident Review and Lessons Learned Group, and the Medication group of the same name. Actions are identified to ensure that learning takes place and most importantly is embedded in practice to ensure that the causes of incidents, once identified are addressed and less likely to recur. Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential

for learning is so great, that a heightened level of response is justified. We reported and investigated 33 serious incidents in 2017/18 compared to 33 in 2015/16 and 32 in 2016/17. All of our investigations are then subject to scrutiny by our commissioning colleagues. .

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A total of 2172 patient incidents were reported in 2017/18 of which 1.7% led to severe harm or death. We record on our DATIX system sudden deaths resulting from inpatient cardiac arrests, surviving cardiac arrests and episodes of self-harm for example in prison, which are not always reportable as serious incidents in line with the serious incident framework but are investigated in other forums, for example mortality reviews.

Learning from Deaths

The Shropshire Community Health NHS Trust considers that this data is as described for the following reasons: We have a process by which all deaths under our direct care, i.e. in community hospitals and prison services, are reviewed. We are also involved in the investigation of any patient death where that patient has been cared for by our staff but where that patient's direct care is the responsibility of another organisation. This process is overseen by the Trust Mortality Group whose remit it is to ensure that patient safety, clinical effectiveness and user experience form the core practice and principles of services by monitoring and reviewing mortality related issues.

The Shropshire community health NHS Trust intends to, or has taken the following actions to improve or learning from deaths.

The Trust has implemented recommendations from the CQC's Learning, Candour and Accountability report (2016) and the National Learning Disability Mortality Review programme (LeDeR) and continues to monitor national guidance learning from deaths. A number of staff have undertaken the LeDeR Reviewer Training and are involved in reviews undertaken with neighbouring Trusts.

The group undertake reviews of all deaths and provides a regular report to the Quality and Safety Committee and the Trust Board as part of the assurance around

management of risk within the Trust. Actions are identified and shared learning is disseminated for implementation in the relevant areas. Actions have included:

- Increasing our access to training on the use of early warning scores to ensure staff are able to recognise and act appropriately to deteriorating patients
- Incorporating the recognition of deteriorating patients in our Intermediate Life Support (ILS) training
- Improving collaboration with our partners in reviewing patient deaths by means of super spell reviews
- Improving the involvement or families and carers

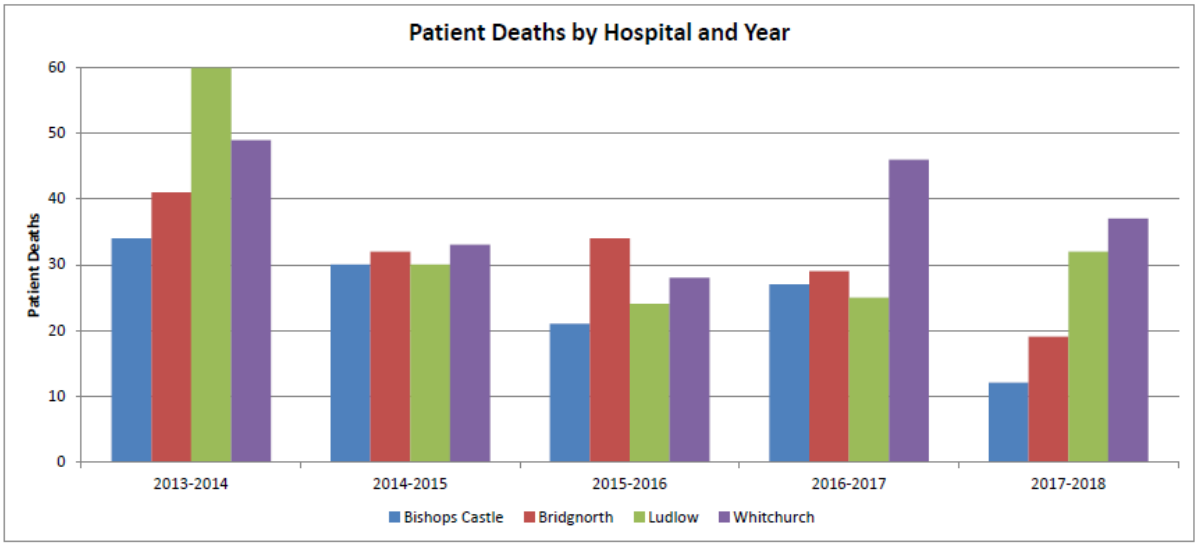
Additionally, findings are disseminated to the Adult Service Delivery Group Quality and Safety meetings, Community Hospital Medical Advisors Group, Clinical Services Managers, Clinical Leads and Team Leaders for further dissemination to medical and healthcare staff within the areas concerned. The Mortality Group also works closely with the End of Life (EOL) Working Group to identify any associated risks and work on implementing resolutions.

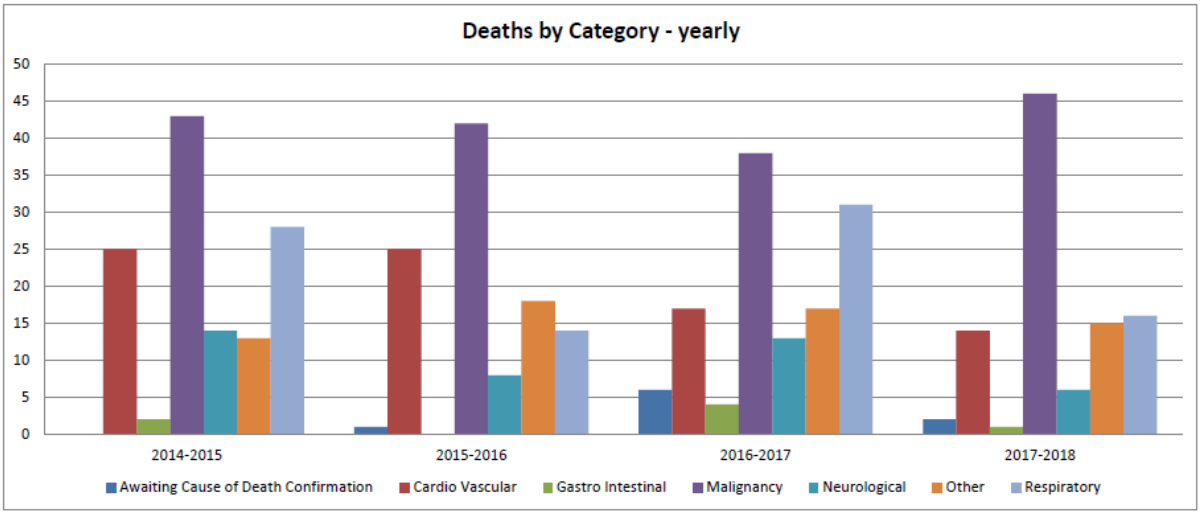
The Trust's Learning from Deaths Policy details the process for reviewing both expected and unexpected deaths within our direct care. In brief, local mortality reviews are carried out on all expected deaths to review aspects of care and treatment of the patient including any additional needs (e.g. Learning Disabilities), spiritual support, End of Life Care planning, completion of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision and of the involvement of family and carers. Any issues and trends are identified and actions agreed to follow these up. All unexpected deaths are investigated by the Mortality Group with a review meeting convened within seven working days. The Mortality Group reviews all unexpected death patient notes and investigation review reports to identify and instigate relevant actions required.

The Mortality Group also monitor any reported "Deaths in Custody" from HMP Stoke Heath and link into the standard HM Prison Death in Custody reporting process under the Prison and Probation Ombudsman (PPO) Investigation. This includes specific clinical reviews.

Reports are also received from the Child Death Overview Panel (CDOP) on Child Death Notifications. The CDOP process covers all child deaths from birth up to 18th birthday (excluding still births and planned terminations). The CDOP considers the death of each child, and is required to complete a national proforma regarding its findings for each child.

Mortality data is also reported monthly on the Trust's performance management system (In Phase) so that the information is available to be monitored at an organisational level. Monthly reports are also disseminated to relevant groups and staff so that trends can be monitored and any learning addressed. Below are two example graphs of the data collected relating to deaths in each community hospital and deaths by category.



