Shropshire Community Health NHS Trust

QUALITY ACCOUNT

2018-2019

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 :shropcom.customerservices@nhs.net

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 2018/19.

The purpose of our Quality Account is our annual report to the public about the quality of 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 and the way that we support and develop our staff to provide that care safely and effectively.

In this Quality Account we look back at the year just passed and present a summary of our key quality improvement achievements and challenges. We also look forward and set out our quality priorities for the year ahead, ensuring that every day we live our Trust values of commitment to quality, respect and dignity, working together, compassionate care and making sure everyone counts .

Some of the content of the Quality Account 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 five 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). The priorities have been identified for 2019-2020 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.

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 this year welcomed a formal, comprehensive inspection of the quality of our services by the Care Quality Commission (CQC) in January and February 2019, followed by a review of our organisation from a 'well led' perspective in March 2019. At the time of writing this introduction we await the formal report from the CQC. We are already working hard to continue to look beyond the inspection towards our aspiration to be outstanding at improving lives in our communities.

You will read about the continuing work that has been undertaken in this Quality Account which includes:

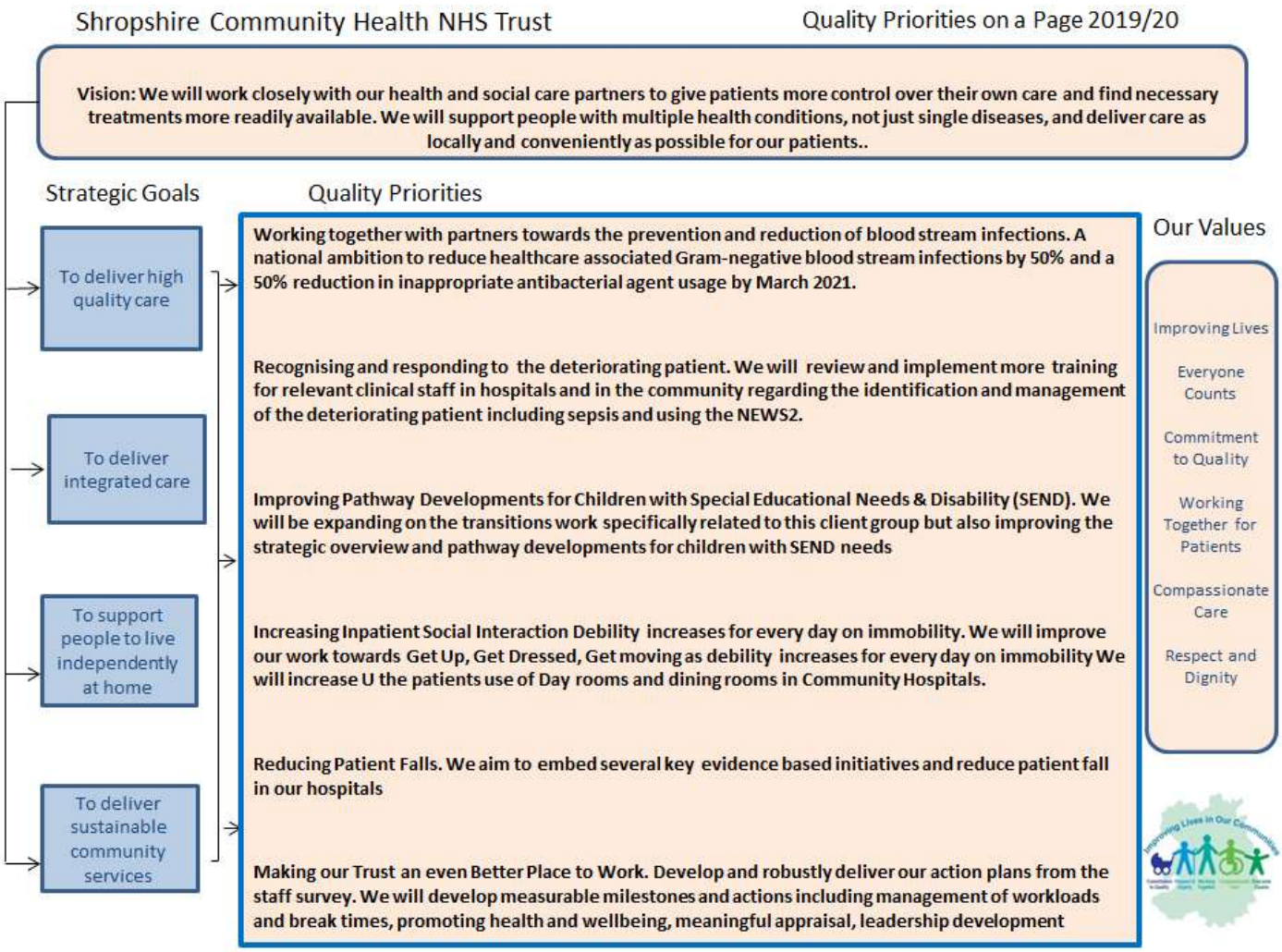
- Work that has gone on towards achieving our quality priorities for last year
- Supported the workforce to deliver high quality care with new roles and reviewed establishments agreed by front line staff
- Improved our measuring and reporting of quality indicators for improved assurance
- Improved our Clinical Audit processes
- Managed changing healthcare provision models

It's been another busy, challenging but rewarding 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.

Steve Gregory
Executive Director of Nursing and Operations

Executive Summary: Our Quality Priorities for 2019/20

Our Quality Priorities for 2019/20 and how we aim to deliver them



Our Key Priorities	Timeframe	How will we know we the priority has been met ? How will we measure this??
In 2019-2020 the SCHT will undertake specific additional activities towards the prevention and reduction of infections arising within the blood. In the community blood stream infections can arise from :- • a urinary infection • a urinary infection caused by an indwelling urinary catheter in the bladder • an open wound, a leg ulcer or pressure sore	March 2020	We aim to meet the governments ambition to • reduce healthcare associated blood stream infections by 50% • reduce the use of treatment by inappropriate use of antibiotics by 50% by March 2021 • Reduce the use of dipsticks in the community hospitals • Introduce a urinary catheter passports • The full introduction of Droplet Hydration Cups and patient education programme in regard to hydration
We want to be responsive to our ageing patient population who are living with lots of other health problems and may be at greater risk of deteriorating.	March 2020	The NHS developed a National system to enable clinical staff to better recognise when a patient's condition may be deteriorating – National Early Warning System (NEWS2). Establish an MDT steering Group to rollout NEWS2 training across the trust. Roll out training for relevant clinical staff in hospitals and in the community regarding the identification and management of the deteriorating patient including sepsis and using the NEWS2. Identify NEWS2 Champions across the organisation with at least 1 in each Adult Team for hospitals and in the inter disciplinary teams Identify how many clinical staff have received training through repeat NEWS 2 / Sepsis clinical audit August/September 2019. Monitor the effectiveness of training through our various reporting and monitoring systems.
We want to improve our patients experience in hospitals and the community by enabling social interaction and reducing loneliness.	March 2020	With our volunteers, develop a structured patients activity schedule in each hospital. Obtain feedback from our Observe and Act process on the use of the hospital day rooms, monitored using observe and act and quality visits. Develop ways in which we can monitor and capture where patients have been signposted to use relevant social support groups We will increase opportunity for relative and carer involvement in care and mobilisation. This will be assisted by broadening visiting times; collaborative care planning and a more flexible and relevant approach to protected mealtimes. Each ward will develop an activity boards and ward information booklet to indicate activities and facilities.

Falls in the elderly are a frequent occurrence, causing pain, injury, increased length of stay, unplanned surgery and delayed recovery. We want to do all we can to reduce inpatient falls.	March 2020	Continue MDT Inpatient Falls reduction steering group. Focus on lying and standing BP for 3 days as standard approach for all mobile patients. Pharmacy communication to prioritise meds review for new admissions, patients at risk of falls with wandering and difference in lying and standing BP with symptoms. Identify ''Falls prevention Champions'' for each hospital and community adult team reinvigorated Falls Champion Forum. Monitor all patient falls and falls that result in a serious injury via our Datix monitoring system to monitor outcomes of the work and provide data for analysis. Patient footwear and reduce use of red socks and falls prevention advice / health promotion for community patients. Safety huddles and shift handover format review in progress to improve communication. Highest incidence of falls is in bays therefore reinvigorate bay safe approach. Education of ''backward chaining ''as a technique to teach a patient how to safely get up from a fall.
We have identified some work to do to continue to work towards meeting NICE guidance and NHSI Learning Disability Standards.	March 2020	We are going to review and combine our action plans from the NICE guidance baseline audit and the recently released NHSI LD standard audit results We will use these plans as a work blueprint for improving our care for patients with Learning disability via an implementation group Develop measurable milestones and actions including Training and engagement and re audit these standards.
We want to improve the coordinated approach to care and support for Children with Special Educational Needs & Disability (SEND).	March 2020	Following on from last year's work around transitions (transition means the process for when a child leaves children's services and enters adult services) the Children, Young People and Families SDG plan a quality focus this year around the SEND agenda. We will be expanding on the transitions work specifically related to this client group but also improving the strategic overview and pathway developments for children with SEND needs.

We will develop and robustly deliver our action plans from the staff survey in particular we want to respond to areas of focus in our staff survey results: Being Too Busy Doing a Good Job, Conversations that Count, Zero tolerance to bullying and harassment.	March 2020	Use these plans as a work blueprint for improving our experience for Staff Develop measurable milestones and actions including management of workloads and break times, promoting health and wellbeing, meaningful appraisal, leadership development, wellbeing conversations, living our values, working together to achieve a 0% tolerance of bullying. Training data will be available to demonstrate uptake in conducting and partaking in appraisals ensure that appraisals meaningful and relevant for staff Improvement evident in Trust staff survey scores relating to quality of appraisals. Staff will be asked to feedback that they have the opportunity for discussion between themselves and managers identifying 'what matters to me' conversations We aim to see an improvement will be demonstrated in the next staff survey in our areas of focus.

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 increased our patient contact activity this year with over 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 (2088 people received inpatient care in 2018 - 2019, an increase of almost 400 from the year previous). In prison healthcare there were 15421 contacts which have increased by over 1000. We also supplied 280,386 items of equipment or medical products.

Patient Activity Figures 2018/19	
Community contacts	717,374
Outpatient attendances	60,396
Inpatient and day cases	865
Inpatient Rehabilitation Episodes	2,088
Radiology examinations	9,866
Minor injuries attendances	30,272
Equipment and products supplied	280,386
Prison healthcare contacts	15,421

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 and this year we have conducted significantly more care planning conversations to help patients with long term conditions feel supported and confident to manage their condition 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, Shropshire Local Authority and Dudley Metropolitan Borough Council who commission us to provide Healthy Child Programme services (Health Visitors, Family Nurses and School Nurses) for children, young people (0-19) 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 The Midlands Partnership NHS Foundation Trust are, and we work closely with them and other NHS Trusts. The Trust is also committed to working with patients, public and other community and voluntary sector groups to make sure that the services it provides are relevant to local people and provided in the best possible way for them.

The table below shows how we organise our clinical services into Service Delivery Groups (SDGs), which are supported by the functions above. Supporting the SDGs clinical functions and reporting to our board are our Corporate and Support

Services, Nursing and Quality, Operational Leads, Medical Leads which include functions such as finance, human resources, information technology, Quality monitoring, Research and Clinical Audit 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
- Rheumatology Outpatients
- Physiotherapy Outpatients
- Podiatry
- Advanced Primary Care Services
- Prison Healthcare
- DAART
- Telford Musculo Skeletal Services
- Falls Prevention Services
- Admiral Nursing (Telford)

Children and Families SDG

- Community Children's Nurses
- Child Development Centres
- Community Paediatrics
- Immunisation and Vaccination
- Dental Services
- 0-19 Public health Nusing Service
- Looked after Children
- Wheelchair service
- Community equipment service
- Community paediatric occupational therapy
- cCmmunity paediatric physiotherapy
- Community Speech and Language therapy
- Community paediatric Psychology

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
- Quality
- Safeguarding

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 2018 -2019

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 : 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 have undertaken in 2018-2019:
We have actively worked to increase feedback on the experience of our services across the range of feedback mechanisms we have. Feedback is used as a resource for improvement and is part of the standardised meeting minutes, including observe and act outcomes, FFT feedback and recovery plans where appropriate, patient experience survey feedback. For example, the discharge experience is a challenge. We have developed a recovery plan and specific actions are underway. OPD is now in a division of its own and senior managers and clinicians are reviewing patient information, waiting room and guides for an improved OPD experience.
This means ✓ We have doubled the number of patients and service users who provide feedback on their experience of our services. ✓ We now know that 85% of teams recently audited were discussing patient/staff feedback as part of their team meetings. This means teams know the experience of care received by patients and service users they have cared for and can make improvements and celebrate success at service level. ✓ We now know that one of the contributory factors influencing a poor experience patients and their families in discharge planning and process

correlates to the use of 'choice letters'. This has enabled us to review content, layout, user friendliness and timing of supplementary verbal communication with patient/family.

- ✓ We were able to demonstrate at our last CQC inspection (2019) that patient feedback was seen to be important in improving services and providing care. Inspectors told us they saw a lot of specific examples where patient feedback had been used to good effect.

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. Health and Wellbeing is an integral part of our Trust People Strategy. A Happy and healthy staff provide better care for patients according to independent research.

Activities we have undertaken in 2018-2019:

During 2018/19 we developed and expanded our group of Health and Wellbeing Champions, and Introduced two new corporate campaigns; The Half Hour Re-power and Fit in Fifty Seconds.

We developed a new role of Wellbeing Practitioner for Mental Health, delivered resilience training to staff and trained key staff in mental health first aid.

Full details of our Health and Wellbeing plan are given below.

Appraisal training pilots held summer 2018 and new training programme subsequently developed & launched February 2019.

Training data available to demonstrate uptake in conducting and partaking in.

Staff survey questions included quality of appraisal and further work identified.

Ensured 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.

Competencies work streams & framework developed across adults and children's services ready to be launched in 2019.

