Quality Account

2019-2020

NHS

Shropshire Community Health

NHS Trust

Improving Lives in Our Communities

Commitment to Quality | Respect & Dignity | Working Together | Compassionate Care | Everyone Counts

Care Quality Commission Rated GOOD

Photographs taken pre-Covid

Part 1 - Introduction
Welcome from Steve Gregory

Executive Director of Nursing and Operations, Director of Infection Prevention and Control

It is my pleasure to introduce our Annual Quality Report for 2019/20.

In line with NHS England guidance, this report is presented later in the year than usual and reflects upon an extraordinary year.

We identified key quality priorities we said were important to focus on for the forthcoming year. We did this in partnership with people; adults, children, young people and families, who use our services as well as our key partners across Shropshire, Telford and Wrekin. We will be talking about our key quality priorities later in the report.

The middle of the year was marked by the very positive news that, following our trust wide inspection early on in 2019, in August, the Care Quality Commission rated Shropshire Community Health Trust (SCHT) as “Good” overall. We had much to celebrate as we had worked hard to improve our rating from ‘’Requires Improvement ‘’ overall in 2016.

The end of the year was the beginning of an incredible journey for us as we played our part in the NHS response to the global Covid-19 pandemic. We had to adapt quickly to the new clinical scenarios and operational challenges it posed for us locally in Shropshire.

We learned a great deal about ourselves, both as ‘Team Shropcom’ and, as individuals in how we responded to the presenting challenge at a magnitude never seen before in the NHS.

We temporarily stopped some of our non-critical services (as per National guidance) and adapted others. We rapidly implemented new ways of working including undertaking virtual patient consultations and treatment wherever it was safe and appropriate. We sought innovative ways to seek feedback from people, adults, children and families during the initial crisis response.

We prepared front line clinical staff and support staff with new skills in preparation for redeployment to sustain our priority one services. Importantly, in parallel, we bolstered our staff welfare and well-being offer, doing all we could to support our teams in times of rapid change and uncertainty.

Indeed we continue to learn about our capacity and capability in our on-going response to risks Covid-19 continues to bring, which will be a major challenge for us and a major focus of 2020/21.

We are committed to continuing our commitment to delivering safe, caring, effective and responsive services and have developed a suite of key priorities proportionate to the remaining year during winter for 2020/21. You can read more about this from page 6.

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.

Part one - Introducing Shropshire Community Trust

Our aim is to be the best local provider of high quality, innovative health services near people's homes, working closely with partners so people receive well-coordinated, effective care. We provide community based health services for adults, children and young people in Shropshire, Telford and Wrekin, and Dudley.

Our focus is on enabling people to receive the care and support they need at, home or their place ore residence to enable people to return to as independent life as possible. We are committed to helping people of all ages; supporting parents with new born babies to achieve the best start in life, right through our life journey to end of their life.

Our services are organised across our geographical area to enable
us to be as responsive as possible to meet the needs of people; adults, children and families whom we care for.

2019/20 was one of our busiest years yet. Our range of services provided care for over one million adults, children young people and their families, the vast majority of which are have taken place in people's homes and place ore residence, outpatient and minor injury units, clinics and in our four in patient wards.

Patient Activity Figures 2019/20	
Community contacts	723,722
Outpatient attendances	55,825
Inpatient and day cases	850
Inpatient Rehabilitation Episodes	2,463
Radiology examinations	9,927
Minor injuries attendances	32,112
Equipment and products supplied	298,592
Prison healthcare contacts	21,127

Our services:

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)
- Community equipment service
- Rapid Response

Children and Families SDG

- Community Children's Nurses
- Special School Nurses
- Paediatric Diabeties TeamCommunity Paediatric Psychology
- Child Development Centres
- Community Paediatrics
- Immunisation and Vaccination
- Dental Services
- 0-19 Public Health Nusing Service
- Looked after Children
- Wheelchair and Posture services
- Community Paediatric Occupational therapy
- Cmmunity Paediatric physiotherapy
- Community Speech and Language therapy

Corporate/Support Services

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

Part two – Introducing our system and our system partners

Shropshire is a mostly rural county with over a third of the population living in villages, hamlets and dispersed dwellings; a relatively affluent county masks pockets of deprivation, growing food poverty, and rural isolation. By contrast, Telford & Wrekin is predominantly urban with more than a quarter of its population living in some of the most deprived areas in England.

