Shropshire Community Health NHS Trust

Quality Report

Shropshire Community Health NHS Trust
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Core services inspected	CQC registered location	CQC location ID
Community Health Services for Adults Community Health Services for Children, Young people & Families End of Life Care Child and Adolescent Mental Health Services Community Dental Services Community Substance Misuse services	Shropshire Community Health NHS Trust - HQ	R1DHQ
Community Health Inpatient Services End of Life Care	Bishop's Castle Community Hospital	R1D25
Community Health Inpatient Services End of Life Care Minor Injury Services	Bridgnorth Community Hospital	R1D22
Community Health Inpatient Services End of Life Care Minor Injury Services	Ludlow Community Hospital	R1D21

Summary of findings

Community Health Inpatient Services End of Life Care Minor Injury Services	Whitchurch Community Hospital	R1D34
Minor Injury Services	Oswestry Health Centre	R1DX5

This report describes our judgement of the quality of care at this provider. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for community health services at this provider	Requires improvement 
Are services safe?	**Requires improvement** 
Are services effective?	**Requires improvement** 
Are services caring?	**Good** 
Are services responsive?	**Requires improvement** 
Are services well-led?	**Requires improvement** 

Summary of findings

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Summary of findings

Overall summary

Shropshire Community Health NHS Trust provides a range of community-based health services for adults and children in Shropshire, Telford and Wrekin, and some services to people in surrounding areas. It has four community hospitals, four minor injury units and seven community dental locations. Community services are delivered from 130 different locations across the county.

The trust covers a geographical area of 1,235 square miles, a population of 455,000 and employs more than 1,600 staff.

We inspected this service as part of the comprehensive inspection programme. We carried out an announced visit from 7 to 11 March and we carried out unannounced visits on 13 and 24 March 2016.

During our announced visit, we carried out a full inspection of the trust testing whether services are safe, effective, caring, responsive to people's needs and well led. We looked at all the services it provided. We inspected community inpatient services; services for adults; services for children, young people and their families; end-of life-care services; CAMHS, community substance misuse, minor injury units (MIU) and dental services.

The community substance misuse service was due to transfer to a new provider on 1 April 2016. During our inspection we became concerned in relation to some of the governance systems in the service. For example, the prescribing GP had had no formal clinical supervision from the trust's medical director since June 2015 (nine months). The UK Guidelines on Clinical Management states; that all NHS staff have an obligation to update their knowledge and skills base and to be appraised regularly. We used our statutory powers to requested further information from the trust regarding this service.

Overall, we rated the trust as Requires Improvement for Safe, Effective, Responsive and Well-Led, and we rated it as good for Caring.

Overall, we rated the trust as Requires Improvement.

Our key findings were as follows:

- Some parts of the trust experienced understaffing and the skill mix did not always reflect the dependency or caseloads of the service. This meant that team meetings, supervision and handover could not always taken place in a structured way.
- We were concerned that systems and processes for responding to changing risks in a patient's condition in the minor injury units were not consistent and patients could be a risk whilst waiting for treatment. Arrangements for treating unwell children under the age of two years were not robust.
- We saw that investigations were carried out when things went wrong. We saw examples of where lessons had been learnt and where Duty of Candour had been applied. Staff understood their responsibilities to raise concerns and were encouraged to do so by the trust.
- Safeguarding procedures were embedded in the organisation, led by a strong team. Staff adhered to policies and over 90% of all staff had completed training for safeguarding adults and children to level 1.
- There was no overall strategy for end of life care. An evidence based care plan for end of life care patients had not been effectively implemented; care was variable and did not consistently follow evidence based practice. Governance arrangements did not enable the trust to monitor the quality of end of life care and improve services.
- Staff across all services were very caring and treated patients with kindness, dignity and respect. Staff communicated in ways that helped patients and their carers understand their care and helped patients and those close to them to cope emotionally with their care and treatment.
- The operation of systems for governance and quality measure were inconsistent and not always robust in end of life care and community substance misuse services.