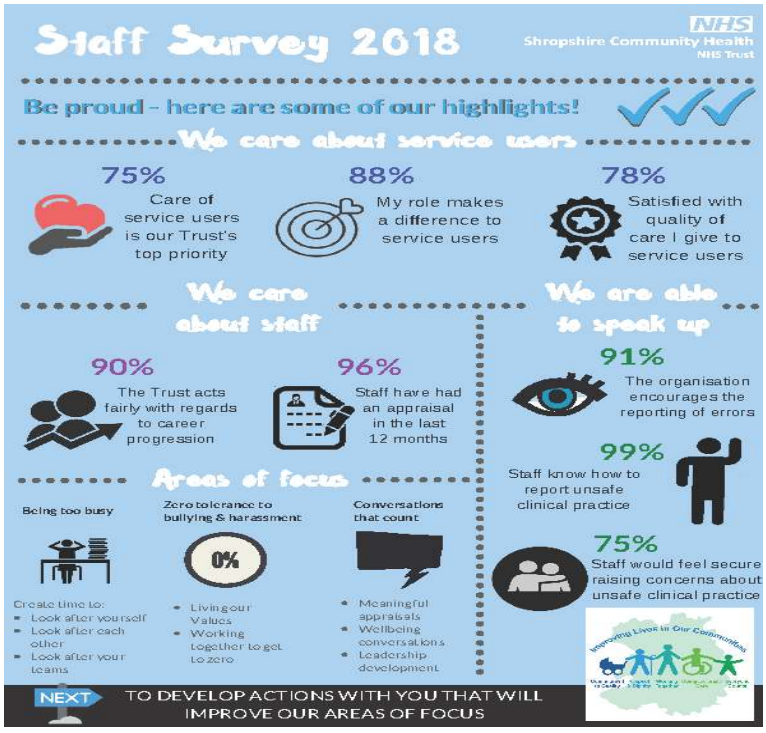
Rio Training Needs Analysis completed post launch and additional training delivered for community services.

The activities we have taken mean

- ✓ We have delivered our health and wellbeing plan for 2018/19, and continue to develop and expand this plan in to 2019/20 and beyond.

- ✓ We have been able to act upon feedback from our teams and have redesigned the appraisal framework to assist in strengthening the appraisal experience to support our employees in recognising the value of their work, ''bring to life'' our Trust values; what they mean to the individual and, how they live those values.

- ✓ We are able to evidence mandatory role specific training and provide targeted support to areas where it is most needed. We will be able to identify and further strengthen governance arrangements for service specific essential clinical mandatory training, and, evidence outcomes of training through a trust clinical competency framework.



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 have undertaken in 2018-2019:

We have undertaken a collaboration exercise expert groups, with our partners and patient and carer representatives and our dementia strategy was finally approved in March 2019. Going forward we have established a strategy implementation group to ensure that over the next two years we deliver on our strategy commitments.

This means

- ✓ We have strengthened the work already taking place through the collaborative and inclusive development of our strategic vision for dementia care.
- ✓ Our vision will ensure our approach to the care of patients living with dementia is modern, evidence based and standardised throughout services.
- ✓ We will be able to translate our vision into a working plan to help us know when we have achieved our vision.
- ✓ We are becoming a more dementia friendly organisation with appropriate environments, skills and processes to reduce harm, and provide safe, effective care.
- ✓ We now have evidence in delivery of individualised care that supports the person living with dementia and their carer and have outstanding examples of this.

The activities undertaken enabled our staff to evidence progress , and, during our 2019 CQC inspection our inspectors told us that ''In all areas visited, a passion for giving good care was observed''

Priority Four: Increasing our contribution to the urgent care challenges
Independent Care Assessors scheme Care Home Multi-disciplinary Team Admission Avoidance / Early Supported Discharges
Activities we have undertaken in 2018-2019
We have reviewed how we promote and manage our Integrated Care Services and Interdisciplinary Team 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 have reviewed how our red to green patient experience and patient progress toward discharge initiative is applied and monitored via our reduced length of stay and delayed transfers of care / discharges. The Red2Green approach is a visual management system to assist in the identification of any areas where we can be more effective and eliminate delays in a patient's journey towards discharge. Red2Green is undertaken on a daily basis across all sites with senior input. The process is embedded but is limited. Red2Green in combination with other initiatives such as MDT meetings, long stay reviews, patient empowerment and the Choice Police has seen a reduction to our overall DTOC and LOS. Independent Care Assessor scheme Prior to implementing the Independent Assessor scheme any patient who, following a period of acute hospital in-patient care, and prior to an individual's discharge to a Nursing or Residential home, practitioners were required to undertake a statutory assessment or review to determine a person's eligibility. Additionally a separate assessment by the potential provider was required in order to enable a safe discharge. Multiple providers were called in to the acute hospitals to assess individuals – resulting in wasteful of resources; assessments may not happen in a timely manner and potentially distressing for the individual. As a result of setting up the Independent Assessors team we have addressed the capacity and timely concerns whilst also delivering quality assessments, based on knowledge of the capacity, skill sets and abilities of providers, and have gained providers trust and respect. The service now completes over 95% of assessments on behalf of care homes and we are currently in process of employing a Registered Mental Health Nurse who will help us gain further

trust for Elderly Mentally Health placement assessment.

The team also attends daily Delayed Transfers of Care meetings and challenge decisions, contributing to facilitating timely discharges / returns to care homes.

The team receive over 100 referrals per month - all data now available via our Electronic Patient Record (EPR).

Admission Avoidance and Early Supported Discharge

The target of 31 per month has always been difficult as the service relies on external referrals into the triage facility. To ensure compliance the following has been implemented:

- Completed review of the triage process – now Nurse led
- All calls to be triage through ICS Health
- Review of in-reach services ensuring the correct role is present
- Daily attendance to the integrated Discharge Hub meeting
- Regular meetings with GP/CCC/SaTH to review pathways
- Data analysis of local GP referring into the service – teams to then visit each GP practice with low referrals to identify blocks
- Realignment of all professionals to address ESD workload
- Live data sheet to record all beds identifying blocks and updated reports

We also monitor closely how our Minor Injuries Units (MIUs) can contribute to patients getting the right care in the right place and have taken several Initiatives and campaigns to promote attendance in the MIUs rather than A&E

We have increased the number of qualified Emergency Care Practitioners across all of our MIU's. This means that we are seeing and treating more

people in the units, reducing the strain on our partner services and more of our patients can be treated well locally rather travelling long distances to A&E. We are also promoting our service publicly through digital and mainstream media so that the public are learning what we can treat and this is increasing footfall to our departments. Our MIUs maintain a good performance for waiting times and other key quality indicators as seen in the table below.

Overall, this means

- ✓ We are better able to support people to live as well as they can in their right place of care, which, wherever possible is at home.

- ✓ We have been able to attract Emergency Care Practitioners to work within our Minor injury units has meant we have significantly reduced the need for temporary agency workers, sustained our capacity to see and treat patients locally rather travelling long distances to our local A&E .

- ✓ This means we are now in a stronger position to promote our service publicly through digital and mainstream media to increase public awareness; this has resulted in an increase in the number of people attending the department, supporting our public as well as our local A&E to see and treat more urgent cases.

	KPI	Target	Actual	YTD Status	Overal Rating
MIU	A&E Left Without Being Seen	5%	1.24%		
	A&E Time to Initial Assessment	95% <=15 mins	100%		
	A&E Time to Treatment Decision	Median 60 Mins	10min		
	A&E Unplanned Re-Attendance Rate	5%	1.32%		
	Total time in department (Arrival to Discharge)	95% <=4 hrs	99.96%		

	KPI	Target	Actual	YTD Status	Overal Rating
Community Hospitals	Length of Stay (overall)	20	15		
	Proportion of delay transfer of care (days)	3.50%	1.74%		

	KPI	Target	Actual	YTD Status	Overal Rating
ICS	Length of Stay (overall) (24 days)	24	20.57		
	Admission Avoidance (overall)	130	57		
	Early Supported Discharge	196	267		
	Readmission (overall)	20%	13.88%		
	Ni125 (81.9%) **(March 17)**	81.9%	No Data		

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 have undertaken in 2018-2019:
We have strengthened the governance arrangements regarding clinical education through the establishment of our clinical education governance group. New Clinical audit strategy and policies, strengthened our audit processes Quality Assurance and Accreditation Scheme in adult Services. Agreed revised establishments in MIU and inpatient wards, with continued monitoring of, complexity and dependency of patient's needs. Strengthened leadership with a move to locality models and increased clinical leaders. Continued our governance work in End of Life Care and undertaken associated clinical audit via themed reviews and EOL audits.
Our patients, our visitors, our commissioners and ourselves are all ''inspectors'' of our services. These activities mean we have strengthened our mantra in ''always being ready for inspection''. This means we are much better able to provide evidence on the delivery of services in accordance to the fundamental standards CQC describe, for which ''care must never fall''.

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 have undertaken in 2018-2019:
All healthcare practitioners who come into contact with looked-after children have role specific training delivered by the safeguarding children team. An audit is in progress to measure the quality of child's health assessment and care plan and identify if completed within local and statutory timeframes. Our Looked After Children's Nurse Specialist, has successfully implemented a new health assessment pilot which has a greater emphasis on the child's

voice and enables looked-after children to participate in decisions about their health care.

A gold standards review health assessments have been completed to support practitioners to provide a comprehensive health assessment.

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.

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.

This means

- ✓ We are better able to support and protect vulnerable children through strengthened safeguarding procedures.
- ✓ We are following National programmes of care and evidence-based practice across all children services.
- ✓ We are better able to provide individualised, child-centred care.

Additional Quality Activities we have undertaken in 2018-2019

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
- Making Handover and Discharge Safer and More Effective
- Reduce the number of people absent from work through sickness

The Trust aimed to have demonstrable improvement against these by the end of 2018 -19 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:

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 lesson's 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, "Permission to Pause", 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.

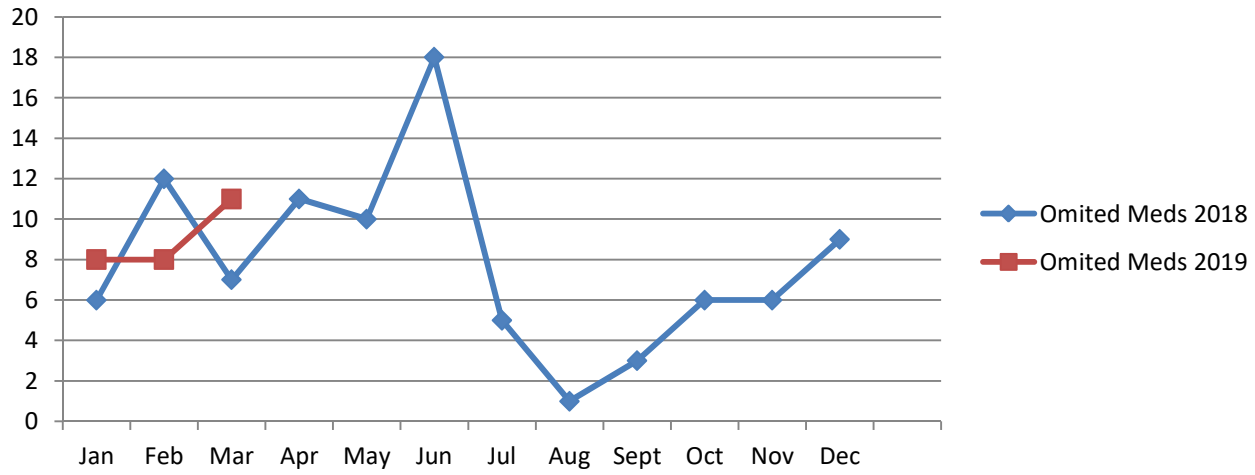
An insulin focus group was convened to improve safety controls around insulin prescribing and administration. This work has improved the access to training and competency assessment and information on the safe use of different forms of insulin. In addition, new documentation has been created for use in the patient's own home / care home. This paperwork is comprehensive and gives the prescriber guidance on prescribing and incorporates mandatory fields. This was trialled as a paper version in Ludlow with success. Following this, it has been converted to an electronic version and added to EMIS (GP Prescribing software) which has since been trialled in Bishops Castle.

As a result of this pioneering work, new pilot sites are currently being determined throughout Shropshire, Telford and Wrekin. This documentation should further reduce insulin incidents due to prescribing errors.

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 implementation of Electronic Prescribing and Medicines Administration (ePMA) remains on the Trust's digital strategy. This will improve the quality of prescribing, highlight in real time any medicine administration omissions so that immediate action can be taken and provides vital safety controls to promote medicines safety.

Below is a graph to demonstrate unjustified administration omission within community hospitals during 2018 and 2019



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.

During 2019, lesson's learned meetings have been themed. The themes cover high risk medicines. Feedback since theming has been extremely positive and the feeling is that deeper conversations are now occurring resulting in more affirmative action into the root causes.

Are aim of course is ultimately to have zero omitted medicines. The introduction of Electronic Prescribing and Medicines Administration (ePMA) system will be essential in achieving this.

Her Majesty's Prison (HMP) Stoke Heath has made significant progress with reduced omissions, monitored via another IT system - SystmOne. The numbers of unjustified omitted doses (where there is no SystmOne record of administration) remains very low. Omission is more likely to be associated with inability to obtain stock.

Omissions due to refusals or failure to attend cannot be prevented by E-Systems. It is also the right of the patient to refuse (a medicine administration). However, initiatives have been put into place to provide these patients with medication reviews to explore alternative treatment regimens.

Development of covert administration of medicines occurred in 2018. This robust process has been presented to the Quality and Safety Committee. Covert administration 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. During 2018, there were 7 Datix reports describing the use of the covert policy (2 of these Datix reports described the closing of the Datix).

Improving Transition

Transition is identified as a key priority for all children and young people (CYP) across all health services including mental health and those with complex and long term health conditions such as diabetes and asthma. When we refer to transition it is a descriptor of when children and young people seen in children's health services move into adult health services. Differences between children's and adults services can be complex this is why well managed transition is essential for both the young person and also their family to be able to navigate through these changes. It also helps to manage expectations and reduce anxiety. A key change can be a family is used to a key practitioner such as a paediatrician who has an overview of all the conditions whereas in adults services a number of medical practitioners may be involved.

The evidence base identifies the optimum time to start transition for a young person is at age 14 years. In order to improve transitions within our services we undertook a baseline audit to determine a starting point to inform an action plan.

Our audit showed that discussions about timing of transition took place at 14 years in only 45% of service users. It is also recommended that an annual discussion is held to facilitate this planning and enable the plans to be updated. The audit found this annual discussion occurred in only 27% of service users.

Despite practitioners demonstrating a passionate desire to help young people transition from their services into adult services; the audit demonstrated minimal evidence of transition planning, including involving practitioners from adult services.

The audit also highlighted that limited information about transition was provided to the young person, their family and/or carer. There was limited but some evidence of

signposting to alternative non-statutory services, including condition-specific support services, during transition planning.

The changes for young people and their families can be daunting and confusing during the transition process a key element is to explore what the young person and family expect from services moving forward. This allows explanation of the differences and what pathways to expect. The audit was unable to identify if this discussion had taken place.

The baseline audit has assisted in planning next steps in our improvement journey. A committed transition steering group are exploring a number of developments. These developments will include stakeholders to give holistic support to young people during this process. Staff training resources have been identified that can be shared with partner agencies such as schools. There are plans to present these training resources during a stakeholder event. In addition to the training resources a transition planning document will be utilised, examples of these will also be available at the stakeholder event. Following the stakeholder event a planning document will be selected to trial based on the feedback. This plan can then be reproduced on the electronic patient record used within the services. This planning document can then be started from the age of 14. To raise awareness, leaflets are being produced for young people, families and carers.