Shropshire Community Trust, together with our partner health and social care organisations, work as a system for the benefit and to improve services for people use our services, referred to as a system transformation partnership (STP).

As the main NHS community health care provider in Shropshire, we work together with our other partners to plan our services in partnership for the benefit of the people we care for and for the people who work within our various constituent partner organisations.

Our relationships with our partners are essential to help us provide the best care possible for our local population.

When we agree our key quality priorities, we do so in partnership with other organisations, as well as with our own staff, our patients, children and families and our expert patient groups.

Part three – our key quality priorities for 2019/20

Our NHS year begins in April and ends the following March. Seven priorities were agreed as the focus for improvement for the year 2019/20.

Priority 1	We wanted to work together with our partners in healthcare across our system to reduce people developing a blood stream infection.
Priority 2	We wanted to expand training to improve how we recognise and respond to patients who may have symptoms suggestive of clinical deterioration.
Priority 3	We wanted to improve social interaction for people we care for at our inpatient wards.
Priority 4	We wanted to do all we can to reduce people from falling whilst our care.
Priority 5	We wanted to improve the experience of people we look after who live with a learning disability.
Priority 6	We wanted to Improve our services for Children with Special Educational Needs & Disability (SEND)
Priority 7	We wanted to look after each other by making our Trust an even Better Place to Work.

The following section of the Quality Account will show the outcome of improvements we have made.

Priority One: Working together with partners towards the prevention and reduction of blood stream infections

Why was this important?

Infection of the blood can be life threatening. If bacteria from a urinary catheter, a urinary tract infection, a wound or skin damage from a pressure ulcer for example, enters the blood stream, in extreme cases, this can result in a person becoming very unwell, lead to sepsis and death.

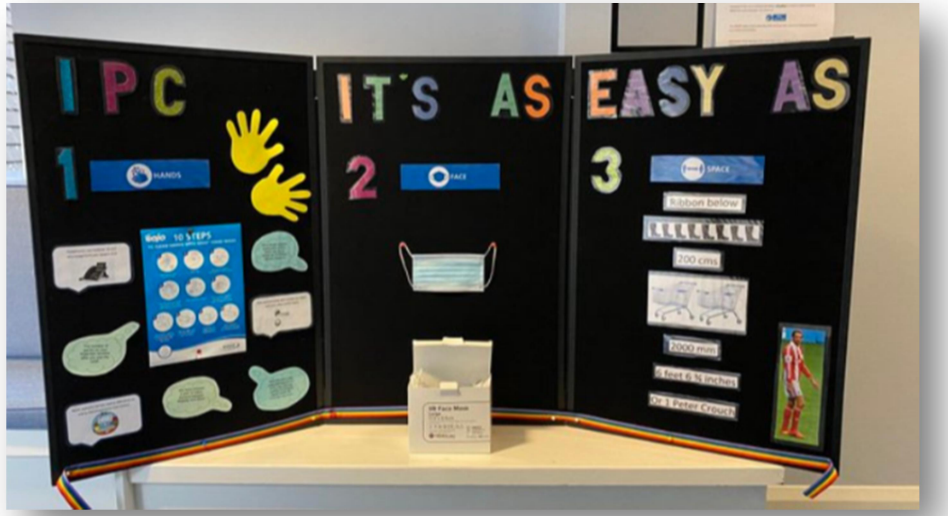
In response to this this is also a national ambition to reduce healthcare associated blood stream infections by 50% and a 50% reduction in inappropriate antibacterial agent usage by March 2021.

Activities we have undertaken in 2019-2020:

- ✓ We are the system lead on this improvement, developing a system wide group and strategy to support required improvements.
- ✓ Reduced the potential for incorrect use of antibiotics by reducing the use of urine dipstick tests in the community hospitals.
- ✓ Introduced a urine tract infection assessment tool to aid the clinical diagnosis of a urine tract infection.
- ✓ As a system, introduced a patient held urinary catheter passport.
- ✓ Implemented nurse led assessments for MRSA screening for inpatient services.
- ✓ Audited how we mange people diagnosed with a urinary tract infection against available NICE guidance.