We saw several areas of good practice, including:

- The effective use of telemedicine to help patients living in very rural areas to remain at home
- Photographs of pressure ulcer and skin damage were reviewed which enabled the tissue viability nurses to provide timely advice on required treatment to prevent further harm to the patient.

Summary of findings

- The tissue viability service had demonstrated that changes to two layer compression bandaging did not compromise wound healing, gave increased patient comfort and provided cost savings to the trust.
- Diabetes patient education programme provided excellent patient outcomes for the management of their diabetes.

However, there were also areas of poor practice where the provider needs to make improvements.

Importantly, the provider must:

- Develop and implement an overall vision and strategy for end of life care services.
- Ensure that the operation of systems for governance and quality measure are consistently implemented and that rigorous and constructive challenge is used to hold services to account.
- Review staffing levels and skill mix in community adult nursing, CAMHS and minor injury services to ensure that staffing meets patients' needs.
- Review systems and processes for responding to changing risks in a patient's condition in the minor injury units to ensure risks to patients are minimised at all times.
- Review arrangements for responding to changing risks in a patient's condition in the minor injury units.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including: Community matrons; physiotherapists; occupational therapists; senior community nurses; community children's nurses; school nurses; health visitors; consultant clinical psychologist; palliative care consultant; nurse practitioner; head of quality; deputy director of nursing; palliative care nurse; substance misuse consultant, substance misuse nurse, CAMHS practitioner.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 7 to 11 March 2016.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a much defined period of time, however we did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held six focus groups with a range of staff across Shropshire who worked within the service. In total, around 20 staff attended all those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

We carried out unannounced visits on 13 and 24 March 2016.

Summary of findings

Information about the provider

Shropshire Community Health NHS Trust provides a range of community-based health services for adults and children in Shropshire, Telford and Wrekin, and some services to people in surrounding areas, covering a geographical area of 1,235 square miles and a population of 455,000.

Children and young people under the age of 20 years make up 22% of the population of Shropshire and 26% of the population of Telford and Wrekin.

The trust provides adult community services, services for children, young people and families and child and adolescent mental health services (CAMHS). It has four inpatient facilities and four minor injury units. Community dental services are provided from seven locations, including Stoke Heath Prison. This service was not included in this inspection. We also inspected community substance misuse services, although this service was due to transfer to different provider on 1 April 2016.

Shropshire Community Health NHS Trust was formed on 1 July 2011 following the merger of the provider arms of Shropshire County Primary Care Trust and Telford and Wrekin Primary Care Trust. The organisation has an income of about £75.3 million, and employs more than 1,600 staff.

The trust has been inspected three times since registration. On all three occasions we found the service to be fully compliant against the standards.

What people who use the provider's services say

Patients and carers across all the areas we visited were very positive about the services and commented that staff were very caring and sensitive, answered all their questions and explained things well. Relatives of end of life patients spoke very highly of the staff and the service they had received.

Patient satisfaction surveys we reviewed all reported high satisfaction rates.

Children, young people and their carers told us that they were treated with compassion, dignity and respect.

Good practice

Photographs of pressure ulcer and skin damage were reviewed which enabled the tissue viability nurses to provide timely advice on required treatment to prevent further harm to the patient.

The tissue viability service had demonstrated that changes to two layer compression bandaging did not compromise wound healing, gave increased patient comfort and provided cost savings to the trust.

Diabetes patient education programme provided excellent patient outcomes for the management of their diabetes.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that the operation of systems for governance and quality measure are consistently implemented and that rigorous and constructive challenge is used to hold services to account and minimise risk.

Summary of findings

- The trust must develop and implement an overall vision and strategy for end of life care services.