During 2016-2017 preparatory work has been undertaken to develop a transitions policy. The next steps include the stakeholder event and finalising and embedding the policy.

This preparatory work has included:

- 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. This guideline has been utilised to inform the policy development.

Individual services compliance has been mapped against the guidance to establish baseline to inform actions going forward.

Handover and Discharge

Clinical Handover

The National Patient Safety Agency (NPSA) has defined clinical handover as a process where there is 'the transfer of professional responsibility and accountability for some or all aspects care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis (2004).

Failures in handover are a major preventable cause of patient harm and are principally due to human factors of poor communication and systemic error.

The Trust had previously identified problems with its patient handovers process and the quality of the handover itself.

During 2018/19 the Trust set out to further improve the safety and effectiveness of both internal and external clinical and nursing handovers.

What has the Trust done to improve Clinical Handover in 2018/19

- The introduction of standards for clinical handover of care internally i.e. within a caseload or ward and externally i.e. to and from an external provider, for example acute care or Out of Hours services

- The introduction of an inter-hospital checklist to support safer transfer of care

- Strengthened the process of incident reporting relating to poor transfers of care especially out of hours

- Ward based handover has been reviewed and evaluated. It was identified that the shift handover did not meet the standard required. A new format handover pilot is in progress at Whitchurch Community Hospital where the team have developed a new version handover template and approach.
  The improvement is focused on ensuring handover is at the bedside/ as near to the patient as possible. It includes the use of patient notes, prescription charts, bedside charts such as fluid charts and the white board behind the patient bed. A progress summary leading to discharge is part of the handover.

- Shift safety huddles which are brief meetings of hospital leaders & key team members at the beginning of every shift to ensure common understanding of the patients who are at risk of deterioration, or recent incidents on the ward have been embedded across all 4 hospital units. The huddle identifies focus and priorities for the shift and provides an opportunity to check that key actions have been completed on admission such as VTE and MRSA screening. Discharge planning is also an element of the huddle, identifying and reducing delays. In addition the Safety Huddle can be convened during the shift as and when required and can support the MDT to utilise the huddle as an opportunity to undertake a team debrief to inform and support staff.

- Revision of Standard Operating Procedures for Community Nursing handovers to ensure standardisation of the process.

- Community/District Nursing teams are using our new electronic patient record system RiO to undertake and record a daily handover for patients on their caseloads.

- A standardised structure for clinical records in the Community/District Nursing teams has been adopted using the SBAR tool. SBAR is an acronym for Situation, Background, Assessment, Recommendation; a technique that is used to facilitate prompt and appropriate communication between clinicians.

- Clinical audits focused on the quality of patient handovers in Community Nursing Teams.

Discharge

What has the Trust done to improve Discharge in 2018/19

EndPJParalysis

The premise of #EndPJparalysis is about enabling hospitalised patients to get up, dressed and moving in order to prevent deconditioning. The evidence of harm from deconditioning has been known for decades and yet we still allow patients to be immobile for up to 90% each day. This immobility will have a negative impact, not only to the patient, but potentially to the wider healthcare system as older patients will often need increased support on discharge.

We have heightened awareness within the ward MDT in this philosophy assisted by promoting awareness using posters, patient and staff leaflets. We have commenced

handover and safety huddle review to provide an opportunity to focus on the clinical plan for mobility and promoting personal care independence and carer involvement. Where possible, we want patients to be fully involved in care plan leading to recovery and independence.

MDT clinical discharge goal setting

Work is underway to strengthen a multidisciplinary approach to establish the criteria for which nurses and therapists can discharge patients. This will potentially enable discharge at an earlier date and reduce length of stay. This assessment should begin as early as possible from admission.

The whole team develop and agree a set of patient goals with the patient which, when achieved, enable the patient to be discharged by either the nurse or the physiotherapist/occupational therapist.

This allows a more responsive approach to patient discharge and removes the need to ''wait'' for a doctor to agree our patients are able to be discharged.

Red2Green

Sometimes patients spend days in hospital that do not directly contribute towards their discharge; we believe that by working better together we can reduce the number of these 'red days' in favour of value-adding 'green days'.

A Red day is a day that adds no value to the patient i.e. our patient is waiting for ''something''. This may be a blood result, an assessment for example.

A Green day is a day that adds value to the patient in pursuit of being ready for discharge i.e. all rehabilitation goals for mobility have been achieved today.

Applicable to in-patient wards in both acute and community settings, this approach is used to identify and reduce internal and external delays as part of the SAFER patient flow bundle.

There is a standard approach across the Community Hospitals to review and assess each patient every day and this information is recorded externally.

Patient and carer feedback

Learning from FFT patient/carer feedback and complaints to inform our priorities regarding improving our discharge planning. Patient feedback via Datix, FFT and complaints suggest that the discharge process from inpatient wards in community hospitals does not always meet patient and carer expectations.

Discharge leaflet

Developing leaflet for patients and carers that will provide information to fully engage and involve them in plan leading to discharge and also provide essential contact details following discharge.

Discharge audit

A retrospective audit of patient notes. The Trust's policy on admissions and transfers to community hospitals contains standards for a safe and effective discharge. An audit will be undertaken in order to identify compliance with the policy and to make improvements to practice and process where required. This audit will begin in April.

Reduce the number of people absent from work through sickness and improving staff wellbeing

The Health and Wellbeing plan forms part of our People Strategy and has the aim of creating a work environment which is beneficial to the health and wellbeing of our staff and to inspire them to improve 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 2018/19 to implement the operational plan for Health and Wellbeing and develop further interventions that will make the most difference to our workforce based on the most common reasons for sickness absence, for example musculo-skeletal issues and stress.

During 2018/19 we continued to raise the profile of the health and wellbeing of our staff in line with our values.

We introduced a range of physical activity schemes for our staff, and developed and expanded our network of Health and Wellbeing Champions around the county as they promote health and wellbeing for our people and help us to plan our corporate events. All health and wellbeing campaigns are publicised through a wide range of media including Twitter, staff away days, corporate induction and through the staff zone of our website.

During 2018/19 we also introduced two major corporate campaigns;

The first is **'Fit in Fifty Seconds'** which is a simple exercise plan that can easily be incorporated into a working day to combat the negative effects of a desk or car-based working life. The plan covers hydration, walking, exercise and nutrition. Fit in Fifty Seconds has been embedded into daily working lives and has been included in staff awaydays and at the monthly Clinical Corporate Induction.

Our second campaign was the '**Half Hour Re-power'** which encourages staff to take their breaks, to go home on time, and to stay hydrated throughout the day. Water bottles and thermal mugs have been given to staff to reinforce this message and to act as a reminder to take their breaks and again, this campaign has been reinforced at corporate events.

During last year, we continued to develop our range of mental health initiatives for staff, including training in Mental Health First Aid for key staff such as Occupational

Health Advisors and Freedom to Speak up Advocates and promoted access to the emotional wellbeing toolkit which is a web-based tool provided by NHS Employers.

We continued to promote staff resilience through Schwartz Rounds, clinical supervision, coaching and mentoring.

Our plans for 2019/2020

During 2018/19 we refined and developed our Occupational Health Service and as part of this work we identified the need for a new role to scope the mental health of our workforce, develop priorities for support and establish appropriate referral pathways to meet the identified needs.

They will also provide advice and support to individuals experiencing mental or psychological health/stress issues at work and assist line managers and HR colleagues on how they support those staff.

We continue to promote healthy travel to work through our Cycle to Work Scheme which is open year-round to all eligible staff and in 2019 we launched weekly social cycle rides from William Farr House. In June 2019 we will start our first staff-led Couch to 5k programmes in Bridgnorth and Shrewsbury.

Our planned Corporate Health and Wellbeing events for 2019/20 include a Menopause Conference in June and a Men's Health event in November.

We will also develop our offer on financial wellbeing during the year.

Freedom to Speak Up (F2SU)

The requirement for Trusts to have a Freedom to Speak up Guardian has been in place since October 2016 in response to recommendations within the Francis Report. SCHT has 7.5 hours of a Guardian per week supported by 9 advocates.

In May 2018, the National Guardian Office (NGO) and NHSI released guidance and accompanying self- assessment tool for Trust Boards on expectations in relation to Freedom to Speak up (F2SU) processes within in NHS and Foundation Trusts.

The report outlines a significant number of expectations to support and strengthen the effectiveness of Trust F2SU processes with an accompanying self-review tool to enable an in-depth review of leadership and governance arrangements in relation to FTSU to be undertaken.

The self-assessment has been undertaken and highlighted the Trust is compliant with a number of recommendations and will take action during 2019/20 to meet those where we are not currently compliant (appendix A).

Our Freedom to Speak Up Strategy

A workshop has taken place involving a cross section of employees, including those who have made referrals to the Guardian team previously, to develop the Trust Vision and strategy for F2SU (appendix B). The strategy is reflective of the contributions of the participants of the workshop and NHSI recommendations.

The Guardian team advocate that employees should feel they can raise concerns with their line manager as first line of communication. The Guardian team are available as an additional resource for employees if there are circumstances where the individual or team feel they cannot talk their line manager in the first instance.

The Guardian team remind employees that there is another route for employees to raise concerns through:-

- Utilising every opportunity to raises awareness verbally at meetings, training and staff engagement generally
- The 'Guardian team poster'' which is noted to be visible in clinical and non-clinical areas visited
- Use of the F2SU employee leaflet
- Wearing of F2SU lanyards by the Guardian team
- A planned programme of availability for employees across our services both clinical and non-clinical as a means to increase visibility and accessibility for Trust employees

Guardian and advocates meet monthly to discuss and share information.

The National Guardians Office has provided guidance on competencies to support F2SU roles. The Guardian team aim to utilise the competencies to support individual and team development.

The Guardian continues to meet with Human Resources to undertake triangulation of any staff issues raised under HR processes with issues raised under F2SU. There have been none to date.

The Guardian continues to meet with our staff side colleagues to continue to foster good working relationships and keep our staff side representatives up to date with systems and processes accordingly. Individual issues raised through F2SU are not discussed with staff side representatives.

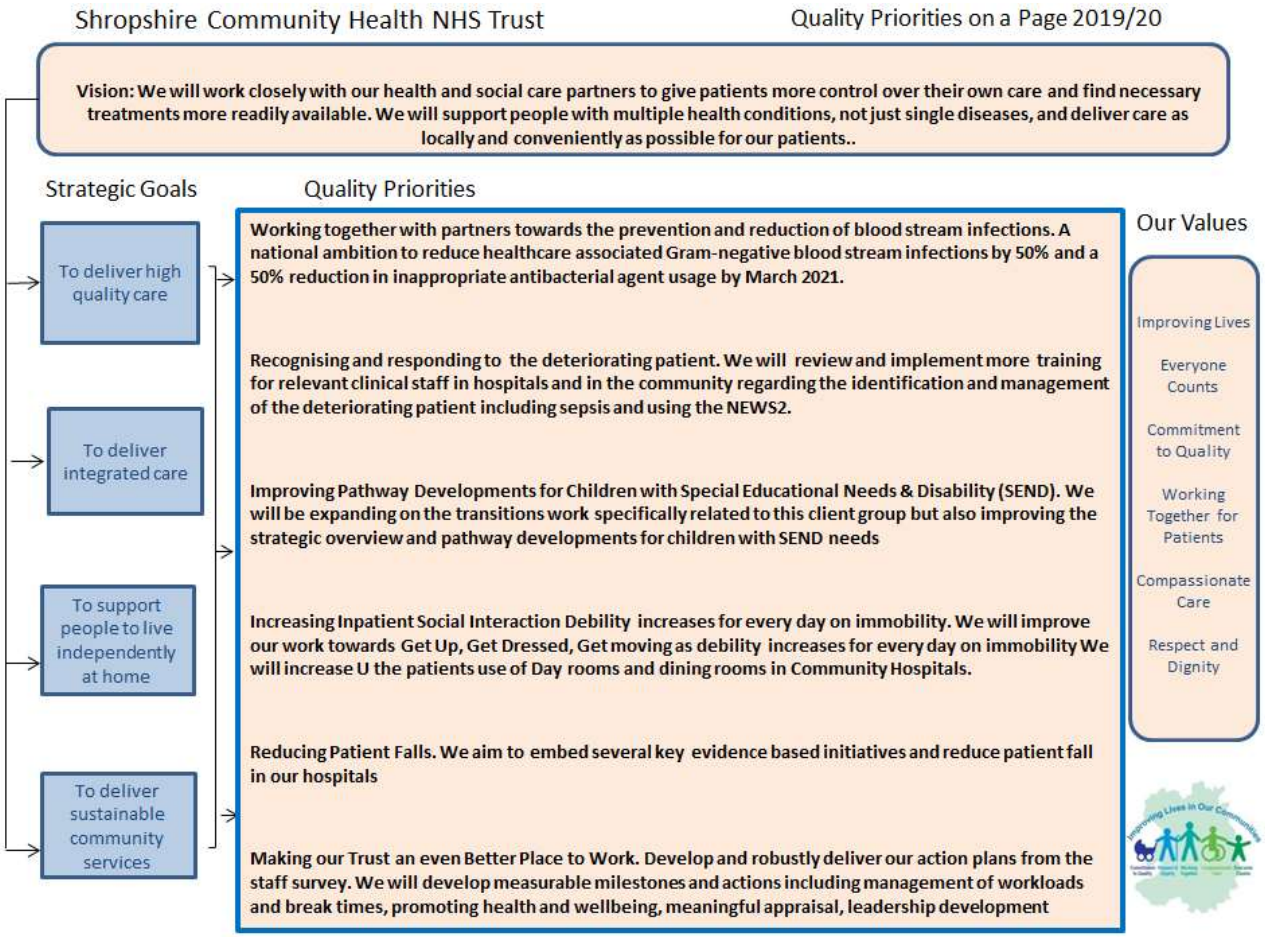
Feedback from the employees attending Trust induction continues to be positive.

In addition to the NHSI recommendations, the key objective for this year is for the Guardian and advocates attending the West Midlands training programme for Guardians.

Part 3: Our Commitment to Quality - Looking forward to our Quality Priorities for 2019 -2020

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 reflective of the Community trusts three key strategic priorities.



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!

Priority One : Working together with partners towards the prevention and reduction of blood stream infections
The government, in response to the Antimicrobial Review, has an ambition to reduce healthcare associated Gram-negative blood stream infections by 50% and a 50% reduction in inappropriate antibacterial agent usage by March 2021. SCHT has not been set a target figure for reduction but the IPC team will continue to work with the Local Health Economy in the prevention of and reduction of Blood Stream Infections.
Activities we will undertake in 2019-2020:
In 2019-2020 the activities SCHT will undertake towards the prevention and reduction of blood stream infections include:- Reduction in the use of dipsticks in the community hospitals in the over 65 age group adopting improved guidance for the diagnosis of urinary tract infections using clinical signs and symptoms. The education of patients, carers and the wider public on the importance of hydration working with partner organisations to support Nutrition and Hydration Week in hospitals and community settings. A patient catheter card has been developed to replace the catheter passport. This is currently being introduced across the Local Health Economy in our community services and has been adopted by NHSI to be implemented across England. SCHT is trialling the use of Droplet Hydration Cups for use with patients who have dementia to try and prevent dehydration and may be used in hospitals and community services.