The outcome of these activities has resulted in:-

- Exceeding our existing high standard of MRSA screening from 95.9% to 97.4%
- Patients now have a patient held passport to support patient self-care and increased opportunity for healthcare professionals to access patient held person centred information at all times.
- 100% compliant in how we care for people with a urinary tract infection based on available evidence.
- 100% compliance being achieved on diagnosis and non-use of urine dipsticks, and 92% on prescribing.
- No patient, whilst in our care has developed a blood stream infection within our inpatient services.



Priority Two: Recognising and responding to the deteriorating patient

Why was this important?

Early recognition, detection and response to an adult who is clinically deteriorating is a key element of patient safety and improving patient outcomes.

Nationally a standardised approach to this has been developed for acute and ambulance trusts. We look after people who live with chronic illness and disease who may be at risk of may be at risk of deteriorating and wanted to increase knowledge and skills across our community staff. We therefore wanted to train 1000 clinical staff.

Activities we have undertaken in 2019-2020:

- ✓ Established an MDT steering Group to rollout NEWS2 across the organisation including community nursing, ICS and rapid response.
- ✓ Review and action any learning from deaths actions related to NEWS2 or Sepsis, or any clinical incidents related to the deteriorating patient.
- ✓ Implemented training for staff.
- ✓ Incorporating the recognition of deteriorating patients in our Intermediate Life Support (ILS) training.
- ✓ Developed patient information for patients and carers.
- ✓ Implemented a post resuscitation event feedback form developed and in our updated Resuscitation Policy to ensure feedback and any learning from 'near misses.'
- ✓ Identified NEWS2 and Sepsis champions identified to support staff across the Trust.

The outcome of these improvements has resulted in:-

- We exceeded our ambition of 1000 staff and delivered training to 1250 staff.
- 60% more staff are now trained on sepsis and recognising the deteriorating patient.
- 41% more staff are now trained on the national early warning system.
- (NEWS2)
- Our Trust and our lead trainer have been recognised for the work undertaken and has been approached by the regional NEWS2 team to look at how this can be rolled out across other community trusts.

We also introduced safety huddles at handover within our community district nursing interdisciplinary teams, and within our inpatient wards.

A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk. With increased knowledge, staff are better informed to identify any patients who may be at the greatest risk of the potential to deteriorate.

No unexpected avoidable deaths are reported this year in our inpatient services.

Safety Huddle Nov 2020

Priority Three: Increasing Inpatient Social Interaction

Why was this important?

Our in-patient wards provide rehabilitation for people in order to reach their potential to life as independent a life as possible. Social interaction is part of rehabilitation and can be important for some people for their mental and physical health and wellbeing.

Inpatient settings can have the potential to reduce the opportunity for patients to socially interact. We therefore wanted to provide the choice for patients to have opportunity to remain as socially active and engaged as possible.

Improvements we made.

- ✓ We strengthened our memory and wellbeing practitioners. We have two registered mental health nurses and three ward based memory and wellbeing practitioners.
- ✓ One to one supervision for distressed/behaviourally challenging patients.
- ✓ Escorting patients, who are not safe to travel alone and unable to access familial support, to outpatient appointments
- ✓ Singing
- ✓ Quizzes
- ✓ TV & Films (utilising ‘’ MyLife‘’ technology)
- ✓ Jigsaws
- ✓ Hair washing & drying

- ✓ Improved how we include loved ones, families and carers in identifying planning and caring for people living with a diagnosis of cognitive impairment.
- ✓ Implemented the ward mobile phone and enabling, when appropriate, the use of video call technology for patients & families
- ✓ "Tea for 2" which is an initiative which enables time each day for a specific patient to have a cup of tea with the memory worker in order to promote sociability, hydration and create a rapport that enables deeper conversation and potentially higher engagement with services
- ✓ Increased opportunity for one to one activities

Outcome of improvements we have made for people we look after:

- 100% of our hospitals have an MDT led ward activity board.
- Doubled the range of opportunities for social activities.
- Implemented the use of video call technology for patients & families.
- Increased involvement of families and loved ones in assessing how we can best care for relatives living with memory loss whilst in our care.