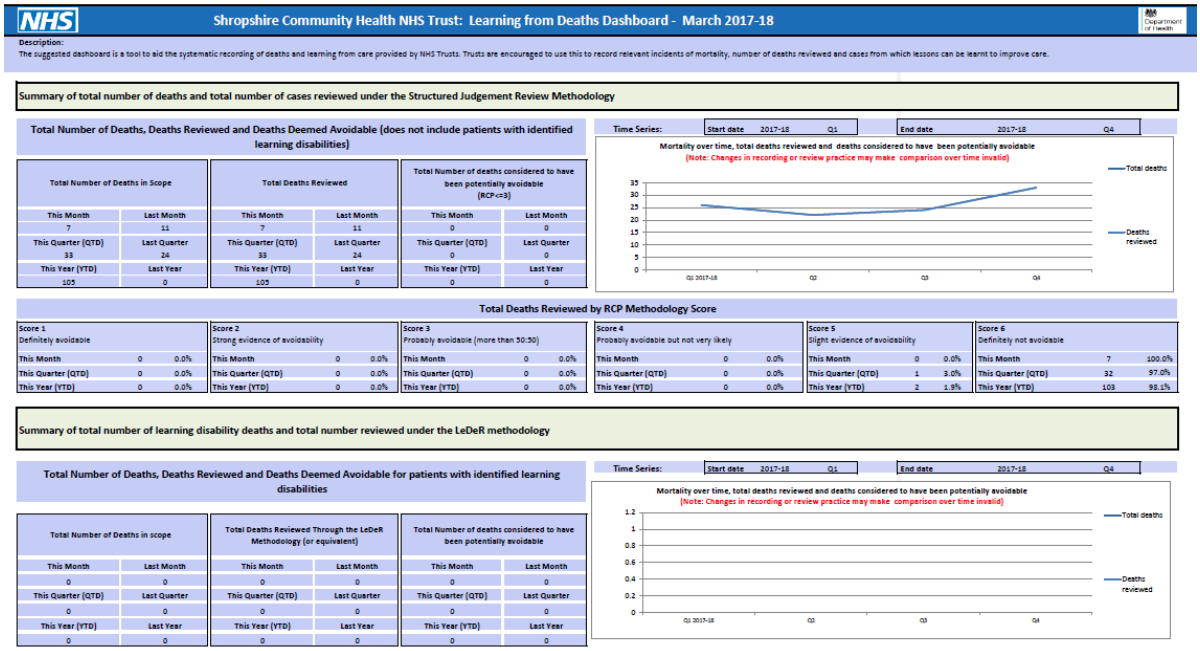


As part of the National Quality Boards guidance on learning from deaths we also provide quarterly mortality data via the agenda of the Trust public board meetings. We use the recommended Department of Health Learning from Deaths Dashboard and report under the following scoring categories:

- Score 1– Definitely avoidable
- Score 2 – Strong Evidence of avoidability

- Score 3 – Probable avoidable (more than 50-50)
- Score 4 – Probable avoidable but not very likely
- Score 5 – Slight evidence of avoidability
- Score 6 – Definitely not avoidable

Below is March 2018 Learning from Deaths Dashboard:



NHS Shropshire Community Health NHS Trust: Learning from Deaths Dashboard - March 2017-18

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
7	11	7	11	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
33	24	33	24	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
105	0	105	0	0	0

Time Series: Start date 2017-18 Q1 End date 2017-18 Q4

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable
(Note: Changes in recording or review practice may make comparison over time invalid)

Total Deaths Reviewed by RCP Methodology Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	7	100.0%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	3.0%	This Quarter (QTD)	32	97.0%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	1.9%	This Year (YTD)	103	98.1%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	0	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2017-18 Q4

Mortality over time, total deaths reviewed and deaths considered to have been potentially avoidable
(Note: Changes in recording or review practice may make comparison over time invalid)

All death in our direct care were reviewed and two categorised as Score 5 Slight evidence of avoidability with the rest categorised as 6 – definitely not avoidable.

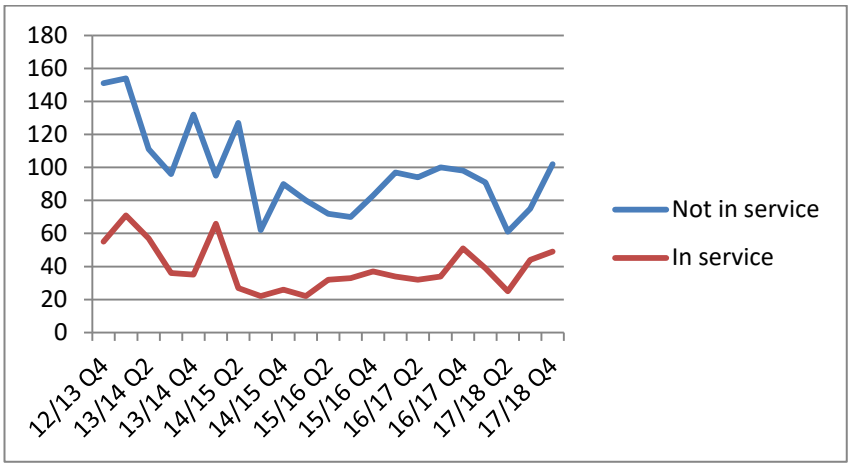
Pressure Ulcers

The chart below shows numbers of ulcers present when patients access our services (Not in service) and those occurring under our services care (In service). The Shropshire community Health NHS Trust considers that this data is as described for the following reasons:

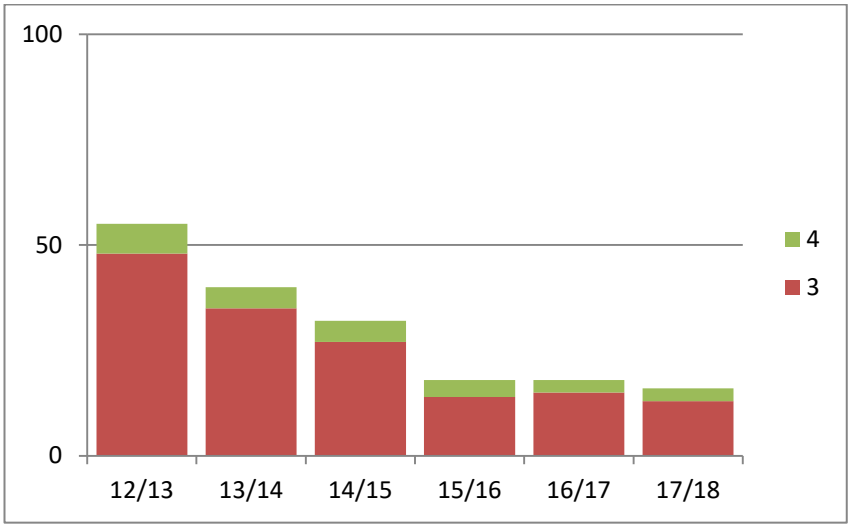
- Increased longevity of winter pressure

- Non- Completion of holistic assessment
- Increased workload pressure.
- Lack of identification of frailty
- Pressure ulcers are one of the main reasons for us reporting SIs and harm to patients.

From Quarter 4 2012/13 both have reduced in number. The number however has continued to be at a higher level for the last 2 years



The chart below shows the numbers of all ulcers developed under the care of our services the more serious grades three and four. These have reduced from 2012/13 to similar level from 2015/16 onwards.



All of these in service acquired pressure ulcers are fully investigated and discussed and reviewed with our commissioners. We agree actions that should be taken and these are shared across our services to make sure that learning takes place everywhere. As mentioned above, we have a very robust review process which helps us to learn lessons in preventing ulcers. We investigate all grade 3 and 4 ulcers under its serious incident framework to identify further means of reducing the number.

The Shropshire community health NHS Trust has taken the following actions to improve our pressure ulcer prevention and management

- Investigation review group for discussion, challenge and agreement of trust wide action and shared learning.

- Tissue Viability review of all suspected pressure ulcers reported via datix.

- Adherence to Duty of Candour

- Revised Patient pressure ulcer prevention leaflet.

- In house training by CPT

- Implementation National Safeguarding of Adults Protocol. PU and the Interface with a safe guarding enquiry

- Strengthening advice and support to staff on management, including pressure relief equipment

- The introduction of 24 hour care plans shared with carers

Further Actions planned

- Implementation of pressure ulcer prevention task and finish group.

- CPT implementation of the “Holistic approach to pressure ulcer prevention” WHY - 11 principles e.g. continence, positioning/mood/nutrition and hydration) and the resource document then goes into further detail as what to consider or think of.