Priority Two: Recognising and responding to the deteriorating patient
As the population ages and lives with ever increasing co morbidities, the threat of sepsis grows. We must support the implementation of NEWS2 in our workplaces and across the system. NEWS2 provides us with a standardised language of sickness that healthcare professionals at every level can recognise and respond to.

Our clinical audit of sepsis in 2018 identified recognition, diagnosis and early response in inpatient areas and MIU to an escalating Early Warning Score as an area for focus.
Our Mortality Group reviews and learning has also identified early recognition and response to the deteriorating adult as an area for learning in our organisation.

Activities we will undertake in 2019-2020:

Establish an MDT steering Group to rollout NEWS2 across the organisation including community nursing, ICS and rapid response.

Use this group to review and action any learning for deaths actions related to NEWS2 or Sepsis, or any clinical incidents related to the deteriorating patient.

Review the training for relevant clinical staff in hospitals and in the community regarding the identification and management of the deteriorating patient including sepsis and using the NEWS2.

Identify NEWS2 Champions across the organisation with at least 1 in each Adult Team for hospitals and in the inter disciplinary teams
.
Repeat NEWS 2 / Sepsis clinical audit August / September 2019.

Priority Three: Increasing Inpatient Social Interaction

Responding to Observe and Act feedback
End PJ paralysis, Get Up, Get Dressed, Get moving
Red to Green
Debility increases for every day on immobility
Use of Day rooms and Dining rooms in Community Hospitals
Patient falls reduction

Activities we will undertake in 2019-2020

Explore opportunity with volunteer recruitment to provide a more structured patients activity schedule in each Community Hospital. This will assist with increasing use of day rooms.
Signposting patients who live alone in the community to use relevant social support groups.
Increase opportunity for relative and carer involvement in care and mobilisation. This will be assisted by broadening visiting times and a more flexible approach to protected mealtimes.
Obtain patient feedback.

MDT approach to patient assessment and mobilisation. Identifying clear and achievable discharge criteria.
Ward therapy teams to support and educate the nursing teams to enable them to feel able and confident to assess patients to mobilise when there is no therapists available.
Focus on patient footwear and reduce the use of red socks.
Use of Red2Green to identify blockages or gaps in the system with action plans to address to promote timely discharges.
Daily plan implementation as communication tool between the person, family and staff.
Use of ward activity boards and ward information booklet to indicate activities and facilities.

Priority Four: Reducing Patient Falls
Falls in the elderly are a frequent occurrence, causing pain, injury, increased length of stay, unplanned surgery and delayed recovery. They are estimated to cost the NHS more than £2.3 billion a year. About 30 per cent of people aged 65 or older have a fall each year, increasing to 50 per cent in people 80 or older. The number of patients falling in our hospitals has increased this year and is a frequent cause of admission to hospital in the first instance.
Activities we will undertake in 2019-2020
Continue MDT Inpatient Falls Reduction Steering Group. Focus on lying and standing BP for 3 days as standard approach. Pharmacy communication to prioritise meds review for new admissions, patients at risk of falls with wandering and difference in lying and standing BP with symptoms. Falls Champions for each hospital and community adult team reinvigorated Falls Champion Forum. Datix form review to better inform and provide data for analysis. Patient footwear and reduce use of red socks and falls prevention advice / health promotion for community patients. Safety huddles and shift handover format review in progress to improve communication. Highest incidence of falls is in bays therefore reinvigorate bay safe approach. Education of backward chaining as a technique to get up from a fall.

Priority Five: Improving within our services, the experience for patients with a learning disability
Continue to work towards meeting NICE guidance and NHSI Learning Disability Standards

Activities we will undertake in 2019-2020
Review and combine our action plans from the NICE guidance baseline audit and the recently released NHSI LD standard audit results. Use these plans as a work blueprint for improving our care for patients with Learning disability via an implementation group. Develop measurable milestones and actions including Training and engagement.

Priority Six: Improving Pathway Developments for Children with Special Educational Needs & Disability (SEND
The service is currently disjointed and not coordinated and easily accessible with examples of multiple appointments requiring the telling of the same story multiple times.
Activities we will undertake in 2019-2020
For families the Following on from last year's work around transitions, the Children, Young People and Families SDG plan a quality focus this year around the SEND agenda. We will be expanding on the transitions work specifically related to this client group but also improving the strategic overview and pathway developments for children with SEND needs. A working group has been developed to ensure our teams provide an integrative service across all disciplines for the children, young people and families. In addition service leads are representatives on the strategic SEND board led by the Local Authority which will enable joint working to improve the families journey.

Priority Seven: Making our Trust an even Better Place to Work
Responding to key areas of focus in our staff survey results: Being Too Busy Doing a Good Job, Conversations that Count, Zero tolerance to bullying and harassment
Activities we will undertake in 2019-2020
Develop and robustly deliver our action plans from the staff survey. Use these plans as a work blueprint for improving our experience for Staff Develop measurable milestones and actions including management of workloads and break times, promoting health and wellbeing, meaningful appraisal, leadership development, wellbeing conversations, living our values working together to achieve a, living our values, working together to achieve a 0% tolerance of bullying.

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 2018 and 31 March 2019 represents 100% of the total income generated from the provision of relevant health services by the Trust during 2018 - 2019.

During the year 01 April 2018 to 31 March 2019, 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

Participation in Clinical Audit

Clinical audit involves improving the quality of patient care by looking at current practice and modifying it where necessary. 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.

This year, the Trust participated in National Clinical Awareness week for the first time. The event is organised by the Healthcare Quality Improvement Partnership (HQIP) to enable Trusts, Health Boards, audit providers and other organisations to celebrate the best in clinical audit and encourage collaboration in improving patient care. A series of events was held at various locations across Shropshire from 19-23 November.
A new clinical audit policy and strategy has been developed and implemented within the Trust with the aim of improving the level of assurance provided by our clinical audit processes.

National Clinical Audit and the Patient Outcome Programme (NCAPOP)

The National Clinical Audit and Patient Outcomes Programme (NCAPOP) is commissioned and managed on behalf of NHS England by the Healthcare Quality Improvement Partnership (HQIP). The programme comprises more than 30 national audits related to some of the most commonly-occurring conditions.

During 2018/19, six national clinical audits covered NHS services that Shropshire Community Health NHS Trusts provides. The Trust participated in five out of the six audits in which it was eligible to take part. A decision was taken to withdraw from the Sentinel Stroke National audit due to unresolved problems in adapting the audit tool to the local model of service delivery. The decision will be reviewed on an annual basis and the Trust is committed to participation in the audit when and if the problems with the audit tool are resolved.

Audit Title	Comments
Falls and Fragility Fractures Audit programme (FFFAP). Inpatient falls	Continuous data collection started January 2019
National audit of intermediate care	Data collection was completed during 2018/19. A total of 280 cases were submitted to the audit This represented 100% of the cases required by the terms of the audit
National Chronic Obstructive Pulmonary Disease (COPD) audit programme Pulmonary rehabilitation	Continuous data collection started March 2019
Sentinel Stroke National Audit programme (SSNAP)	The Trust did not participate in this audit
National Audit of Care at the End of Life (NACEL)	Data collection was completed during 2018/19. A total of 19 cases or 19% of those who had died in one of our community hospitals between April and June were reviewed. This exceeded the minimum of 5% required by the terms of the audit
NHSI Learning Disabilities project	Data collection was completed during 2018/19 Publication of the audit report is due in May 2019

The reports of two national clinical audits for which data was collected during 2018/19 were reviewed by Shropshire Community Health NHS Trust during 2018/19. The Trust intends to take the following actions to improve the quality of healthcare provided. The action plan developed in response to the 2017/18 national inpatient falls audit is also referenced below.

National Audit of Care at the End of Life (EOL)

The chart and table shown provides a summary of the Trust's scores compared with national summary scores.
Each theme is the result of a number of component indicators.

The Trust intends to take the following actions to improve the quality of healthcare provided:

- Introduce ReSPECT process: this will also help GPs to achieve their contract End of Life Quality Indicator. Improve Frailty recognition
- Record relevant activity – RiO EOL form to support this. Fully complete the Shropshire EOL Plan. 'If it isn't documented it didn't happen'
- Provide all patients with Thinking Ahead document on admission. Use SPICT tool. The tool to support recognition of dying
- Participate in the 2019/20 National Audit of Care at the End of Life

6.0-10.0		In lowest quartile: Use of SPICT (Supportive and Palliative Care Indicators tool) should improve this. Small audit numbers may be reducing this value
2.0-9.7		Lack of medication discussions reducing this score. ReSPECT process should improve this theme
2.5-9.6		Lack of discussion regarding medication side effects with relatives/carers reducing this score
3.3-10		In lowest quartile: possibly reflecting lack of documenting this activity; the ReSPECT process will address this theme
0.6-9.6		In lowest quartile: probably in part reflecting lack of documenting this activity
2.8-9.2		Highlighting the impact and benefit of the Shropshire End of Life Plan
4.3-9.7		Although all responses outstanding, only one report collected so not in summary
2.5-10.0		Reflects impact of EOL strategy, Leadership arrangements, and Shropshire EOL Plan
1.7-10		Input data too small to provide NACEL summary

National Audit of Intermediate Care

Overall 93% of service users either maintained or improved their level of independence with regarding to Activities of Daily Living.
Patient reported experience measures (PREM) generally reported a positive experience, 99% said they felt treated with dignity and respect.
Despite increased pressures on Intermediate care this was not matched with increased funding and "were significantly under-resourced".
Too much emphasis on supporting discharge rather than avoiding admissions.
Shropshire compared well with national average in waiting times and length of stay.
Patient Reported Outcome Measures (PROMS) were slightly higher than the national average.

Proportion of AHPS in workforce has remained relatively consistent throughout the years of the audit.

Falls and Fragility Fractures Audit programme (FFFAP). Inpatient falls. A comprehensive action plan has been drawn up in response to the findings of the 2017/18 national inpatient falls audit. The audit identified the main areas of falls as bay, side room and bathroom and the main activity when falling as walking or wandering. Only 54% of footwear was identified as appropriate at the time of falls. An inpatient falls steering group has been established, a reduction in the use of 'red stocks' promoted, a 'Get up, get dressed, get moving' initiative introduced and graphics placed in bathroom areas prompting patients to wait for assistance.

Local Clinical Audits

The reports of 22 local clinical audits were reviewed by the Trust in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided.

Clinical record keeping audits. Each year the Trust undertakes a programme of clinical record keeping audits and during 2018/19 audits for five services were completed: Podiatry, Safeguarding Children, MIU, Looked After Children, Children's Speech and Language Therapy Service. Overall, compliance with record keeping audit standards was good and where areas of non-compliance were identified, action plans have been developed by individual services. It is anticipated that the roll-out of the RiO Electronic Patient Record across the Trust will address many of the issues raised in relation to record keeping in this year's programme of audit.

Audit of Royal College of Paediatrics and Child Health (RCPCH) Guidelines on Children's Attendance at MIU. The Trust was compliant with the majority of RCPCH standards. Pain scores were not always completed on the patient's arrival at MIU. Staff have been reminded via email and at team meetings that all patients must receive a pain score regardless of their age.

Audit of the Handover Process in Community Nursing/Interdisciplinary Teams (IDT). The audit revealed that handover is not taking place consistently, on a daily basis, across the six localities as stated in the handover Standard Operating Procedure (SOP). There is also wide variation between localities in relation to the minimum and maximum number of times handover takes place per week. Team leaders must ensure that handover discussions are clearly documented on the Electronic Paper Record (EPR) and that that the SBAR format (situation, background, assessment and recommendation) is used as the model for handover discussion.

Mental Capacity Act Audit. The audit highlighted the use of implied consent rather than a best-interest decision-making process. The Trust Consent policy has been revised and best interest training incorporated into Level 3 safeguarding training.

Re-audit of NICE guidance CG183 on drug allergy in MIUs. The initial audit revealed that drug reaction and time of reaction were not routinely recorded. For the re-audit, the Electronic Patient Record (EPR) – not in place at the time of the initial audit – was interrogated. It emerged that although a field on EPR was present for the recording of drug reaction, there was not a field for the timing of drug reaction. Additional fields are to be added to EPR to bring the Trust into line with NICE guidance and a documentation training package introduced for staff working in the community.

Audit of NICE guidance CG97 on Lower Urinary Tract Infection in Men. In general, compliance with audit standards was good. However, not all men had received a digital rectal examination (DRE) as part of their initial GP assessment and those who presented with post micturition dribble (PMD) were not always given information on how to perform urethral milking. If DRT has not been performed at the time of referral, the advisor is to write back to the GP requesting that this is done and written information on PMD is to be made available at clinics.

Intermediate care audit. This audit was based on the standards used in the National Audit of Intermediate Care although the Trust did not submit data to the national audit during financial year 2017/18. The audit highlighted that overall compliance

with audit standards was good, although not all patients had their intermediate care goals set on admission and not all service user care plans had been reviewed at least once a week by the multidisciplinary team. Work is to be undertaken with the RiO electronic patient record (EPR) configuration team to embed outcome measures in EPR to facilitate monthly reporting on outcomes.

Audit of the uptake of podiatry appointments for high risk diabetes patients. 18% of diabetes patients at high risk of developing foot problems did not have a clinical alert on EPR and the majority of these patients did not receive a diabetes foot assessment in line with current NICE guidance.

Clinical audit of sepsis: recognition, diagnosis and early management. Recognition of sepsis is inconsistent in our inpatient areas and minor injuries units, the GP sepsis decision support tool (for 12 years old and over) is not always used where indicated, and we are not always following the EWS/PEWS clinical response triggers. Education and training on sepsis recognition is to be provided to Trust staff including community pharmacists, nurses, healthcare assistances and health visitors to include use of the GP sepsis decision support tool and EWS/PEWS clinical response triggers. Use of NEWS2 is to be introduced and standardised in the assessment and management of acute deterioration.

Children's Occupational Therapy Outcomes (OTOMS) Audit. Use of the OTOMS form as an outcomes measure was below 50% for the team as a whole. This needs to increase. All team members planning treatment sessions should aim to complete an OTOMs form, setting client centred goals and scoring at the start and end of an intervention and the completed form uploaded to RiO. Examples of goals commonly used within each clinical team to be shared at team meetings, an OTOMS champion from each team to be identified.

Audit of NICE guidance NG43 on transition from children's to adult services audit. Discussion about transition did not always commence at age 14 and or take place annually thereafter, there was minimal evidence of transition planning, limited information was provided to the young person/carer, including signposting, to support services. It was unclear as to whether families' expectations were discussed. Staff training is to be provided, a transition plan on electronic patient record (EPR) is to be created, the transition process will commence at age 14. A leaflet on transition has been produced for patients and carers.