Priority Four: Reducing Patient Falls

Why was this important?

Falls in the elderly are a frequent occurrence, causing pain, injury, increased length of stay, unplanned surgery and delayed recovery. We wanted to do all we can to reduce inpatient falls.

Activities we have undertaken in 2019-2020

- ✓ We implemented a Multi-Disciplinary Inpatient Falls Reduction Steering Group
- ✓ All ward areas have a ‘’falls champion’’ with roles and responsibilities
- ✓ Our pharmacy colleagues prioritise and target medication reviews for all newly admitted patients assessed as being at risk of falls
- ✓ We implemented the Rockwood frailty tool in use at one of our sites which is ready for roll out during 20/21.
- ✓ We have implemented a falls prevention exercise group.
- ✓ Implemented as standardise approach to recording once a day lying and standing Blood Pressure for 3 consecutive days from admission used at each of the Community Hospital inpatient wards as standard.
- ✓ We implemented safety huddles at shift handover format review in progress to improve communication between therapists and nurses in identifying people at risk across the ward.
- ✓ Reinvigorated our ‘’safe bay ‘’

The outcomes of these improvements are:

- 40% reduction in the number of patients who experienced a fall resulting in a harm requiring admission to our acute hospital due to a fracture.
- 11% decrease in the number of patients who experienced a fall of any kind (minor, slips & trips)
- 90% compliance with patients wearing correct footwear.

Picture taken in 2019

Priority Five: Improving within our services, the experience for patients with a learning disability

Why was this important?

People with learning disabilities, autism or both and their families and carers should be able to expect high quality care across all services provided by the NHS. They should receive treatment, care and support that are safe and personalised; and have the same access to services and outcomes as their non-disabled peers.

637 people recorded on our electronic patient record system as living with a learning disability

In response to understanding and improving the experience of people who use our services who live with a learning disability, autism or both, we identified this as a key priority.

Activities we have undertaken in 2019-2020

- ✓ We started by completing a self-assessment against the NICE Quality Standard NG96 care and support for people growing older with learning disabilities in the community.
- ✓ This enabled us to identify areas where we were already good and areas where we needed to improve.
- ✓ We established an improvement steering group which reviewed the audit and created a plan for improvement. This led to using our Electronic Patient Record (EPR) to easily identity patients with a learning disability and to record in one place what adjustments they needed to get the most of their interactions with us.

- ✓ We identified that we need staff to act a champions in our teams to support their colleagues and act as a resource for other staff.
- ✓ We now have 22 staff identified to be champions for learning disability across our services who have either completed or will be completing additional training to support them in this role.
- ✓ We worked with our colleagues at Shropshire Council to arrange this training and to date have trained 7 staff. Unfortunately due to the Coronavirus pandemic the remaining staff training was paused.
- ✓ Learning disability deaths, if they occur in our care, are subject to a rapid mortality review followed by a full Learning Disability Mortality Review (LeDeR programme) by an external reviewer.

Outcome of improvements we have made for people we look after:

- ✓ 22 Learning Disability Champions have been identified in the Trust
- ✓ We have achieved 9 out 10 recommendations
- ✓ We have one delayed recommendation for Q4 due to COVID. We will continue to pay attention to this in 20/21

Priority Six: Improving Pathway Developments for Children with Special Educational Needs & Disability (SEND)

Why was this important?

We wanted to improve the coordinated approach to care and support for children with Special Educational Needs & Disability (SEND

Activities we have undertaken in 2019-2020

- ✓ 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 are working in partnership with the Clinical commissioning Group and Telford and Shropshire Councils to make improvements to the services we offer children and young people with a special educational need. Improvements include:

Ensuring children, young people and their families are involved in service design, development and evaluation

- ✓ Increasing the number of two year olds who have their needs assessed by the health Visiting Service
- ✓ Commenced the redesign of the Speech and Language Therapy service to ensure a more responsive and effective service

Priority Seven: Making our Trust an even Better Place to Work

Why was this important?