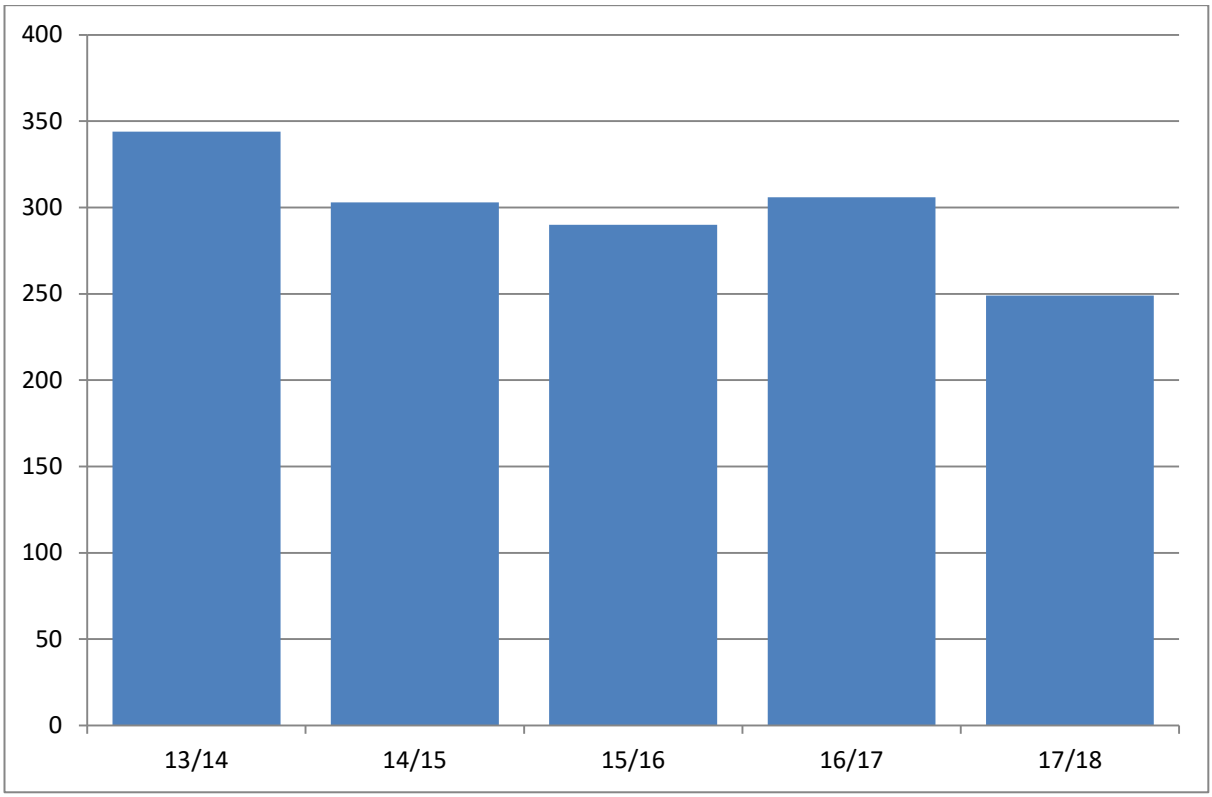
- Increased caseload supervision/identifying and allowing more visit time for frail patients.

- Pressure Ulcer U training part of corporate induction.

- Frailty assessment training

Patient Falls

The chart below shows the total number of patient falls that have occurred in the community hospitals over the last Five years. This shows a reduction from 344 in 2013/14 to 244 in 2017/18.



Following a small increase in 2016/17 the number of falls has reduced from 306 in 16/17 to 244 in 17/18. This is the lowest number in the last five years, Serious falls, those that lead to fractures or other serious injury have fallen slightly in the last year from 10 to 8. Each of these was investigated using Root Cause Analysis methodology and discussed with the clinicians involved at our monthly challenge meetings. The Shropshire community Health NHS Trust considers that this data is as described for the following reasons: Balancing the need for rehabilitation with increasing frailty, and initiatives to reduce debility by hospitalization, and an increase in patient s with reduced capacity for compliance with mobility care plans.

The has taken the following actions to improve the number of falls], and so the quality of its services, by initiatives that were put into place the previous year, including the appointment of an Advanced Practitioner in Mental Health and the appointment of Memory and well-being workers have had an impact on the number of falls. The Trust continues to look into ways of reducing the number of falls including the purchase of additional high - low beds which was an action from a root

cause analysis review, a pharmacy review of medications that could increase the risk of falls, and routine lying and standing blood pressure measurement

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 "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. We help our staff to have these conversations with patients and their families by providing support through our risk manager and Complaints team. We require staff, when completing an incident form on Datix, to say whether they think the incident is applicable to the Duty of Candour and therefore that they will need to comply with the regulation. Examples of a Duty of Candour appropriate incident could be when a patient has developed a pressure ulcer and our investigations conclude that it could have been avoided by our staff, or that a patient has fallen and suffered a fracture in one of our community hospitals. Staff continue to be open with patients, as well as recording those incidents that lead to harm, they also record verbal notifications where there has been no harm to the patient

Safety Alerts

In addition to incident reporting, our electronic system called Datix enables the Trust to monitor and distribute National Safety Alerts which are managed appropriately by the Risk Manager. Any actions that we take on alerts are monitored in the same way as serious incidents.

Between 01 April 2017 and 31 March 2018 a total of 96 safety alerts have been received by the Trust, all of which have either been actioned or are in progress and if the latter, are still within the timescale set.

Safety Thermometer

We have contributed to the national data collection via the NHS Safety Thermometer throughout the past year. The Safety Thermometer is a point prevalence tool which allows nursing teams to measure four specific harms and the proportion of their patients that are free from all of these harms on one specific day each month.

The NHS Safety Thermometer acts as a "temperature check" and can be used in conjunction with other indicators such as incident reporting, staffing levels and patient feedback to indicate where a problem may occur in a clinical area. The NHS Safety Thermometer is a national tool – on the set day each month more than 198,000 patients are included in the national data collection to which our data contributes to give a snapshot of care in the country on that day.

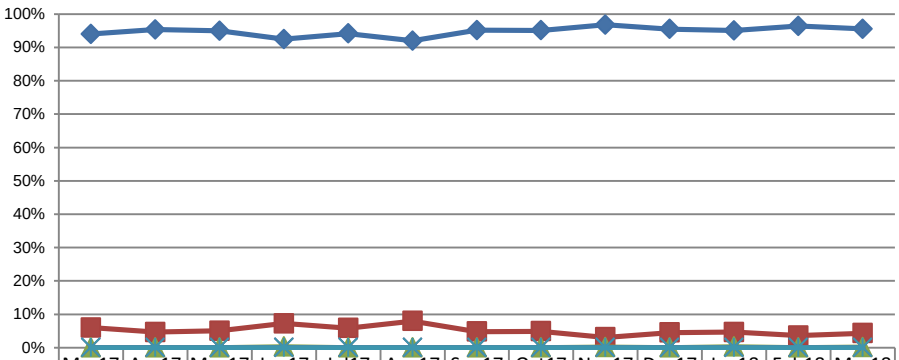
The national target for the Safety Thermometer is that it demonstrates that more than 95% of patients are free from any of the four harms on the data collection day.

The four harms measured are

- Falls
- Urinary Catheter Associated Infections
- Venous Thromboembolism,
- Pressure Ulcers

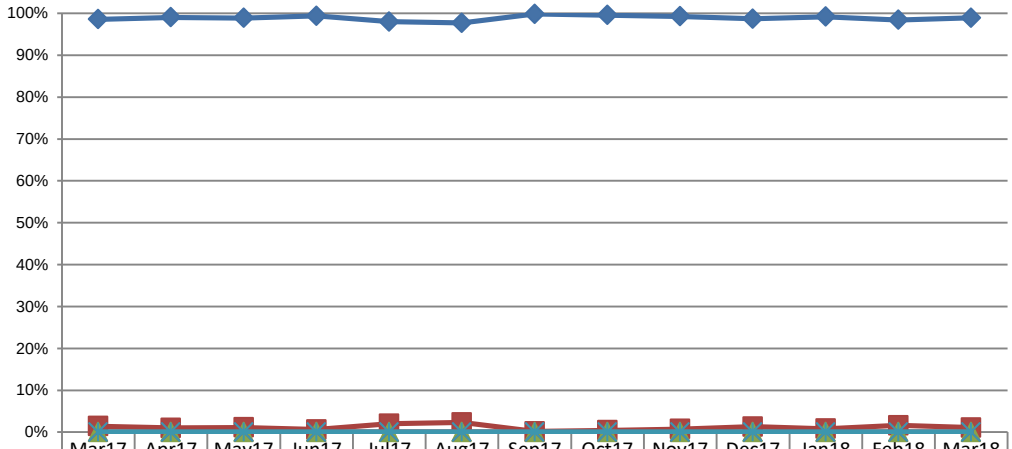
The following charts show the percentage of "Trust harm free" scores. The first chart relates to all patients with one of the four harms whether they came into our care with it or developed it under our care and the second chart is "no new harms" score which relates to the percentage of patients in our care that did not develop one of the four harms whilst in our service. The latter has stayed above 98% across the whole year. We will continue to work hard to make sure all our patients are kept free from harm in our care.