Preventing ill health by risky behaviours - CQUIN (9) – alcohol and tobacco. The baseline audit demonstrated low levels of screening for both alcohol and tobacco use and patients given brief advice or offered intervention where appropriate. Education to ward staff on how to obtain this information from patients was

provided and paperwork developed for an alcohol screening tool. Compliance with audit standards increased significantly (to 99%) by the end of the two year CQUIN period.

Improving the assessment of wounds audit – CQUIN 10. The baseline audit showed that an appropriate wound assessment had not been completed in 30% of cases. Staff training in wound assessment and management was increased and a revised wound assessment chart and staff competency framework implemented. By the end of the 2 year CQUIN period 98% of patients had received an appropriate wound assessment.

Identification of children at risk of blood borne virus (BBV) infections in the looked after children population. Appropriate information was not always available to paediatricians at the time of the LAC medical and not all children in whom a risk was identified were recommended for BVV. Known parental health issues are to be made available by social workers at the time of the initial medical, antenatal/birth forms are to be requested at the time the child enters the care system, appropriate pathways for assessing risk, gaining consent for testing and managing results are to be put in place.

Trust adherence to the Accessible Information Standard (AIS). The majority of staff did not know how to record AIS in the electronic patient record and most felt they needed additional training. Alerts were recorded on RiO for only a small number of patients with a sensory impairment or learning disability and of these, few had been correctly applied. A mandatory field is to be included on RiO asking whether the patient has additional communication needs and mandatory training for all staff is to be introduced.

RiO (electronic patient record) scanning and uploading audit. With the initial roll-out of the Rio electronic patient record system and the need for teams to upload documents, a scanning and uploading audit was carried out by individual teams. Staff adherence to the recommended processes was generally good.

Audit of new inflammatory arthritis referrals (NICE QS33). Our referral and appointment system did not allow us to book patients into clinics within three weeks of referral so they could not be assessed promptly to see whether they had inflammatory arthritis and needed to start DMARD (Disease-Modifying Antirheumatic Drugs) therapy. The clinical pathway for rheumatology referrals has been modified and new internal triage guidelines developed for the Triage Team.

Understanding our compliance with Independent Parental Special Education (IPSEA) recommended standards of Educational Health Care advice from children's

Shropshire Community Health NHS Trust Therapists and Community Children's Nurses. The needs of children and young people were not always specified as educational (pertaining to the education/training) or non-educational (health). The frequency, number of hours and level of expertise of provision to meet educational needs was not always stated and documented needs were not always linked to provision. Training has been provided for staff involved in writing these reports and a new report template has been developed.

Participation in Clinical Research

"Patients, carers and the public play a vital role in helping us to develop and improve our services and we are constantly looking for ways to work with local communities, patients and the public to innovate and improve".

Research remains essential to the ethos of the NHS to deliver evidence based diagnosis and treatment to our service users and deliver it in the most cost effective way.

To support and increase Trust activity and keeping with this agenda, this year it has been agreed that the Clinical Research Network (CRN) will provide external resource to support a consortium agreement with Midlands Partnership Foundation Trust to provide Research Delivery, Management and Governance oversight. This will be for 12 months in the first instance to support the development and delivery of a substantial research portfolio and a target of 182 patients, services users and carers for the year and has been set by the CRN.

The Trust receives income to deliver the national LCRN portfolio through an activity based funding model, with allocations being directly linked to recruitment activity. The current portfolio is made up of 3 studies with 4 patients being recruited to studies in 2018/2019. The aim is this, is to increase this to 182 2019/20.

Local Picture - Shropshire Community Health NHS Trust

Research-active trusts invariably experience improved care and support, growth in reputation and greater strategic and financial rewards – together with increased patient, service user and carer satisfaction. Research and innovation activities also enable the delivery of Trust visions, values, goals and objectives and to evidence 'well led' enquiries.

By engaging fully with the West Midlands Clinical Research Network, the Primary Care Network and in partnership with Midlands Partnership Foundation Trust, an

increase in the research activity within Shropshire Community Healthcare is achievable. By using, expertise and experience of an experienced research team from the Midlands Partnership Foundation Trust (MPFT), a research portfolio can be built to deliver short term targets and long term sustainability.

Work has already been undertaken within MPFT to assess which studies currently being delivered within the Trust can be transferred to Shropshire Community to bring an 'instant' hit in terms of research activity; along with members of staff having dedicated time to set up and deliver these studies.

In the immediate term, a scoping exercise needs to take place to assess the suitability of these pre-identified studies and to identify all the clinical areas into which research can be brought. Once the services, patient groups and pathways, and colleagues to co-support the projects have been mapped out, the MPFT governance team will contact study sponsors to begin the set up process.

During this time, the dedicated band 7 research nurse will undertake the relevant training and begin to introduce herself to all the identified colleagues and services, assisting in training and 'pump-priming' to pre-identify patients to try and ensure that once capacity and capability is confirmed on behalf of the Trust, participants can immediately begin to be recruited.

Commissioning for Quality and Improvement (CQUIN)

Our CQUINs for 2018/19 were based on national priorities and best practice and applied across our commissioners in Telford and Shropshire. The CQUINS covered 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).

This is published data nationally and is also covered later in the report under Staff Wellbeing.

Healthy Food Options for Staff Patients and Visitors.

80% of drinks lines stocked have less than 5 grams of added sugar per 100ml.
80% of confectionery and sweets do not exceed 250 kcal.

At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.

Uptake of Flu Vaccinations

We set out to target 1166 staff identified as frontline healthcare workers, and vaccinated 885 of them – equating to 76.6% of this group.

Alcohol and Tobacco cessation - offering support

Baseline audit showed low levels of compliance in relation to screening for alcohol (0%) and tobacco (49%) use.
Staff educated on how to ask questions regarding smoking and alcohol status and what advice/referral pathway to follow.
Paperwork developed for alcohol screening tool; table/stamp/label developed for smoking tool.
Q4 2018/19 audit results showed 99% compliance on screening for both alcohol and tobacco use.

Effective discharge

The current priority is to focus supporting discharges for older people (65-81 years) from the front door and assessment wards to prevent patients being transferred into the deep bed base and becoming deconditioned.
The Community Trust continues to work collaboratively with our partner Acute Trust in streamlining pathways and building upon the CQUIN work carried out as reported in 2017/18.

Wound Care

The audit looked at full wound assessments undertaken for wounds that had failed to heal after 4 weeks in patients cared for by Community Nursing Teams/IDTs
The baseline assessment showed that an appropriate wound assessment had been completed in 70% of cases.
Training was provided to all staff, wound assessment chart implemented, patient information leaflet devised.
Q4 2018/19 audit results showed 98% compliance with the standard.

Management of Long Term Conditions – Personalised care and Support Planning

Our goals this year were to follow-up the use of our survey instrument (questions from the GP patient survey) to assess whether the level of patients' skills, knowledge and confidence to self-manage has improved.

The staff who are the primary care providers for a patient with a long term condition continue to hold conversations between a person with long-term conditions and their carer (if applicable) to understand what is important to that individual and what support they need in order to help build their knowledge, skills and confidence to manage their health and wellbeing. 759 Patients have had a care planning and support conversation 1804 Patients have had an activation measure (level of confidence score) recorded as part of our common assessment form.

NHS England (Prison Healthcare)

Our Prison Health Care Services at Stoke Heath were inspected in 2018 by a joint inspection with the CQC, and Her Majesties Inspectorate of Prisons in November 2018 and following this we have made the following improvements:

A total of 10 further emergency bags are to be situated on all residential areas and the segregation and reintegration unit. The smaller bags will now become obsolete. All new bags will be fully equipped and include defibrillators. Additional funding for emergency bags sourced from NHS England in March 2019.

HMP and healthcare have reviewed and audited shared safeguarding arrangements, policy and procedure. All staff have completed the safeguarding training.

A new pharmacist has been appointed in late December 2018. The pharmacy technician has also been recruited.

Policy, Procedure and Standard Operating Procedure has been reviewed and communicated to all staff.

There was no CQUIN agreed last year. We are currently working with NHS England to agree one this year.

Our Commitment to Data Quality

We operate several different administrative systems to manage our work across services, with the majority of services utilising the Electronic Patient Record. 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 2018 –2019 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics data. Following implementation of Rio, our Electronic Patient Record, we are 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
- 99.5% 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
- 99.9% for outpatient care
- 99.8% for accident and emergency care
- 98.6% 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 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 following implementation of the electronic patient record, RiO.

- 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
- Validity checks
- Timeliness checks
- Accessibility checks – the Trust has a process in place that is aligned to the national operational guidance for the Registration Authority (issuing Smartcards) which ensures that access is assigned to users based on the job role that they have within the Trust e.g. Position Based Access Controls (PBAC). Managing access to all trust systems is monitored and audited as part of the Data Security and Protection Toolkit (DSPT) requirements and is aligned to the current data protection legislation.

- The trust has an Information Quality Assurance policy that defines roles and responsibilities for data quality audits. This is also a requirement for the DSPT submission.
- 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.

- The Trust's Information Asset Owners in conjunction with Service Managers will be responsible for establishing 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 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. Through the Information Governance Framework, the IG Operational Group will report on the progress against the action and recovery plans relating to data quality issues.

- 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

The Trust completes the Data Security and Protection Toolkit (DSPT) which sets out the National Data Guardian's (NDG) data security standards. By completing this Toolkit self-assessment the Trust provides evidence to demonstrate that it is working towards or meeting the NDG standards. The NDG standards are aligned to the General Data Protection Regulation (GDPR) and the Data Protection Act 2018.

Standard 1 of the DSPT is about Personal Confidential Data and this includes ensuring that the Trust meets the standard for Data Quality and Records Management, including policies, procedures, auditing and training.

For the year 2018-19 the Trust provided evidence that it met the ten standards set out in the DSPT and successfully published the assessment at the end of March 2019.

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 50 serious incidents in 2018/19 compared to 33 in 2017/18 and 33 in 2016/17. All of our investigations are then subject to scrutiny by our commissioning colleagues.

A total of 2926 patient incidents were reported in 2018/19 of which 1.5% 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 Trust has implemented recommendations from the NHS Improvements Learning from Deaths in the NHS, CQC's Learning, Candour and Accountability report (2016) and the National Learning Disability Mortality Review programme (LeDeR) and continues to monitor national guidance on learning from deaths. A number of staff have undertaken the LeDeR Reviewer Training and are involved in reviews undertaken with neighbouring Trusts.

The Mortality 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:

- Increased staff access to training on the use of early warning scores to ensure staff are able to recognise deteriorating patients in a timely manner and take the appropriate actions.

- Increased monitoring of observations being carried out at ward levels and by the Quality Team to ensure appropriate actions are taken for deteriorating patients.
- Incorporating the recognition of deteriorating patients in our Intermediate Life Support (ILS) training.
- Review and updating of the current Venous Thromboembolism (VTE) policy following updated NICE guidelines and the introduction of a revised nurse led model.
- Working group formed in order to progress the introduction of the new National Early Warning System (NEWS2) linking in with raising awareness of the requirement for robust Sepsis management.
- Review and updating the Local Mortality Review and reporting process to ensure any issues and/or trends are identified and relevant actions are taken to ensure all staff are learning from deaths within our care.

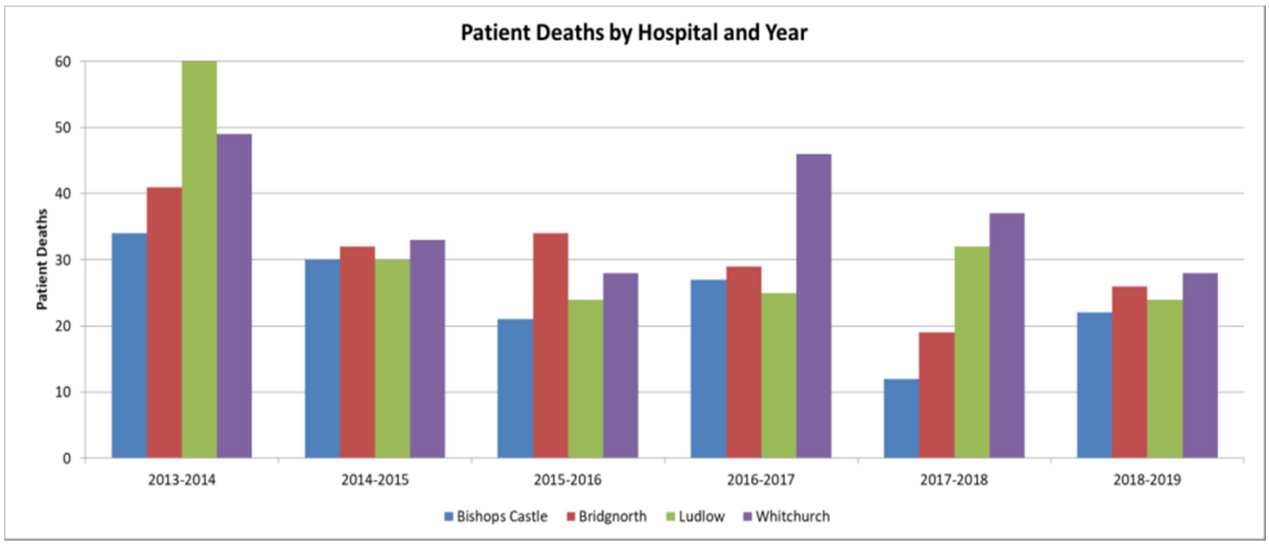
Additionally, findings and agreed actions are disseminated to the Adult Service Delivery Group Quality and Safety meetings, Community Hospital Medical Advisors Group, Clinical Services Managers, Clinical Leads and Team Leaders for further dissemination to medical and healthcare staff within the areas 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.