Making out trust an even better place to work is part of our Health and Wellbeing plans which form part of our People Strategy. The overall ambition is to create 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.

Picture taken in 2019

Activities have undertaken in 2019-2020

- ✓ Expanded our Corporate Campaigns to support wellbeing including a Menopause Conference and Men's Health Day.
- ✓ Introduced a new partnership with Just Credit Union to improve financial wellbeing.
- ✓ Our first cohort of Team Shropcom Couch to 5 K runners completed Shrewsbury Parkrun.

Our absence due to sickness position overall was improving before CV19 and was lower in 2019/20 than the previous year. March 2020 saw the beginning of the impact of CV19 without this absence due to sickness was on track to be below 5%.

Staff who experienced absence due to muscular skeletal problems also improved from 16.3% down to 12.3% in 2019/20.

Our Wellbeing Practitioner
During 2018/19 we successfully introduced a new mental health practitioner role as part of our occupational Health team. This has proved a key role to support staff that may be experiencing mental or psychological health/stress issues whilst at work as well as assisting line managers and HR colleagues on how they support those staff.

Speaking up about things could impact on patient safety is also an important aspect of the health and wellbeing of our staff.

Our Freedom to speak up Guardian and team of advocates are an additional route of staff to raise concerns if they feel they cannot do so directly to their line manager underpinned by the trust Freedom to speak up whistleblowing policy.

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
- part of induction for all new staff

If a staff member seeks the support of the Guardian team, they do so in absolute confidence. In 2019/20 six people sought a member of the team to raise a concern about something that was troubling them. 100 % of people were satisfied their case has been appropriately dealt with and that they feel supported.

In 2019 the F2SU work was inspected by CQC. Under the well led domain inspectors told us our Trust culture:

- Encouraged openness and honesty at all levels within the organisation.
- Has a strong emphasis on the safety and well-being of staff.
- Leaders at all levels are visible and approachable.
- Managers across our Trust promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Is committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.
- Leaders encourage staff to strive for continuous learning, improvement and innovation.
- Encourages staff to work effectively with other organisations to develop and implement innovative practices.
- Has a positive working culture where learning from incidents is encouraged.
- Leaders and managers across our Trust who promote a positive people first culture, focused on ensuring staff are supported and valued.
- Leadership, governance and culture promoted the delivery of high-quality, patient-centred care.
- Improving our safety culture has not stopped since publication of our CCQ ratings.

Thanks to people speaking up on issues that affect patient safety, we were able to respond to support concerns being raised about poor team culture and morale some people said they were experiencing within one of our services. Poor team culture can have the potential for poor patient outcomes and safety and of course lead to low morale amongst staff. Because people were brave and told us things were not right, we were able to respond and improve.

Following a programme of support from our organisational development team, members of the team were invited to our Quality and Safety Committee to feedback on how their culture had improved

and how this has strengthened patient safety through improved team communication.

As a trust, all incidents that affect people who use our services, particularly in relation to patient safety, are reported using our internal reporting system. Things can go wrong in healthcare. This is often unexpected and unintended but can result in harm or distress to a person. Therefore reporting incidents is key to improving our track record for patient safety.

In line with national patient safety incident reporting guidance, all incidents are categorised.

Thanks to our staff feeling safe and supported to report and raise concerns, our track record for patient safety is improving. In 2019/20 our staff reported 3152 patient safety related incidents; 34 were categorised as serious incidents.

This compares with 2926 incidents reported in the previous year, 2018/19, when 50 incidents were categorised as serious incidents.

Our improvements have been led by our three lessons learned groups.

Part four – key priorities for winter 2020-2021 (October 2020 – March 2021)

During our extraordinary year we have continued to ensure our oversight and quality assurance.

As the year ends and we enter what will be our most challenging winter ever. Our specific quality account priorities for the remaining year are proportionate to these challenges and are considered to be achievable by March.

Safe

Priority one - infection prevention and control (IPC) is everybody's business not least during a pandemic of this magnitude. IPC is fundamental to the safety of people who use our service; patients, children, young people families staff and visitors.