Harm Free: patients with Harm Free Care



	Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18
Harm Free	94	95.35	94.97	92.46	94.14	92.02	95.19	95.11	96.79	95.51	95.09	96.4	95.55
One Harm	6	4.65	5.03	7.23	5.86	7.98	4.81	4.89	3.06	4.49	4.64	3.6	4.3
Two Harms	0	0	0	0.31	0	0	0	0	0.15	0	0.27	0	0.15
Three Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Four Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients	1200	1010	796	650	648	564	645	675	686	690	733	750	651

New Harm Free: patients with New-Harm Free Care



	Mar17	Apr17	May17	Jun17	Jul17	Aug17	Sep17	Oct17	Nov17	Dec17	Jan18	Feb18	Mar18
New Harm Free	98.58	99.01	98.87	99.38	97.99	97.7	99.84	99.56	99.27	98.7	99.18	98.4	98.92
One New Harm	1.42	0.99	1.13	0.62	2.01	2.3	0.16	0.44	0.73	1.3	0.82	1.6	1.08
Two New Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Three New Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Four New Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients	1200	1010	796	650	648	564	645	675	686	690	733	750	651

Risk Assessments for Venous Thromboembolism

VTE Risk Assessment	Year End 16/17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	YTD 2017/18 %	EOY Target
VTE % Risk assessment on admission (A)	**96.16**	95.97	95.14	98.4	96.12	94.35	93.75	95.08	95.68	92.38%	95.86	93.68	74.6	**93.42 %**	**95%**

Shropshire Community Health NHS Trust considers that this data is as described due to some screenings being missed in transfers from our acute partners to us.

The Trust has taken the following actions to improve this and so the quality of its services. We have reviewed all our VTE data for last month against agreement/criteria for OOH weekends management and have held discussions with Ward manager and GP in the lowest % reporting area (Bridgnorth) and processes strengthened to achieve compliance. All medical advisors have been informed.

A ward Transfer aide memoire being developed to ensure staff request VTE status and a Vitalpac (electronic observation record) observation history information as part of the inter- hospital transfer documentation for admissions.

The Trust is exploring nurse led VTE assessment, following appropriate training which we aim to be available before the end of June 2018.

Registration with the Care Quality Commission (CQC)

We are required to register with the CQC and current registration status is “Registered without restrictions”.

In March 2016 the CQC carried out an announced comprehensive inspection of our services (excluding HMP/YOI Stoke Heath). The CQC inspectors were with us for a week, carried out numerous site visits talking to and observing our staff, talking to patients, their families and carers and cross referencing what they saw and heard with data that we provided to them before and during the inspection. When the

CQC visited our services in March 2016, they felt that there were some areas where improvements were required and the ratings grid is shown below.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Community health services for children, young people and families	Good	Good	Good	Good	Good	Good
Community health inpatient services	Requires Improvement	Good	Good	Requires Improvement	Good	Requires Improvement
End of life care	Requires Improvement	Requires Improvement	Good	Good	Inadequate	Requires Improvement
Community dental services	Good	Good	Good	Good	Good	Good
Urgent Care	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
CAMHS	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Substance Misuse	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement

As a result of this the CQC issued "Requirement Notices" to the Trust in relation to the following

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

- Effective handover between nursing teams did not consistently take place; this did not enable staff to share key information about patient care in a systematic and safe way.
- Arrangements to enable quick identification of a deteriorating patient especially children in the MIUs were not consistently in place across all four MIUs.

Regulation 17 HSCA (RA) Regulations 2014 Good governance

- Governance systems and processes were not sufficiently established and operated to enable the trust to assess, monitor and improve the quality and

safety of end of life care services. The trust did not have an overall vision and strategy for end of life care.

- The approach to identifying and managing risk across the MIU's was inconsistent.

Regulation 18 HSCA (RA) Regulations 2014 Staffing

- Staffing and skill mix levels within each community nursing team were not reviewed systematically and at regular intervals to ensure that patients' needs were met and there was sufficient capacity for staff supervision, training, team meetings and staff handovers.

- Staffing levels and skill mix in the MIUs were not reviewed systematically and at regular intervals to ensure sufficiently skilled numbers of staff were on duty at all times in order to meet the needs of the service.

- There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people using the service. In particular, within the Child and Adolescent Mental Health Service (CAMHS) learning disability team and tier 2 staffing.

- Increased patient acuity in the community hospitals was not considered when staffing levels were planned so patients requiring support and assistance did not always receive this appropriately.

As a result of receiving the requirement notices, we have implemented actions to address the areas of concern. We continue to focus on our aim to be a provider of outstanding care.

There are 19 must do or should do actions described in detail in the main body of the CQC report along with other information about our services identified.

All must do and should do actions have been completed with the exception of two which are partially completed

- A review of staffing establishments for in patient and MIU

- End of Life Care – all patients eligible are on an EoL (end of Life) care plan

Current position of these partially completed actions:-

A staffing review has been undertaken for MIU and the in- patient areas with a proposal being taken forward to March RPC and JNP.

The use of the EoL care plan (which is for the last days and hours of life) has been re-audited. The use of the plan is showing a lower position than the previous inspection. Our response to this has been a review of the format of the care plan and to pilot this in April. This is being undertaken with the acute provider and the Hospice. In addition, we now have a clinical educator with an extensive palliative care background who will support EoL education across our services. An internal audit has been commissioned into our EOL getting to good actions and will be presented to committee and board in April 2018; we are currently predominantly showing all the actions as green or on track.

Our EoL 'must do's' from CQC have been subject to an internally commissioned audit. The report findings were good with all actions achieving a green 'achieved' status.

Sustaining Getting to Good actions

It is important to have confidence that the achieved improvements as part of ''Getting to Good'' have been sustained by the relevant services, and that their leaders and clinical teams recognise the improvements i.e. where we were to where we are now.

The SDG Managers for Adults, Children's and Families (C&F) and Heads of Nursing have discussed their dashboards at their respective service delivery groups.

In addition to this in C&F services each individual C&F service has an individual 'Getting to Outstanding' action plan on C&F SharePoint. Individual service leads are responsible for their actions. To provide assurance of progress and improvement there is an annual programme where services report through Q&S SDG. Action plans are available for all services to see to support sharing of information and wider learning.

In Adults services the in-patient areas utilise the QAAS self-assessment processes to support compliance with the fundamental standards.

With the exception of Bishops Castle, due to temporary closure, the inpatient areas have been undertaking self-assessments against the CQC Key lines of enquiry from July 2017.

The self-assessments have been reported within the Q&S committee paper.

Bishops Castle commenced self - assessment in January 2018.

With the exception of Bishops Castle, the inpatient areas will be internally peer reviewed during the month of April and early May 2018 to enable the teams to achieve their Quality Status.

We hold regular meetings with our link CQC Advisor, and report progress on our actions.

Specific examples of change since 2016 we have made are:

- We now have a formatted and effective handover system for community staff

- A skill mix and establishment review has taken place for all community teams and we are recruiting to meet that revised establishment

- Minor Injuries Unit (MIU) staff have received training on sepsis and follow guidance for sepsis recognition from the Royal College of General Practitioners

- MIU have protocols so they can directly contact the Children's Assessment Unit in our local acute Trust

- We have used a caseload waiting tool to minimise risk to Children &Young People in our Children & Mental Health Services (CAMHS) and we are going to implement a new model of service provision.

- At present, the Trust is not subject to periodic reviews by the CQC. The Trust has not participated in any special reviews or investigations by the CQC during the reporting period and has not been subject to regulatory warning notices.