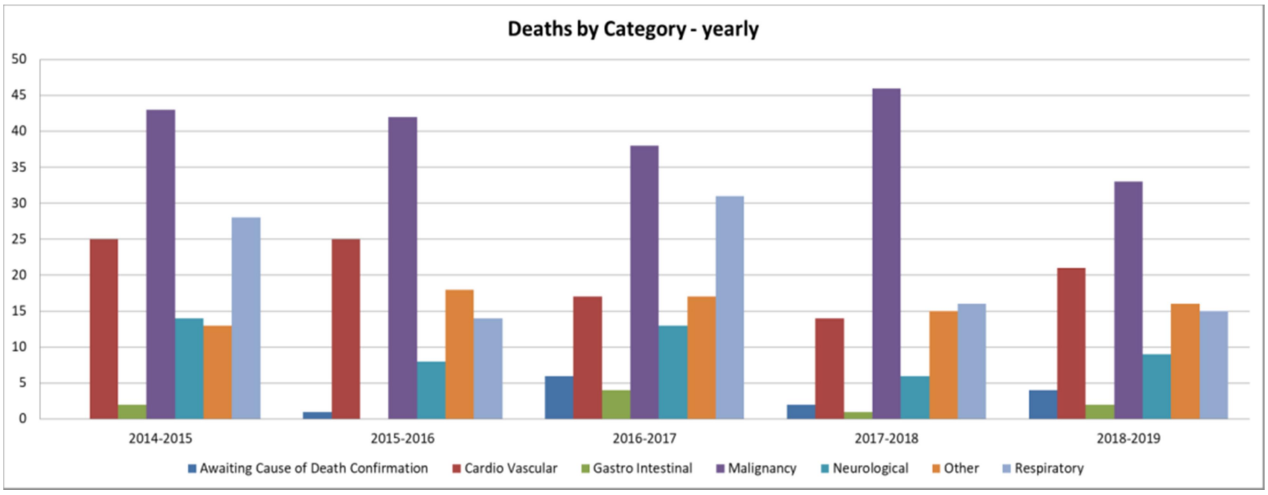
Reports are also received from the Child Death Overview Panel (CDOP) on Child Death Notifications. The CDOP process covers all child deaths from birth up to 18th birthday (excluding still births and planned terminations). The CDOP considers the death of each child, and is required to complete a national 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 the March 2019 Learning from Deaths Dashboard:

Shropshire Community Health NHS Trust: Learning from Deaths Dashboard - March 2018-19

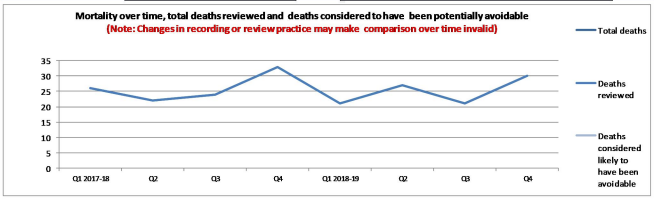
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
10	13	10	13	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
30	21	30	21	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
99	105	99	105	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q4



Total Deaths Reviewed by RCP Methodology Score

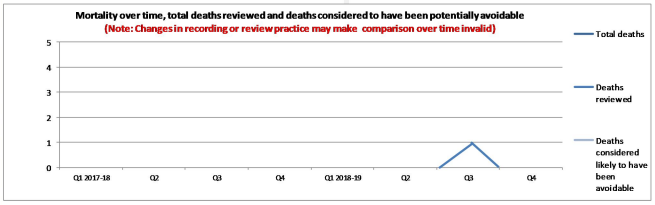
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	10	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)	0	0.0%	This Quarter (QTD)	30	100.0%
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)	1	1.0%	This Year (YTD)	98	99.0%

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	1	0	1	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1	0	1	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q4



During the last year all deaths in our direct care were reviewed and one categorised as Score 5 Slight evidence of avoidability with the rest categorised as 6 – definitely not avoidable. The one scoring 5 followed a reported Unexpected Death which was reviewed by the Mortality Group and agreed to be an explainable death but some actions were identified in order to ensure learning from deaths took place.

There has been one reported death of a patient with Learning Disabilities and this has been reported through the LeDeR programme so they can carry out their investigation of the case. Initial local investigations did not identify any issues or concerns related to learning disabilities around this patient's death.

Pressure Ulcers

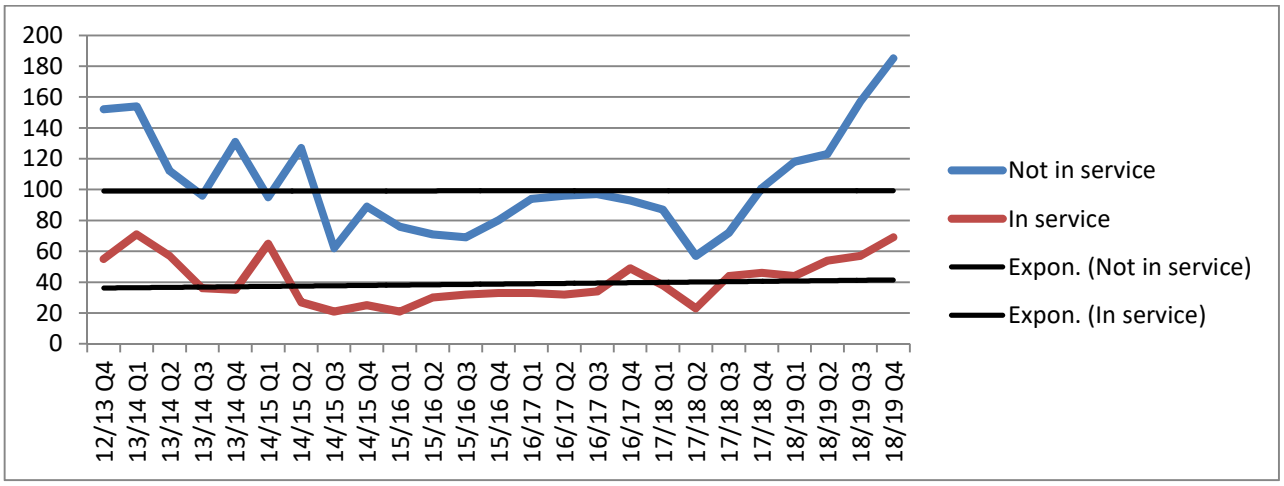
It is estimated that 80-95% of all pressure ulcers are avoidable. Pressure ulcers are painful, may lead to chronic wound development and can have a significant impact on a patient's recovery, their quality of life, as well as increase length of hospital stay.

Pressure ulcers (or bed sores as they are more commonly known) occur when the skin and the tissue beneath it becomes damaged. In very serious cases, the muscle and bone can also be damaged.
Pressure ulcers are classified according to their estimated tissue depth and graded 1-4 with 4 being the most serious. The Trust is required to report all stage 2 and above pressure ulcers as a clinical incident

Grade /Category	Description
1	Intact skin but its colour may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler compared to adjacent tissue
2	Partial loss of dermis (deep skin layer) with an ulcer with a red /pink wound bed. It may also appear as a blister
3	Skin loss occurs throughout the entire thickness of the skin and subcutaneous fat may be visible although the underlying muscle and bone are not. The ulcer appears like a cavity type wound and the depth can vary as to where it is on the body
4	The skin is severely damaged and the underlying muscles, bone or tendon may be visible. People with a grade 4 are high risk of developing a life threatening infection
Ungradable /Grade 3 wound bed not visible	Full thickness tissue loss is present but the wound bed is not visible because it is covered

The chart below indicates the numbers of pressure ulcers identified when patients first access our services (Not in service) and those occurring whilst the patient is under our care (In service) since 2012.

From the high point in Quarter 4 2012/13, both the in service and not in service pressure ulcer numbers have reduced year on year until a noticeable rise this year. The last two years has seen numbers begin to rise again. This graph shows 185 pressure ulcers developed prior to the patient being referred to us and 69 whilst under our care.



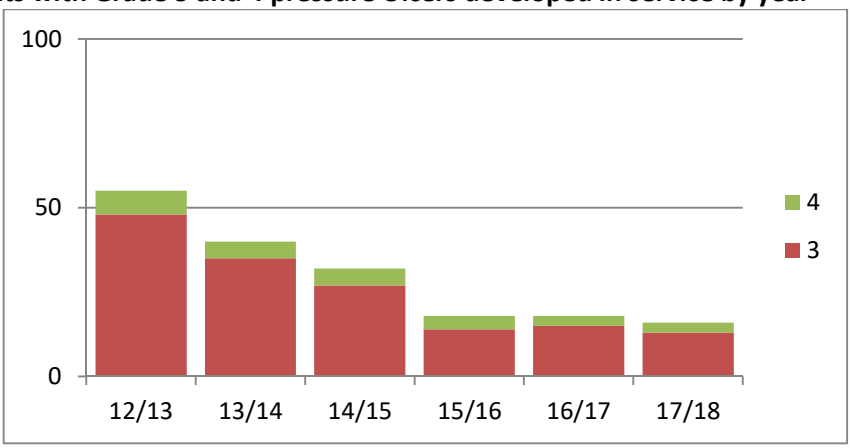
Number of patients with pressure Ulcers developed in service and not in service by year

This has been attributed to a number of factors some which the Trust can influence and others which it cannot. Shropshire has an ageing population living with more complex health and care needs on our communities. The number of elderly patients requiring our support in the community and the extended winter period during 2017/18 was felt to be a contributory factor to the rise in pressure ulcer development. People with impaired mobility and nutrition are more at risk of developing pressure ulcers.

However despite the trust being committed to reducing the incidence of pressure ulcers there were areas of where we could have done better. These included the earlier identification of frail patients, the early completion of a full comprehensive patient assessment and senior nurse oversight.

The chart below shows the total numbers grade 3 and grade 4 pressure ulcers developed under the care of our services. These are the more serious grades of ulcer indicating skin and tissue loss. Whilst the overall numbers have reduced since 2012/13 they remain at a similar level to that seen in 2015/16 and subsequent years.

Number of patients with Grade 3 and 4 pressure Ulcers developed in service by year



All of these in service acquired pressure ulcers are subject to a full investigation and multi-disciplinary review panel. Any service or care delivery problems that are identified have actions assigned to address shortfalls and these are shared across our services to make sure that learning takes place across the Trust.

All grade 3 and 4 ulcers are reported and investigated under its serious incident framework and are discussed and reviewed with our commissioners to identify further areas of improvement and wider learning.

What has the Trust done to improve pressure ulcer prevention & management in 2018/19

- Formation of pressure Ulcer Task & Finish Group with multi-disciplinary representation
- Strengthening the Investigation Review Group membership to include Podiatry representation.
- Introduction of a rapid improvement change programme across District Nursing teams
- The incidence of pressure ulcers is monitored daily which provides caseload holders with an overview of all pressure ulcers reported in the preceding 24 hours
- Mandated pressure daily safety huddle for district nursing caseloads
- Weekly monitoring & identifying non-compliance with all essential pressure ulcer checks for district nursing caseloads Implementation of pressure ulcer prevention task and finish group.

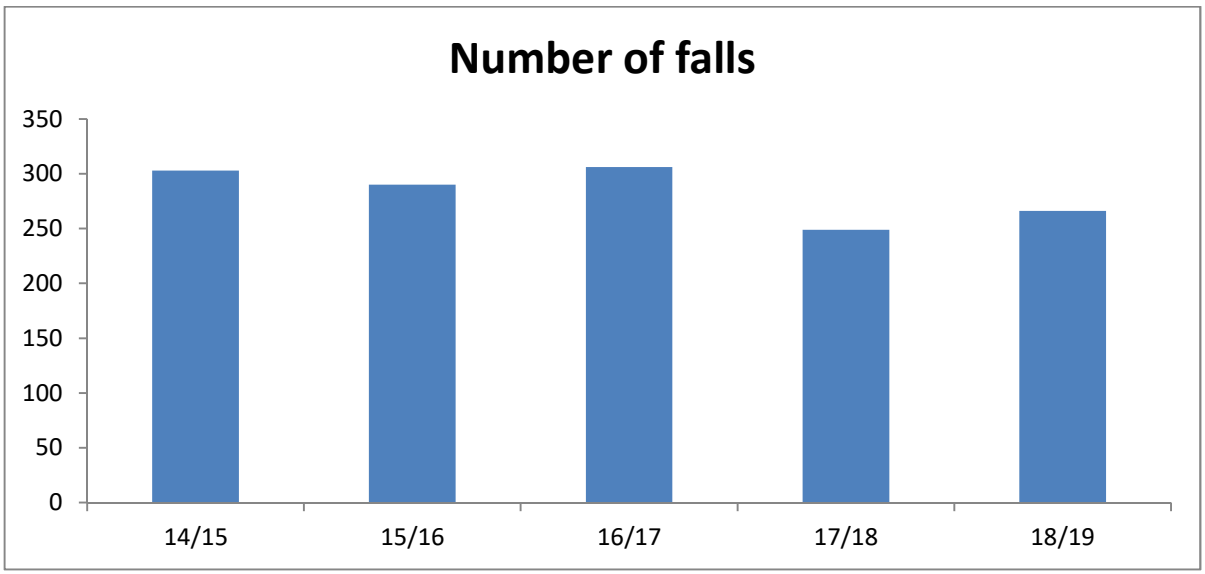
- Community Practice Teachers (CPT) implementation of the “Holistic approach to pressure ulcer prevention”
- Increased caseload supervision/identifying and allowing more visit time for frail patients.
- Pressure Ulcer prevention training is now a core component of corporate induction
- Mandated compliance check for skin inspections & senior nurse reviews
- Stop the pressure campaign
- Revision of our patient Pressure Ulcer Leaflet
- Tissue Viability Review of all reported pressure ulcers & confirmation of grading
- All ungradable pressure ulcers reported as a grade 3 until proven otherwise
- The continued completion of the national safety thermometer; this is a monthly point prevalence audit aimed at capturing any pressure ulcer that has taken place of a set day each month
- Introduction of a bespoke training programme
- Implementation National Safeguarding of Adults Protocol.
- Strengthening advice and support to staff on management, including pressure relief equipment
- Revision and updating of carer 24 hour pressure ulcer prevention care plans
- Thematic Review at Quality & Safety Committee

Further Actions planned for 2019/20

- Expansion of the bespoke pressure ulcer training programme to include podiatry care and equipment
- A pressure ulcer resource pack development
- A support tool to discuss concordance conversations with patients
- Roll out of Rapid Improvement package to Community Hospital in patient areas
- Clinical Documentation Audit
- Strengthening the review process for all reported pressure ulcers with Tissue Viability Service assurance
- Revitalising the Tissue Viability Link Roles

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 303 in 2014/15 to 244 in 2017/18. There was a small increase in the number of falls in 2018/19, which may correlate with the implementation of the #EndPJParalysis initiative, which encourages patients to be up and mobile to limit the impact of deconditioning. There were 5 reported falls resulting in with a fracture or significant head injury in 2018/19 since the last Quality Account with 6 the year before.



Shropshire Community Health NHS Trust considers that a number of falls will continue to happen due to the following reasons:

- Balancing the risk of deconditioning with initiatives to support patients to be up and moving
- The impact of cognition on the ability to engage with and follow rehab plans
- The increasing incidence of frailty

The Trust continues to utilise the skills and knowledge of the memory and well-being workers, led by the Advanced Practitioner in Mental Health to support patients with identified needs to reduce the incidence of falls. An Inpatient Falls Reduction Steering Group has been set up, meeting monthly, to coordinate a trust wide approach to reduce the impact and incidence of falls. Target areas include:

- A standardised approach to lying and standing blood pressures on admission
- A review and reduction in the use of anti-slip socks
- Integration of pharmacists in falls prevention through medication reviews

- A review of falls link workers and engagement with the falls prevention service

A thematic review has been undertaken of the timing, location, activity and footwear at the time of fall, as captured on Datix. This has identified areas for improvement, including data reporting, to more accurately target areas of higher numbers of falls. The Datix form has also been updated to capture more information to aid in reducing the incidence of falls.