In addition to existing standards for IPC, we will ensure IPC is responsive to national guidance and work with system partners to ensure a collaborative approach to IPC.

Measure of success

We will ensure we are 100% compliant with COVID specific guidance.

Priority two - at times of extreme pressures human factors can play a part in the potential for care fall below standards our regulators, CQC; tell care should not fall below. Our regulators continue to pause formal inspections and as importantly, informal core service engagement visits. In response to this in addition to our quality governance arrangements core service leads will undertake an internal self-assessment against CQC rating and we will undertake a programme of quality assurance engagement visits during winter.

Measure of success

- Completion of internal service led CQC self –assessment
- Completion of a minimum of 20 quality assurance engagement visits

Effective & responsive

Priority three - the impact of COVID-19 has been enormous requiring significant changes to NHS services never seen before. The need to adapt quickly and keep people safe became imperative and for the first time ever, the NHS stopped the majority of non-emergency services. Whilst our services are now restored, the temporary pause has inevitably resulted in delays and extended waiting times for some of our adults, children, young people and families'.
We will increase access to services for people; children and their families including prison healthcare, through the use the use of digital technology.

Measure of success

- A further 25% of services will use of our virtual appointment system (Attend anywhere)

Priority four - responding to people in crisis is an important part of health and social care. For some people responding to their needs and helping people to remain at home is the right thing to do. We will work with our social care partners to ensure people can remain in their usual place of residence, avoiding the need for admission into acute care where it is safe to do so.

Measure of success

- establishment of an ''admissions avoidance service''
- achievement of 100% response rate within 2 hours of referral to the service
- implementation of integrated documentation

Priority five - children and young people with special educational needs or disabilities (or both) often receive a number of different services. These can be provided by nurseries, schools or colleges and specialist therapists, as well as professionals in education, health and social care. We recognise the need to work with our partners including parents and carers to identify areas for improvement and ensure services available for children and young people are well communicated.

Measure of success

- We will work with partners to agree and contribute to reporting timely relevant data on measures of success across the system to improve outcomes for children and young people with SEND
- Identifications of areas we need to improve
- A clear offer of services through co -design in partnership with clinical staff, children and families who user our services and our partner organisations across Shropshire and Telford to improve services for children who require access to speech and language therapy assessment and intervention

Caring

Priority six -our main systems and processes that enabled people who use our services to feed back on their experiences were also paused during the early NHS response to COVID. Hearing about the experiences of people who use our services is important to us and while some services created innovative ways to hear the voice of people who use our services, we want to restore this as another priority for winter.

Measure of success

Restoring the national friends and family test across all 100% of services

Priority seven -the wellbeing of our workforce is a key priority at all times not least in response to the impact of COVID. We will continue to make this another priority for winter. A component of helping

people to feel well is ensuring people continue to feel confident and supported to talk about and raise issues about patient safety, that concern or worry them.

Measure of success

- We will undertake two ‘’listening exercises’’ to take feedback from staff experience of working through COVID.
- We will implement four ‘’emotional support sessions for clinical staff involved in caring for patients at end of life.

We can evidence we’ve improved against all key priorities we said were important to us.

We are proud to be team Shropcom.

We have shared our Quality account with our external partners.

healthwatch Telford and Wrekin

Paul Shirley General Manager Telford Wrekin Health Watch said :-

The 2019/20 Quality Account is an excellent report; a powerful document well presented. It provides a positive vision of a highly motivated and committed workforce and Good Strong Leadership in all areas of work.

The report captures a good portrayal of collaborative work between the trust and other agencies with positive plans established for future work priorities and addressing the demands of Covid 19.

I like the priorities and how goals have been achieved.

The best thing about it is in plain English, no acronyms and set out well.

Overall, the trust is to be congratulated for the Quality of Care they have achieved which has been acknowledged by the CQC.

NHS Telford and Wrekin Clinical Commissioning Group

NHS Shropshire Clinical Commissioning Group

Our Clinical Commissioning group have fed back very positively on the report and acknowledged the improvements made during the year.