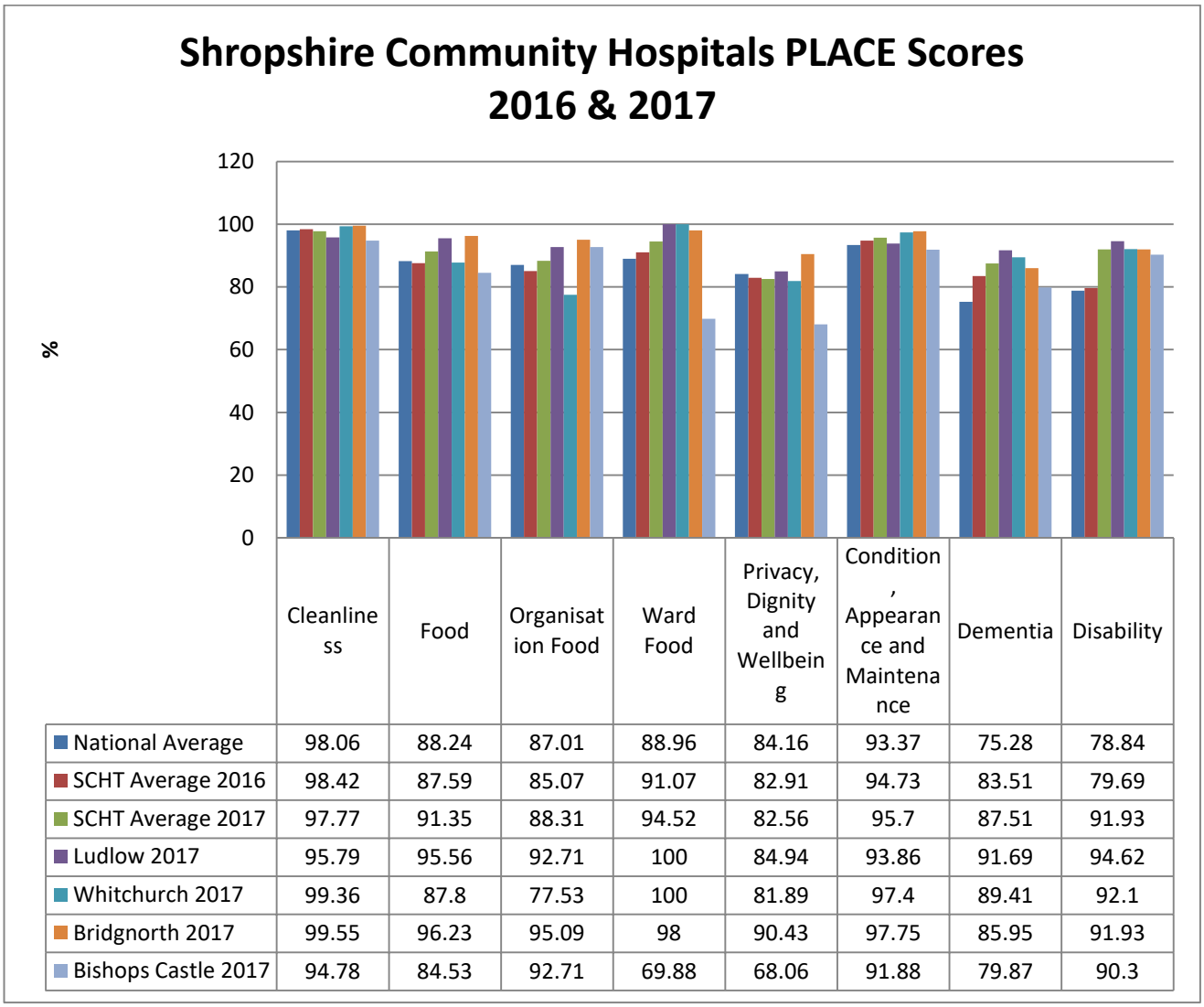
Patient Led Assessments of the Care Environment (PLACE)

Patient-Led Assessments of the Care Environment (PLACE) are a self-assessment of non-clinical services which contribute to healthcare delivered in both the NHS and independent/ private healthcare sector in England. The self-assessments are carried out voluntarily and were introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) assessments which ran from 2000 – 2012 inclusive. These are the fourth set of results from the revised process.
At least 50% of the inspectorate team are non-Community Trust staff and consist of Healthwatch representatives, patients and carers as well as health professionals.

The criteria for inclusion in the programme are that a site has ten or more inpatient beds and therefore all four of our Community Hospitals take part. The aim of PLACE assessments is to provide a snapshot of how an organisation is performing against a range of non-clinical activities which impact on the patient experience of care. The non-clinical activities that assessed are:

- Cleanliness
- Food and Hydration
- Privacy, Dignity and Wellbeing (the extent to which the environment supports the delivery of care with regards to the patient's privacy dignity and wellbeing)
- Condition, Appearance and Maintenance of healthcare premises
- Dementia (whether the premises are equipped to meet the needs of dementia sufferers against a specified range of criteria)

The tables on the next page gives detail of how our hospitals scored when compared with the national average at site level in 2017. Shropshire Community Health NHS Trust considers that this data is as described due to the independent findings of our patient assessors, who identified passes or fails in multiple areas of assessment. The results show that in relation to condition, appearance and maintenance, provision for patients with dementia and disability we exceeded the national average scores. We did not achieve the national average in some areas, particularly in relation to ward food and privacy and dignity at Bishops Castle.



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
National Average	98.06	88.24	87.01	88.96	84.16	93.37	75.28	78.84
SCHT Average 2016	98.42	87.59	85.07	91.07	82.91	94.73	83.51	79.69
SCHT Average 2017	97.77	91.35	88.31	94.52	82.56	95.7	87.51	91.93
Ludlow 2017	95.79	95.56	92.71	100	84.94	93.86	91.69	94.62
Whitchurch 2017	99.36	87.8	77.53	100	81.89	97.4	89.41	92.1
Bridgnorth 2017	99.55	96.23	95.09	98	90.43	97.75	85.95	91.93
Bishops Castle 2017	94.78	84.53	92.71	69.88	68.06	91.88	79.87	90.3

The Trust has taken the following actions to improve this and so the quality of its services. The food at Bishops Castle is provided by an external partner and we have since changed some of the choices and worked with them to improve the quality. In terms of privacy and dignity the main issue was positioning of toilets in relation to

gender specific bays and this has been resolved, a ligature risk identified in the grounds has been removed, however the design of Bishops Castle means we have no rooms specifically designed for family visiting or a multi faith room, although we have access to and provide multi faith spiritual support as required. The flooring identified last year at Bridgnorth and Bishops Castle hospitals is complete.

Following receipt of the report we identified specific actions for each hospital based on the findings and some of the actions were immediately done, e.g. where a cleanliness issue was identified in one area of a hospital it was corrected immediately. The action plan has been monitored through the Service Delivery Group Quality meeting and we have also shared it with our commissioners to show what we have done to improve.

There are some actions that are not complete, but underway as part of our 2017-2018 capital bid programme including a new sluice at Ludlow MIU and storage area at Whitchurch. The work at Bridgnorth has commenced and Bishops Castle has a planned date this year.

Infection Prevention and Control (IPC)

Infection Prevention and Control (IPC)

The Infection Prevention and Control Team work across the Trust to ensure that no person is harmed by a preventable infection whilst in our care or in our facilities. We are contracted by our commissioners to comply with national and local targets related to Infection Prevention and Control measures.

These relate to Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemia (bloodstream infections) with a zero tolerance, no more than two Clostridium

difficile infections (CDI) and at least 97% of patients to be screened on admission for MRSA each month.

To reduce the risk of patients acquiring MRSA while in one of our community hospitals, all patients on admission are screened. SCHT have achieved 96.19% compliance across the four community hospitals during 2017-2018.

During 2017-2018 SCHT recorded zero cases of pre 48 hour MRSA bacteraemia and one case of post 72 hour Clostridium difficile infection (CDI) in the Community Hospitals.

Other organisms including Meticillin Sensitive Staphylococcus aureus (MSSA), Escherichia coli (E. coli), Carbapenemase-producing Enterobacteriaceae (CPE) and Vancomycin Resistant Enterococci (VRE) blood stream infections (bacteraemia) are recorded but currently there is no target. In 2017-2018 SCHT recorded zero MSSA, E.coli, CPE and VRE bacteraemia.

The main Infection Prevention and Control priorities for the Trust in the coming year are to:

- Achieve Health care associated infections (HCAI) targets of zero pre 48 hour MRSA bacteraemia and no more than one post 72 hour CDI in the community hospitals
- Achieve 97% admission screening for admissions to the Community Hospitals
- Support the local health economy to reduce E. coli blood stream infections
- Ensure compliance with the Health and Social Care Act (2008: revised 2015) Code of Practice on the prevention and control of infections
- Complete the IPC team annual programme which is aligned to the 10 criterions in the above code of practice
- Support staff to complete the Trust IPC annual programme also aligned to the 10 criterions in the above code of practice
- Continue to strengthen and develop IPC relationships with SCHT staff, our partner organisations and the wider health care economy
- Continue to develop the role of IPC link staff to act as a resource and role model for IPC in the clinical area

Infections in Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
MRSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0
Clostridium difficile	0	0	0	0	0	0	1	0	0	0	0	0
MSSA Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0
E-coli Bacteraemia	0	0	0	0	0	0	0	0	0	0	0	0
Rolling 12 months count												
MRSA Bacteraemia	-	-	-	-	-	-	-	-	-	-	-	0
Clostridium difficile	-	-	-	-	-	-	-	-	-	-	-	1
MSSA Bacteraemia	-	-	-	-	-	-	-	-	-	-	-	0
E-coli Bacteraemia	-	-	-	-	-	-	-	-	-	-	-	0

Occupied Bed Days in Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Bishops Castle	434	461	422	268	0	0	0	271	387	442	418	430
Bridgnorth	690	727	469	407	725	712	643	688	739	739	640	738
Ludlow	652	690	645	645	688	654	658	625	595	672	632	668
Whitchurch: GP	421	343	349	287	257	324	369	435	347	233	129	755
: Salaried GP	409	485	501	618	561	531	477	466	545	711	755	135
TOTAL	**2606**	**2706**	**2386**	**2225**	**2231**	**2221**	**2147**	**2485**	**2613**	**2797**	**2574**	**2726**

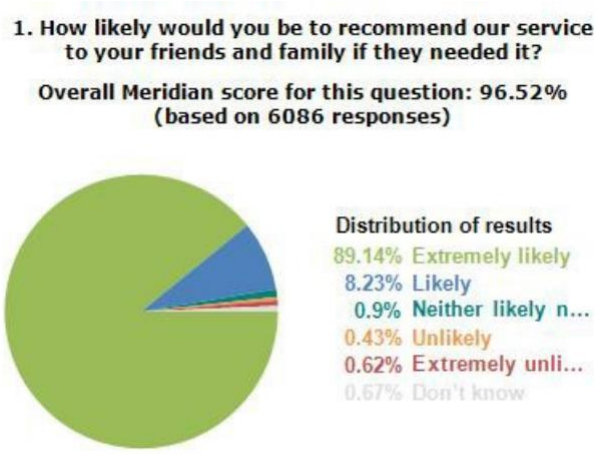
Rolling 12 months average	2476.42
100,000 beds / Average	40
MRSA RATE =	
Incident count / Bed Average per 100000	**0.00000**
C-diff RATE =	
Incident count / Bed Average per 100000	**0.02477**
MSSA RATE =	
Incident count / Bed Average per 100000	**0.00000**
E-Coli RATE =	
Incident count / Bed Average per 100000	**0.00000**

Part 5: A Listening and Learning Organisation

Friends and Family Test

Our score for this year 2017-2018 is shown below.