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 2018 and 31 March 2019 a total of 55 safety alerts have been received by the Trust, all of which have either had actions completed 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.

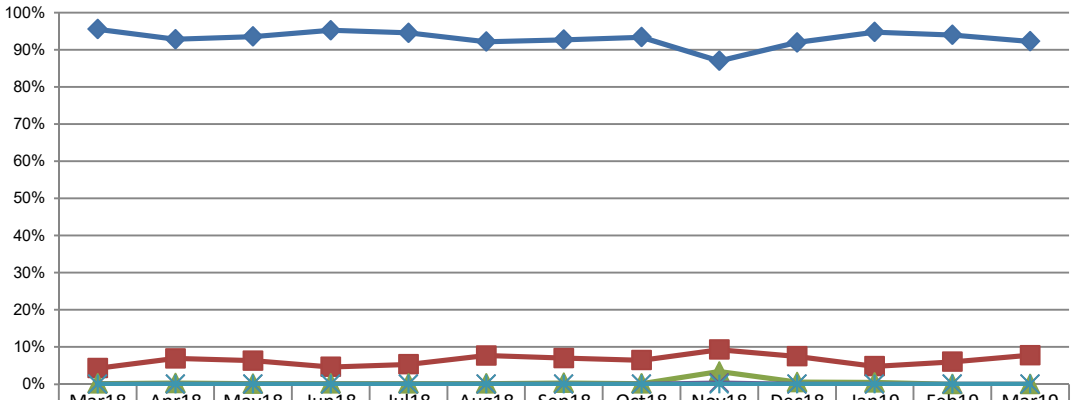
The four harms measured are

- 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

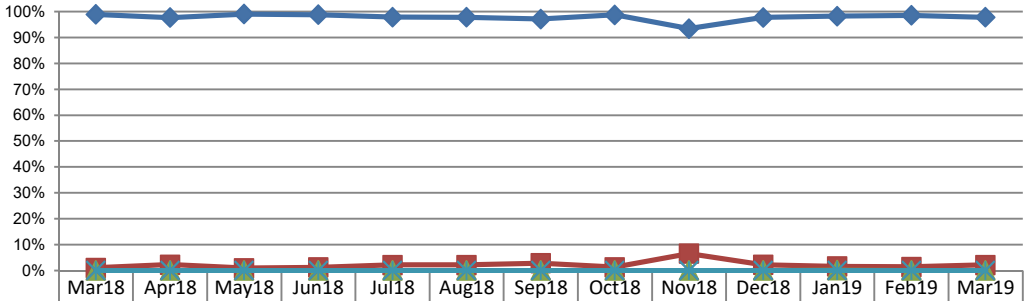
SHROPSHIRE COMMUNITY HEALTH NHS TRUST - R1D, All Wards and Teams, All Settings, All



	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19	Mar19
Harm Free	95.55	92.8	93.57	95.22	94.55	92.19	92.69	93.4	87.02	91.96	94.74	93.97	92.24
One Harm	4.3	6.92	6.3	4.62	5.31	7.67	7	6.44	9.27	7.48	4.82	6.03	7.76
Two Harms	0.15	0.29	0.13	0.15	0.14	0.14	0.32	0.16	3.37	0.56	0.44	0	0
Three Harms	0	0	0	0	0	0	0	0	0.34	0	0	0	0
Four Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients	651	694	746	649	697	691	629	621	593	535	685	564	554

New Harm Free: patients with New-Harm Free Care

SHROPSHIRE COMMUNITY HEALTH NHS TRUST - R1D, All Wards and Teams, All Settings, All Services, All Ages, All Sexes



	Mar18	Apr18	May18	Jun18	Jul18	Aug18	Sep18	Oct18	Nov18	Dec18	Jan19	Feb19	Mar19
New Harm Free	98.92	97.69	99.06	98.77	97.85	97.83	97.14	98.71	93.42	97.76	98.25	98.58	97.83
One New Harm	1.08	2.31	0.94	1.23	2.15	2.17	2.86	1.29	6.58	2.24	1.61	1.42	2.17
Two New Harms	0	0	0	0	0	0	0	0	0	0	0.15	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	651	694	746	649	697	691	629	621	593	535	685	564	554

Risk Assessments for Venous Thromboembolism

Patients admitted to hospital are at an increased risk of developing Venous Thromboembolism (VTE). In 2010 the national NICE guidance for VTE risk assessment and intervention was introduced.

The NICE quality standard aims to reduce patient's risk of developing VTE and a mandated 95% target for risk assessment completion on admission to hospital was established.

The current VTE quality standard has not yet been achieved within the Trust.

VTE Risk Assessment	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
VTE % Risk assessment on admission	95.65	90	88.4	89.33	81.03	86.99	91.18	87.50	92.64	93.59	87.58	90.79
Target 95% unless otherwise stated	95	95	95	95	95	90	90	90	90	90	95	95

Hospital	YTD total percentage
Bishops Castle	91.00%
Bridgnorth	87.68%
Ludlow	92.66%
Whitchurch	87.37%

Issues over the previous 12 months include:

- Trust policy limited to Doctor led assessment only
- Staff understanding and application of Trust VTE Policy
- Staff understanding their individual role and responsibility within the risk assessment process
- Processes within the system
- Empowering Nursing staff
- Appropriate clerking in of new admissions over the 24 hour period

Following monthly analysis of non-compliance data it appears that the majority of

patients who are not risk assessed are those admissions out of hours, including weekends. Discussions have been held with the Ward managers and ward staff who reported issues with clerking patients. The admission policy regarding patients admitted out of hours is robust and staff have been reminded that they are to follow policy and report any non-adherence. An 'out of hours clerking in' document was developed to ensure that appropriate action was taken/requested in a timely manner and that agreed escalation protocols were being followed.

Update on our progress:

During March 2019 significant progress has being made in terms of Nurse training and sign-off of Case Based Discussions. It is envisaged that following the completion of the Nurse training, the issue of risk assessing patients out of hours will no longer be a problem, although this does not negate the need for formal medical admission assessment.

As part of securing competency Community Hospital staff are working towards completion of Case Based Discussions by end of April 2019, for all Registered Nurses where appropriate.

We expect to achieve target of 95% from May 2019, provided that all GP input is available as planned for competency sign off.

We will continue to monitor and review training programmes with Ward Managers

Training details as of 29th March 2019:

- Whitchurch – 6 staff have completed the Case Based Discussions and 11 staff have commenced this. Planned completion April
- Bishops Castle – All bank and substantive staff have completed eVTE and face-to-face training. All staff commenced the Case Based Discussions. Aim completion of CBD by mid-April
- Bridgnorth - 7 staff have completed the Case Based Discussions and 12 staff have commenced this. Aim completion April
- Ludlow - 4 staff have completed the Case Based Discussions and 10 staff have commenced this. Aim completion April

Over the last 12 months the Trust has taken the following actions to improve its compliance with VTE assessment

- Trust agreement to include Nurses for completion of VTE risk assessment
- Medical advisors informed of change and requirements for Nurse's to be able to complete VTE risk assessments
- VTE awareness training all CHs – completed July 2018
- VTE risk assessment pathway review with ward clerks/ward managers – Completed August 2018
- Nurse led model - Nurses to complete VTE risk assessments (update reflected in Trust policy
- Transfer checklist developed and includes date VTE risk assessment completed by transferring ward. Document rolled out to all Community Hospitals – December 2018
- Update VTE template to facilitate easy identification of patients seen OOH by and include column for patients transferred from ward to ward
- Completion of Datix for incidents of non-compliance discussed at January's Ward Managers meeting. No assurances that VTE is a rolling agenda item
- Ward champions to roll out face to face training
- Out of hours clerking in document commenced mid-January 2019 to troubleshoot and capture any issues, including completion of the VTE risk assessment
- Bridgnorth produced VTE training pack including scenarios. Pack distributed to all sites.

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 and in (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 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.

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 relationship manager, and report progress on our actions and any new areas of challenge or outstanding practice.

We have this year welcomed again a formal, comprehensive inspection of the quality of our services by the Care Quality Commission (CQC) in January and February 2019, followed by a review of our organisation from a 'well led' perspective in March 2019. At this time of writing this account we await the formal report from the CQC. We are already working hard to continue to look beyond the inspection towards our aspiration to be outstanding at improving lives in our communities. The Trust is not subject to periodic reviews by the CQC 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.

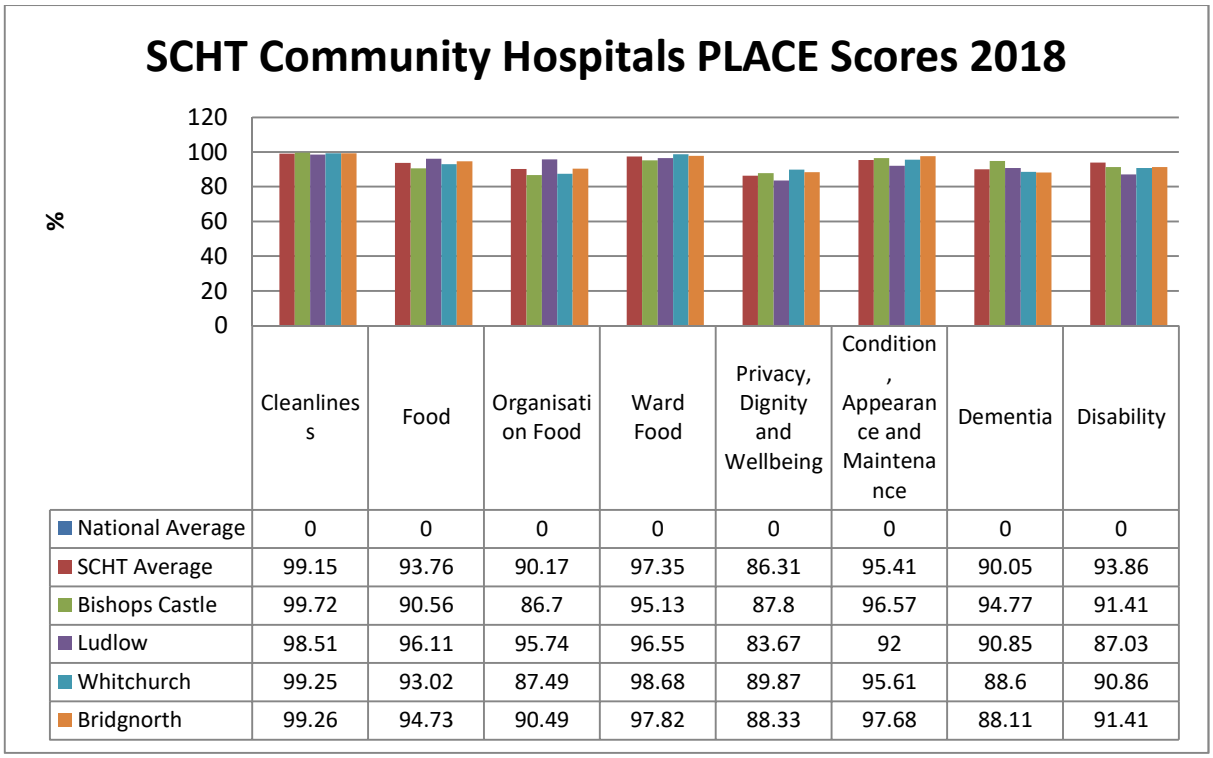
At least 50% of the inspectorate team are non-Community Trust staff and consist of Healthwatch representatives, patients and carers as well as health professionals.

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)

Formal assessments using PLACE continue. The PLACE 2018 visits were undertaken between March and June 2018. An overall cleanliness score of 99.15% was achieved in 2018 compared with 97.77% in 2017 and 98.42% in 2016. Table 7 shows the Community Hospitals' scores.

Community Hospitals' PLACE scores



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
National Average	0	0	0	0	0	0	0	0
SCHT Average	99.15	93.76	90.17	97.35	86.31	95.41	90.05	93.86
Bishops Castle	99.72	90.56	86.7	95.13	87.8	96.57	94.77	91.41
Ludlow	98.51	96.11	95.74	96.55	83.67	92	90.85	87.03
Whitchurch	99.25	93.02	87.49	98.68	89.87	95.61	88.6	90.86
Bridgnorth	99.26	94.73	90.49	97.82	88.33	97.68	88.11	91.41

National Average scores have not been reported by NHS Digital this year.
Scores in the vast majority of areas have improved from last year.

Areas with a reduction in score are:

Ludlow ward food score from 100% to 96.55%
Ludlow Disability score from 95% to 87%
Bridgnorth organisational food 95% to 90.49%
Bridgnorth Privacy from 90.5% to 88.33%
Bishops Castle organisational food 92.5% to 86.7%

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. An action plan is being led by one of the Locality Clinical Managers and managed through a reformed Community Hospitals Environment Group.

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 one *Clostridium difficile* infection (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 95.84% compliance across the four community hospitals during 2018-2019.

During 2018-2019 SCHT recorded zero cases of pre 48 hour MRSA bacteraemia and two cases 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 2018-2019 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 three post 48 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

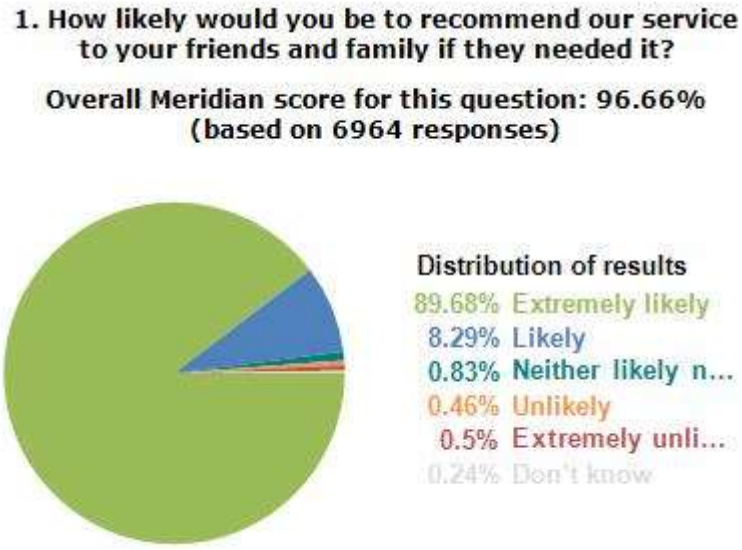
- Complete the SCHT IPC annual programme which is aligned to the 10 criterions in the above code of practice
- Continue to strengthen and develop IPC relationships with SCHT staff, our partner organisations and the wider health care economy
- Continue to develop the role of IPC link staff to act as a resource and role model for IPC in the clinical area

Part 5: A Listening and Learning Organisation

Friends and Family Test (FFT)

Our score for this year 2018/19 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.



The Community Trust overall score is higher than last year and responses are also increased by 878.

How we use feedback to develop our culture

Patient & Carer Volunteer Group

The Community Trust Patient & Carer Panel is now called the Patient & Carer Volunteer Group. The Group which consists of volunteer/patients and carers also invites staff and key partners to its three meetings per year. It also has numerous steering group meetings throughout the year and many of the volunteers are very active within the Community Trust.

New Volunteers

Since the large recruitment volunteer event last year, the Community Trust has not needed to advertise for volunteers as sufficient numbers continue to apply. We

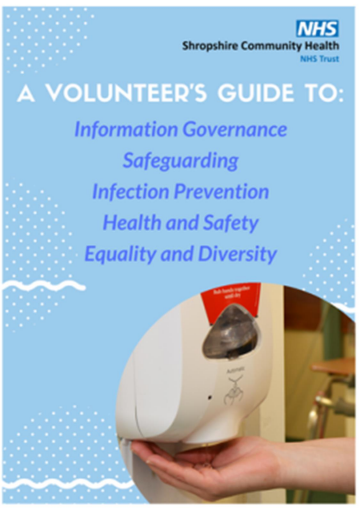
have over 40 Patient & Carer Volunteer Group (PCVG) volunteers and over 100 Community Hospital and League of Friends volunteers. Both volunteers and staff have co-produced two publications to assist with induction and mandatory training, as well as a checklist of information and tasks required.

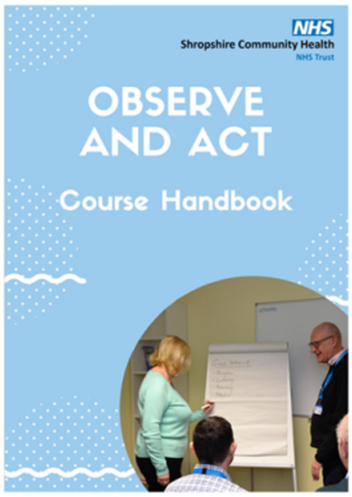
PCVG volunteers are involved with a wide variety of feedback activities, as well as representational and project roles. There are over ten groups within the Trust that volunteers are represented on and 7 volunteers are represented on the Feedback Intelligence Group alone.

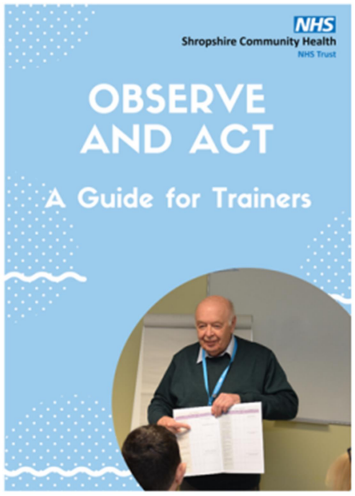
Patient Experience Training and Publications (co-production approach)

Volunteers have taken a lead on designing, developing and delivering tools/and processes to be used by staff and volunteers. Volunteers also train staff in a number of patient feedback methods. Two of the Shropshire PCVG tools have been supported and highlighted nationally by NHS England. One of these is the Observe & Act tool, that is used by a number of Trusts in the West Midlands and a growing number of bodies further away, such as the Manchester Alliance.

The six publications are as follows:

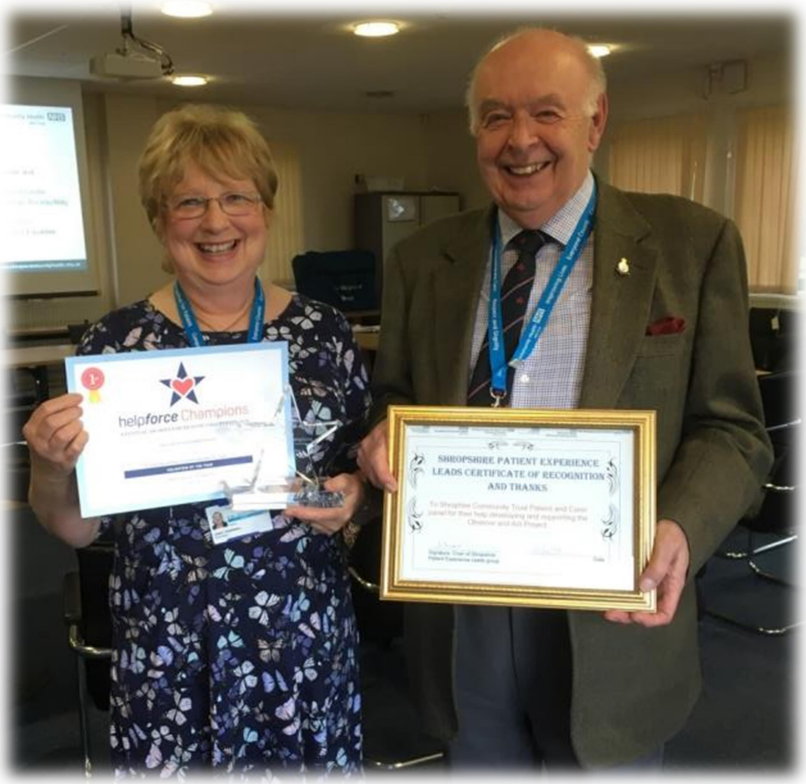






Awards and Growing Reputation.

The Shropshire community Trust volunteers not only continue to be recognised and undertake joint patient experience work with NHS England but have again recently received awards for the Volunteer Award of the year and the Observe & Act tool.



Feedback Intelligence Group and 'Joining the Loop'

The Feedback Intelligence Group consists of key staff and volunteers who collectively scrutinise trends around both patient and staff feedback. The group meets quarterly. It has an overview around feedback and explores learning and key themes. It also continues to encourage staff to action feedback and 'join the loop'.

Project and Equalities work

Volunteers continue to undertake activities with patients, with a particular focus on dementia at Whitchurch Hospital. We are hoping to roll more of this volunteer activity out this year.

Other new emerging and existing project work is around End of Life, Respiratory service and Community Neuro Rehabilitation Centre activities and representation.

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 care and patient 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 and is reflected as one of our priorities going forward.

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 2017/18 and 2018/19:

	2016/17	2017/18	2018/19	Difference
Complaints	117	77	88	+14%
Compliments	455	337	291	-14%
PALS enquiries	306	303	106	-65%

There have been 88 complaints during the year which is a 14% increase on the number of complaints received during the previous year (77).

PALS received 106 contacts during the year 2018/19 in comparison to 303 received from 1 April 2017 to 31 March 2018; this is a drop of 65%. This is accounted for by a change in recording, where the enquiry is a simple re-direct these are no longer recorded.
During the same period of time (2017/18) we received 337 compliments about our services and have received 291 this year, a 26% decrease.

Stoke Heath Prison remained the top single service area in terms of numbers of complaints (17).Community nursing received 11 complaints and community hospitals 16. Children's services received 17 complaints, and Telford Musculo-skeletal service 13. Quality of care, appointment problems and communication account for the majority of both complaints and PALS cases.

Complaints and PALS themes and actions taken are highlighted in reports to the Trust's Quality and Safety Committee throughout the year.

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.

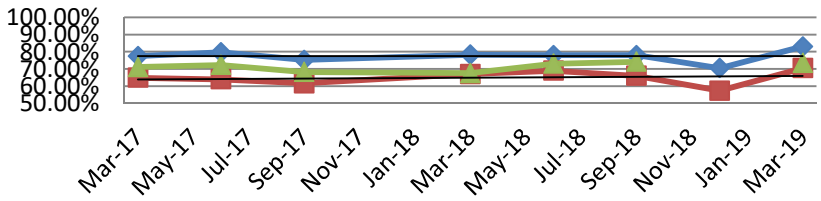
If you would like to see more about our Complaints and PALS work and the action we have taken to ensure that people's concerns are addressed, please visit our website where you will find our annual Complaints and PALS report.

Staff Survey & Staff Friends and Family Test

We are committed to ensuring that our staff feel valued and are able to give and receive feedback through a number of mechanisms.

1330 staff members answered the question would you recommend the Trust as a provider of care to their family or others during the year 2018/19 and the mean average satisfaction score for the whole year is 77%. The chart below shows our Friends and Family Test for Staff trajectory since March 2017.

Staff Friends and Family Test % Positive Scores

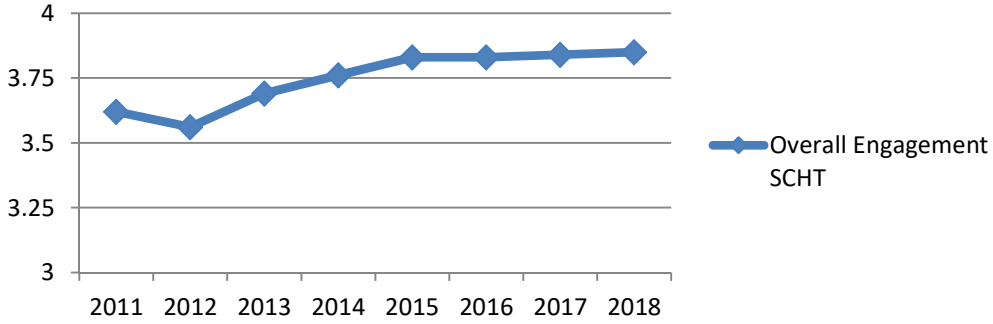


	Mar-17	Jun-17	Sep-17	Mar-18	Jun-18	Sep-18	Dec-18	Mar-19
Care	77.43%	79.70%	75.23%	78.28%	78.00%	78.00%	70.50%	83.00%
Work	64.96%	63.96%	61.69%	67.03%	69.00%	66.00%	57.40%	70.50%
Satisfaction	71.18%	72.36%	68.29%	67.65%	73.10%	74.18%		73.50%

The annual Staff Survey provides an opportunity to ask how staff feel. National reporting has changed from key findings to themes this year, and we have maintained our position in all ten themes. Our results are similar to comparable Trusts (other Community Trusts) in nine of the ten themes and our scores for quality of appraisal are a little lower than our peers.

Our overall staff engagement scores have improved over the last five years and remained consistent this year.

Overall Staff Engagement Scores SCHT 2011 - 2018



Our analysis of our most recent survey showed:

- Our staff are proud of the care they deliver
- They feel safe to speak up when things are not right
- Staff feel that we act fairly on career progression and nearly all who responded said that they had an up to date appraisal

Detailed discussions about our results have resulted in three areas of focus for the coming year and plans have been developed to deliver change in these areas:

- Creating time to look after ourselves, each other and our teams
- Working together and living our values to get to zero bullying and harassment
- Continuing to develop our leaders to have conversations that count around staff wellbeing and appraisals

Statement of Directors Responsibilities in respect of the Quality Account *(To be agreed at June 27th 2019 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 are included.

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
27th June 2019

Section Five: Statements from our Partners

NHS
Shropshire
Clinical Commissioning Group
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL
Tel: 01743 277598

NHS
Telford and Wrekin
Clinical Commissioning Group
NHS Telford and Wrekin CCG
Halesfield 6
Halesfield
Telford
TF7 4BF
Tel: 01952 580300

Mr Steve Gregory
Executive Director of Nursing and Operations
William Farr House
Shrewsbury
Shropshire
SY3 8XL

27th June 2019

Dear Steve,

NHS Shropshire and Telford & Wrekin Clinical Commissioning Groups are pleased to have had the opportunity to review Shropshire Community Health NHS Trust (SCHT) Quality Account for 2018/19.

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

SCHT have worked collaboratively with the CCG and partners throughout 2018/19 to progress the organisational wide commitment to quality improvements - continuously striving to get to good and beyond.

A comprehensive quality framework including nationally mandated quality indicators alongside locally agreed quality improvement targets has driven this. The report demonstrates learning from feedback from the previous CQC inspection in 2016. There have been vigorous processes in place to embed the improvements required and to monitor and review the actions implemented.

It is acknowledged that the formal report from the latest Care Quality Commission (CQC) inspections of the quality of services carried out in January and February 2019, followed by another review in March 2019, is still awaited and this may further identify priorities for 2019/20. The CCG support the current plans the Trust have identified in order to achieve the aspiration of being outstanding at improving lives for our communities.

The key highlights in the report the CCG would like to comment on are as below:

The staff survey results were positive, as comparable to other Trusts in all domains, with only the quality of appraisals being lower than peers. Compliance of carrying out appraisals for staff has improved throughout the year, so it is right that the Trust now look to review the quality of the

appraisals. The CCG support the Trusts philosophy that happy and healthy staff provide better care for patients and support this being a priority for 2019/20.

It is pleasing to note, that in line with the NHS Long term plan, the Trust are planning to utilise the information from the GP patient survey, for patients with long term conditions, to assess levels of patients' skills, knowledge and confidence in how they self-manage their own care.

The Trust have successfully implemented the RiO electronic patient record (EPR) throughout the year and the CCG acknowledge the significant amount of work that has taken place to make this happen. The work will continue in order to embed outcome measures in EPR to facilitate monthly reporting on outcomes across the whole Trust. The CCG look forward to reviewing the outcomes which will be shared at CQR meetings.

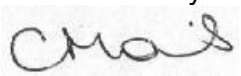
The Looked After Children (LAC) Team has continued to work with the CCG on implementing and improving quality of health services for children in care. Concerns raised over the last twelve months in relation to monitoring processes of looked after children, are showing signs of improvement, with clearer systems and processes now in place for monitoring and reporting. We recognise there are still improvements to be made and therefore the CCG support 'that looked after children reach their full potential through the delivery of high-quality care' as another priority area for 2019-20.

Commissioning for Quality and Innovation (CQUINs) for 2018/19 were based on national priorities. The CQUINS covered a two year period from April 1st 2017 – March 31st 2019. It is noted that compliance with audit standards increased by the end of the two year CQUIN period in all CQUINs identified.

Infection Prevention and Control (IPC) has been another successful area of work during 2018-19. Recording zero cases of pre 48 hour MRSA bacteraemia; MSSA, E.coli, CPE and VRE bacteraemia. Two cases of post 72 hour Clostridium Difficile infection (CDI) in the Community Hospitals were reported. MRSA screening compliance was consistently good. Nurse Led VTE Risk Assessment is embedding across all inpatient sites although not yet delivering the standard consistently. The role of IPC link staff to act as a resource and role model for IPC within clinical area's has been implemented and will seek to address this when consistently in place across the teams. The link role has been observed as good practice during CCG quality assurance visits.

In conclusion, based on the information provided, the CCGs believe the 2018-2019 Quality Account provides an accurate picture of the success and challenges the Trust faces and the evidence of improvements in key quality and safety measures. The CCGs recognise the Trust's commitment to working closely with commissioners and the public.
We look forward to continuing to work together in 2019/20 on new and transformational models of service delivery which demonstrate continuous improvements in the patient experience and the quality and safety of care delivered by an inspirational sustainable workforce.

Yours sincerely



Christine Morris

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