Scores are accessed and shared with teams, and any particularly negative scores or comments are alerted to managers directly for responses and action.



How we use feedback to develop our culture

Patient & Carer panel (PCP)

The Community trust Patient & Carer Panel is the voice and representative body for volunteers /patients and carers. The Panel continues to meet throughout the year and recently held a consultation meeting around the Quality Account and Patient Experience and Equality strategies. The Panel updates members, staff and stakeholders about its activities particularly patient experience feedback and special projects, as well as representative roles.

New Volunteers

The Patient & Carer Panel volunteers and Community Trust staff held a new volunteers day, which attracted over 60 people including 30 new volunteers (with others also joining up later). Staff and volunteers run workshops around a wide

range of Trust volunteering and representative roles. Both the planning and the actual running of the event were co-produced by staff and volunteers together.

Patient Experience Training and Publications (co-production approach)

Volunteers have taken a lead on designing, developing and delivering tools/activities, such as Observe & Act observations, patient stories and volunteer induction. The Observe & Act tool has been supported by NHS Improvement and NHS England. The special relationship between staff and volunteers has earned the Trust a positive respected reputation and culture in this close partnership and delivery work regionally and nationally.

Representative roles examples include:

- Resources & Performance committee
- Quality & Safety committee
- Transformation
- Charitable Funds
- IPC
- MIU Forum
- Feedback Intelligence Group
- Culture Group
- Interview Panels

Feedback Intelligence Group and 'Joining the Loop'

With the Friends and Family Test (FFT) we continue to use the real time Meridian system to support this area of work and average a response rate, We have

introduced more tablets and volunteers still to support real time feedback in our work in Community Hospitals.

Patient Stories continue to be used at Quality and Safety, team and Board meetings. We did design the guidance that is used on the NHS England website as well. Most importantly many people took the time to give us written feedback as well so where things were not quite right we could do something about it. We call this 'You Said….We Did'

Project work

Dementia and activities work continues to grow strong at Whitchurch Hospital. Other hospitals are looking at more use of day rooms that has been highlighted through observations with new activities and meals.

We have also undertaken equality visits involving representatives of protected characteristic groups and have improved signage and hearing loops as a result.

Complaints and Patient Advice and Liaison Service (PALS) Contacts

The Shropshire Community Health NHS Trust considers that this data is as described for the following reasons: All complaints or PALS contacts are recorded on our

DATIX tracking system. Information on how to express a concern is available in all of our locations and on our website.

The table below shows the difference in numbers of Complaints and PALS enquiries between 2016/17 and 2017/18:

	2015/16	2016/17	2017/18	Difference
Complaints	**88**	**117**	**77**	**-34%**
Compliments	**482**	**455**	**337**	**-26%**
PALs enquiries	**368**	**306**	**303**	**-1%**

There have been **77 complaints** during the year which is a **34% decrease** on the number of complaints received during the previous year (117).

PALS received **303** contacts during the year 2017/18 in comparison to **306** received from 1 April 2016 to 31 March 2017; this is a **drop of 1%**.

During the same period of time (2016/17) we received **455** compliments about our services and have received **337** this year a **26% decrease**

Stoke Heath Prison remained the top service area in terms of numbers of complaints (22) and PALS contacts received. Children's services and community nursing both shared 9 complaints each. The themes of clinical treatment; access and appointments/referrals were common to both complaints and PALS. The Shropshire community health NHS Trust intends to, or has taken the following actions to improve and share our learning from complaints

The theme of communication/staff attitude and behaviour continued to feature through both PALS and complaints contacts either as primary or secondary issues.

This has been highlighted in reports to the Trust's Quality and Safety Committee throughout the year.

There has been a decrease in CAMHS complaints as the service is now under South Staffordshire and Shropshire Foundation Trust.

Both the complaints and PALS services continue to ensure they remain visible and accessible to patients and to welcome feedback about our services. We value and recognise the opportunity that feedback provides in helping us to learn lessons from

patients' experiences and in turn developing and improving the services that we provide to them.

If you would like to see more about our Complaints and PALS work and the action we have taken to ensure that people's concerns are addressed, please visit our website where you will find our annual Complaints and PALS report.

Staff Survey & Staff FFT

711 staff members answered the question would you recommend the Trust as a provider of care to their family or others during the year 2017/18 and the overall satisfaction score for the whole year is 78.31%

Overall, our staff survey results significantly improved on those for the previous year on 11 questions, significantly worsened on one question, and remained about the same on the rest. We were significantly better than the Picker average for Community Trusts on 88 questions, significantly worse on 6 and about the same on the remaining 74.

Table A2.1: Changes in the Key Findings for Shropshire Community Health NHS Trust since 2016 survey

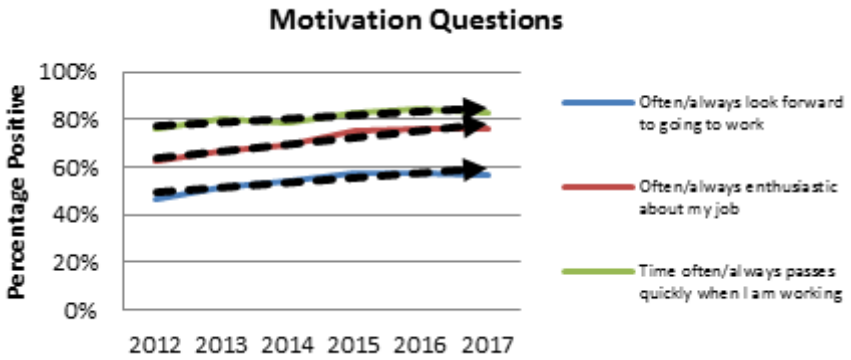
	Shropshire Community Health NHS Trust			
	2017 score	**2016 score**	**Change**	**Statistically significant?**
Response rate	49	52	-3	N/A
Appraisals & support for development				
KF11. % appraised in last 12 mths	95	94	1	No
KF12. Quality of appraisals	3.02	3.06	-0.04	No
KF13. Quality of non-mandatory training, learning or development	4.09	4.07	0.02	No
Equality & diversity				
* *KF20. % experiencing discrimination at work in last 12 mths*	6	5	1	No
KF21. % believing the organisation provides equal opportunities for career progression / promotion	88	90	-2	No
Errors & incidents				
* *KF28. % witnessing potentially harmful errors, near misses or incidents in last mth*	18	16	1	No
KF29. % reporting errors, near misses or incidents witnessed in last mth	93	87	6	No
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	3.78	3.73	0.05	No
KF31. Staff confidence and security in reporting unsafe clinical practice	3.82	3.77	0.05	No
Health and wellbeing				
* *KF17. % feeling unwell due to work related stress in last 12 mths*	43	38	5	Yes
* *KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure*	57	54	3	No
KF19. Org and mgmt interest in and action on health and wellbeing	3.78	3.70	0.08	No
Working patterns				
KF15. % satisfied with the opportunities for flexible working patterns	57	53	4	No
* *KF16. % working extra hours*	76	74	3	No

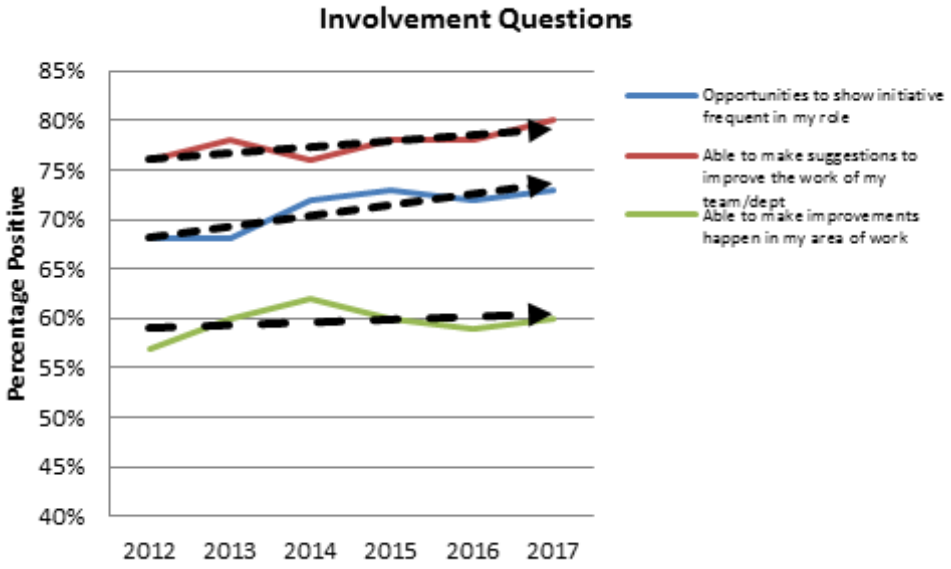
	2017 score	2016 score	Change	Statistically significant?
Job satisfaction				
KF1. Staff recommendation of the organisation as a place to work or receive treatment	3.78	3.77	0.02	No
KF4. Staff motivation at work	3.98	4.01	-0.03	No
KF7. % able to contribute towards improvements at work	73	72	1	No
KF8. Staff satisfaction with level of responsibility and involvement	3.90	3.86	0.04	No
KF9. Effective team working	3.87	3.82	0.05	No
KF14. Staff satisfaction with resourcing and support	3.30	3.20	0.10	Yes
Managers				
KF5. Recognition and value of staff by managers and the organisation	3.55	3.47	0.08	No
KF6. % reporting good communication between senior management and staff	36	29	7	Yes
KF10. Support from immediate managers	3.90	3.83	0.07	No
Patient care & experience				
KF2. Staff satisfaction with the quality of work and care they are able to deliver	3.72	3.70	0.02	No
KF3. % agreeing that their role makes a difference to patients / service users	90	88	2	No
KF32. Effective use of patient / service user feedback	3.68	3.59	0.09	No
Violence, harassment & bullying				
* *KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths*	7	6	0	No
* *KF23. % experiencing physical violence from staff in last 12 mths*	0	1	0	No
KF24. % reporting most recent experience of violence	74	66	8	No
* *KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths*	20	20	-1	No
* *KF26. % experiencing harassment, bullying or abuse from staff in last 12 mths*	15	17	-2	No
KF27. % reporting most recent experience of harassment, bullying or abuse	41	44	-4	No

The Shropshire Community Health NHS Trust considers that this data is as described for the following reasons:

Overall, our staff survey results significantly improved on those for the previous year on 11 questions, significantly worsened on one question, and remained about the same on the rest. We were significantly better than the Picker average for Community Trusts on 88 questions, significantly worse on 6 and about the same on the remaining 74.

Our results show that engagement levels have remained the same as last year, with no decline.





Team working and involvement scores are showing a slight improvement overall although scores around conflicting demands, working unpaid hours and presenteeism are a concern.

Patient and carer feedback is being collected in most areas and more staff received regular updates on that feedback in 2017. Staff reporting that they use patient and carer feedback to make informed decisions is still fairly low at 50%.

Satisfaction around training and development has remained good this year and reported mandatory training compliance levels are good. Appraisal compliance levels are also good, but staff satisfaction around quality has declined this year.

There is an overall positive trend around staffs' view of leadership and management with significant improvements in four of the questions. Of the 11 questions, two

show low satisfaction which are senior managers involving staff in important decisions and acting on staff feedback.

Staff are reporting significant improvements in their managers and in the organisation taking a positive interest in their health and wellbeing. However, responses around staff feeling unwell through stress and MSK issues have stayed around the same this year. So, despite concerted efforts around the Health and Wellbeing Strategy this year, we have not met the required improvements in these two questions for this section of the Health and Wellbeing CQUIN.

Our results for Key Finding 26 – Scores for bullying and harassment, violence, discrimination and witnessing and reporting errors have stayed fairly static this year although we have seen two significant changes. Firstly improvements in staff reporting that the organisation treats people fairly when they are involved in errors and secondly being given feedback on changes made following the reporting of errors. More staff have said that they did not report their last experience of bullying, harassment or abuse.

Question	**CQUIN Requirement**	**2015 score baseline** for 17/18 results due in Feb 18	**2017** score required to meet CQUIN And score achieved
9a Does your Organisation take positive action on H&WB? 'Yes, definitely' scores	5% improvement or 45% of staff answering 'yes, definitely'	28.7%	33.7% **Actual 2017 score - 37%**
9b In the last 12 months have you experienced musculoskeletal problems as a result of work activities? 'no' scores	5% improvement or 85% of staff answering 'no'	75.8%	80.8% **Actual 2017 score - 76%**
9c During the last 12 months have you felt unwell as a result of work related stress? 'no' scores	5% improvement or 75% of staff answering 'no'	59.2%	64.2% **Actual 2017 score - 58%**

The table above shows the staff survey element of the Health and Wellbeing CQUIN requirements. The requirement to meet the CQUIN is to make improvements (to the level shown above) in two out of the three questions.

Although we have seen a significant improvement in question 9a 'Does your Organisation take positive action on H&WB?' this year, the scores relating to stress and MSK issues have not changed significantly. This means that we have not met the requirements for this element of the Health and Wellbeing CQUIN for year one.

Responses from Nursing and Operations Directorate show slightly lower than average positive scores for all three questions and the satisfaction scores for the Adult SDG are significantly lower than the organisational average for the question 'Does your Organisation take positive action on H&WB'. Scores for Corporate Affairs and Finance are higher.

Responses relating to whether immediate managers take a positive interest in health and wellbeing have shown a significant improvement again this year, with positive scores increasing from 71% in 2016 to 76% in 2017. The trend since 2012 for this question has been a positive one with an increase of 23 percentage points from 53% to 76% since then.

Three overarching themes for action have been agreed for areas of focus for the coming year with detailed action plans underpinning each theme:

1. **Doing a Good Job**
   Your feedback has helped us identify areas where we can help you to do your job to the very best of your ability. These are:
   a. Appraisal and training – getting better at setting objectives, identifying training and development and talking about our values
   b. Effective leadership conversations and continuing to improve visibility of leaders in the organisation
   c. Equality and Diversity – delivery of our Equality and Diversity Strategy through our Everyone Counts Group
   d. Using patient feedback to improve our services

2. **Looking After Ourselves**
   We have made progress. Your feedback has helped us identify three areas in which we can help you to look after yourselves:

a. Continue work under the Health and Wellbeing Strategy, to include continued focus on MSK and stress. Explore further the links between MSK and stress and also help our staff to take personal responsibility for health and leading by example.
b. Review of how we support people who are unwell and unable to work, and how we support people to return to work and keep up good attendance
c. 'My name is ….. and I will take a lunch break and go home on time today because it is good for me and my patients' campaign (working title)

3. **Having the Right Equipment**
    a. A theme that has come up before is staff saying they don't have all the equipment they need to do their job. We want to explore what this means to teams, and work with you to rectify this.

Statement of Directors Responsibilities in respect of the Quality Account *(To be agreed at June 28th 2018 Trust Board meeting)*

The Trust Board Shropshire Community Health NHS Trusts produce this document as required by the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the NHS Quality accounts Amendment Regulations 2011 and with additional reporting arrangements as per the Regulation schedule for 2017/18. These Regulations are cited as the National Health Service (Quality Accounts) (Amendment) Regulations 2017. These Regulations come into force on 1st November 2017. The Quality Account publication on the NHS Choices website fulfils the Shropshire Community Trust's statutory duty to submit to the account to the Secretary of State

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

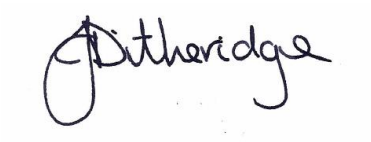
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account and these controls are subject to review to confirm that they are working effectively in practice

- 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 NHSI prescribed information for this year on Duty of Candour, Sign Up to Safety, some key clinical quality indicators including Clostridium Difficile rates, VTE assessment, and re admissions. Additionally NHS staff survey indicators KF26 and KF21 and our CQC ratings grid with examples of actions in response.

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

By order of the Board



Jan Ditheridge,
Chief Executive
Shropshire Community Health NHS Trust
28th June 2018

Section Five: Statements from our Partners

Telford and Wrekin CCG 4th June 2018

Telford and Wrekin CCG welcome the opportunity to review and provide a statement for the Trust's Quality account for 2017/18.
The CCG recognises the progress that the Trust has made over the last twelve months to strengthen and develop the processes that underpin services and the quality of care provision.

These are clearly identified in the examples provided for priorities for improvement carried out during 2017/18.

Priority One: Continue our Work to be a provider of good or outstanding Caring, Responsive, Effective, Well Led and Safe services for patients using Quality Accreditation and Assurance Tools

The CCG continues to support the Trust in rolling out a Quality Assurance and Accreditation Scheme (QAAS) in all Services. The outcomes of this scheme are reviewed on a monthly basis via the CCG's and provider Clinical Quality Review Meeting (CQRM).
Currently used in Inpatient Wards and Community Interdisciplinary teams and based on the Care Quality Commissions key lines of enquiry, the QAAS asks clear and unambiguous questions on the quality of individual services. This is particularly useful for Commissioners to as a component of the quality assurance processes of providers.

Priority Two: Improving the Discharge from Hospital Experience
This was identified as a priority from SCHT's patient's panel at a stakeholder meeting and is also a priority for the local health economy and should be considered as a system wide process.
The initiatives undertaken as part of delivery of this priority has demonstrated improved outcomes for patients and also areas for further work. The CCG looks forward to seeing further evidence of positive outcomes from the on-going improvement.

Priority Three: Transition of Care – Ensuring patients transfer from one service to another, safely, easily and without disruption or gaps in service provision

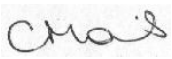
Telford and Wrekin CCG recognise the work that the Trusts has undertaken to improve transition for all children and young people (CYP) across all services including mental health and those with complex and long term health conditions.
This together with the development of partnership working between children's and adult services will support improved health outcomes for young people transitioning to adult services.

Priority Four: Sign up to Safety: Putting Safety First, safer care of the deteriorating patient. Recognising and responding to deterioration and promoting successful recovery from an ill health
Patients of all ages are known to suffer harm if deterioration in their condition is not detected or acted upon in a timely or effective manner. This is a clinical issue contributing to death and severe harm.
The CCG works closely with Trust in applying the NHSE serious incident review framework. The Trust has implemented recommendations from the CQC's Learning, Candour and Accountability report (2016) and the National Learning Disability Mortality Review programme (LeDeR) and continues to monitor national guidance learning from deaths. The Trust undertakes reviews of all deaths and provides a regular report to the Quality and Safety Committee and the Trust Board as part of the assurance around management of risk within the Trust. This is also reported to the CCG's via the CQRM.

The Trust and its staff have wholeheartedly embraced the National Commissioning for Quality and Innovation (CQUIN) Scheme and in particular Health and Wellbeing and are continuing the implementation of its Health and Wellbeing Strategy and Five Year Forward plan.

Priorities for improvement for 2018/19 will be reviewed and the outcomes monitored via the CCG Clinical Quality Review Meetings and contracts meetings.

The CCG wish to state that to the best of their knowledge, the data and information contained within the 2017/18 Quality Account is accurate.



Christine Morris
Executive Nurse, Lead for Quality & Safety
May 2018

Shropshire CCG

Mr Steve Gregory
Director of Nursing
Shropshire Community Health NHS Trust
William Farr House
Shrewsbury
SY3 8XL

19th June 2018

Dear Steve

Re: Quality Account 1 April 2017 - 31 March 2018

NHS Shropshire Clinical Commissioning Group (Shropshire CCG) is pleased to have had the opportunity to review the Quality Account 2017/18 for the Shropshire Community Health NHS Trust (SCHT).

In a joint vision to maintain and continually improve the quality of services SCHT has worked collaboratively with commissioners to sustain and progress a comprehensive quality framework that includes nationally mandated quality indicators alongside locally agreed quality improvement targets. There are robust arrangements in place with SCHT to agree, monitor and review the quality of services, covering the key domains of safety, effectiveness and experience of care.

In preparing this statement, key intelligence regarding quality, safety and patient experience has been reviewed to test the accuracy of the information reported in the account. It is the CCG's view that the account accurately reflects the achievements made by SCHT in 2017/2018. The CCG however notes the report is difficult to read in places, for instance the Learning from Deaths Dashboard. Also the Quality Account makes reference to Meticillin Sensitive Staphylococcus aureus (MSSA) as a multi drug resistant organism which is factually incorrect.

SCHT has taken positive steps to ensure that patient safety and experience of care is maintained and the CCG acknowledges the important contribution of all Trust staff in achieving this. Key achievements include the good progress made with improving the care of patients through the End of Life pathway and we note your prioritised use of the National Early Warning Score (NEWS) to quickly recognise and appropriately manage clinical deterioration in patients.

The CCG recognises the improvements made as part of the Trust's Sign Up to Safety campaign, comprising of the reduction in Medication Errors; improved medicines procedures for covert administration; improved transition between paediatric and adult services handover and discharge and reduced number of people absent from work through sickness.

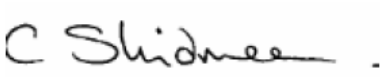
SCHT's Looked After Children Health Team has faced several challenges during the year and continues to work with the CCG on implementing their service recovery plan to assist with providing us with assurance around progression of work related to monitoring the health and well-being of looked after children. The CCG looks forward to receiving positive progress reports during 2018/19 especially now that SCHT has recruited a second Looked After Children's nurse to join the workforce.

The National NHS Contract and Commissioning for Quality and Innovation (CQUIN) Scheme provides us with additional processes and evidence that quality improvements the Trust are undertaking over the two year period. Of particular note is the progress made delivering the important national CQUIN on Wound Care for patients with the aim to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks. Further progress and improvement in delivering the National CQUIN supporting proactive and safe discharge will be welcomed by the CCG.

SCHT has shared with the CCG its proposed priorities for 2018/2019 which include further work to improve personalised care, engagement of staff to enhance their health and well-being, urgent care, dementia care and Looked After Children provision. We recognise there are still improvements to be made in these areas and therefore support the priorities chosen.

In conclusion, based on the information provided, the CCG believes that the SCHT has made good progress over the last year with evidence of improvements in key quality and safety measures. The CCG recognises the trusts commitment to working closely with commissioners and the public to ensure the ongoing safe delivery of safe, high quality services and we look forward to continuing this positive collaborative relationship in the forthcoming year.

Yours sincerely



Mr Simon Freeman
Accountable Officer
Shropshire CCG

Healthwatch response to draft SCHT Quality Account

Healthwatch Shropshire welcomes the opportunity to comment on these Quality Accounts.
The inclusion of an executive summary of the priorities set out for the coming year is very useful. We welcome the focus on looked after children and will be interested to hear how the children, parents and carers will be engaged.

It is difficult to see how the Trust is progressing in some areas as there is a lack of benchmarking, detailed reporting and assessment against measurable targets. For example, it would be useful to see where the Quality Assurance and Accreditation Scheme, highlighted in Priority 1 (2017-18), has been implemented and what the ward and team scores were and how this relates to any targets the Trust may have.

Understanding is hindered by a series of typographical errors, by some unexplained acronyms and use of terminology that is not always easily understood by the lay reader.
There is no reporting on the 2017/18 CQUIN scheme for HMPYOI Stoke Heath. In some other areas, for example the Learning from Deaths, there is a lot of detail of the actions put in place to improve the leaning but little insight into the effectiveness of these measures.
Serious incidents numbers remain constant but it is difficult to understand how the 1.7% of reported patient incidents (37) that 'led to severe harm or death' relate to the '33 serious incidents' in 2017 - 18.

In some areas clearer reporting would be helpful, the inclusion of figures to accompany the pressure ulcer data graph would help understanding.

The work the Trust is carrying out to reduce falls is obviously having very welcome positive effects and with the continued focus we look forward to further reductions.

It is disappointing that Bishop's Castle Community hospital is below the national average on PLACE scores but obviously the Trust is addressing the issues where it can. It should be highlighted that Bridgnorth exceeds the national average in all areas.

The number of complaints and compliments has fallen significantly compared with the previous year while PALS enquiries have remained almost constant. Some analysis would be welcome as would some detail of the actions the Trust intends to undertake to improve and share learning.
The Trust acknowledges that their work to improve staff stress and MSK related illness has not shown any improvements in the feedback from the staff survey. It would be useful to see some indication of how they intend to address the issues.
The Trust is to be commended on its commitment to improve quality but improved reporting would help understanding.

Comments from Telford & Wrekin Council Health and Adult Care Scrutiny Committee on the Shropshire Community Health NHS Trust Quality Account 2016/17

Awaiting Feedback

Comments from Shropshire Council's Health and Adult Care Scrutiny Committee on the Shropshire Community Health NHS Trust Quality Account 2016/17

A presentation was given on out quality Account to the HOSC on 6th June 2018 and we await feedback