- The trust must review staffing levels and skill mix in community adult nursing, CAMHS and minor injury services to ensure that staffing meets patients' needs. Where increased patient acuity is considered staffing levels must be planned so that patients requiring support and assistance receive this appropriately.
- The trust must review systems and processes for responding to changing risks in a patient's condition in the minor injury units to ensure risks to patients are minimised at all times.
- The trust must review the systems for monitoring waiting time for patients requiring a neurodevelopmental assessment and put in place systems to reduce length of wait.
- The trust must review arrangements for monitoring and improving the outcomes for patients, encourage greater use of audit within the organisation and ensure that audit results are acted upon.
- The trust must ensure that effective handover and team meetings are allowed to enable staff in the community adult nursing service to share key information in a systematic and safe way.

- The trust must review the admission criteria for community hospitals or ensure it is complied with and that the vision for community hospital's is revisited
- The trust must ensure that when local social care arrangements are required for a patient's discharge further collaborative working is required; an increase in therapist teams to support patients with complex needs is needed to promote timely discharge

Action the provider SHOULD take to improve

- The trust should seek to ensure that where staff felt more could be done to actively engage with them, arrangements are made to remedy this.
- The trust should ensure that learning for incidents and complaints is shared consistently across the trust and between teams to ensure action is taken beyond the affected area.
- The trust should ensure that the serious incident framework is consistently applied when accessing medication incidents.
- The trust should ensure that lone working arrangements in the MIUs reflect trust policy at all times and protect staff from the risk of harm
- The trust should ensure that incident reporting is consistent and reflects good practice
- The trust should review its participation in national clinical audits and local audit of its services, and improve staff understanding of the benefit of audit including of the outcomes for children
- The trust should ensure that staff in the MIUs are familiar with the significant morbidity and mortality associated with sepsis and possess the knowledge and skills to recognise it early and initiate resuscitation and treatment.
- The trust should review systems for documenting consent to treatment on record for patients in the MIUs .
- The trust should ensure that staff receive training in awareness for patients with dementia, learning disability and mental ill health.
- The trust should review the arrangements for clinical leadership of physiotherapy and occupational therapy.
- The trust should have a specific policy for ensuring patients' needs are met during adverse weather conditions.
- The trust should review arrangements for obtaining feedback from patients and their carers.
- The trust should ensure that information regarding the outcomes for people who use services is collected, collated and analysed so that improvements in patient outcomes can be measured.
- The trust should ensure that end of life care plans provide sufficient information to identify the personal wishes and preferences of patients and their families.
- The trust should ensure that all eligible patients are place on the End of Life Care Plan, that staff have been trained in its use and compliance with the plan is regularly monitored.

Summary of findings

- The trust should ensure systems are in place to monitor staffs compliance with children's safeguarding training and ensure that all eligible staff are up to date with required training levels.
- The trust should review the impact of noise and vibrations within premises used for CAMHS services upon staff and patients.
- The trust should review arrangements for provision of dementia friendly diversional therapies.
- The trust should ensure that patient records are fit for purpose and kept secure at all times.
- The trust should ensure that nursing staff are able to access regular, formal clinical supervision.

Shropshire Community Health NHS Trust

Detailed findings

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

We have rated the trust as requiring improvement for safe. This is because:

- Some parts of the trust experienced understaffing and the skill mix did not always reflect the dependency or caseloads of the service.
- There was inconsistent evidence of lessons being shared across the trust and between teams to ensure action taken beyond the affected area.
- The trust did not always correctly apply the serious incident framework, when accessing medication incidents.
- Staff working in some areas were not up to date with safeguarding training beyond level 1.
- Handover was carried out inconsistently in some parts of the adult community services.
- Systems and processes for responding to changing risks in a patient's condition in the minor injury units were not robust.

However we also saw that:

- Staff understood their responsibilities to raise concerns and were encouraged to do so by the trust.
- We saw that investigations are carried out when things go wrong and we saw examples of where lessons had been learnt.
- The trust was aware of its Duty of Candour responsibilities and we saw examples of where it had been applied.
- Safeguarding procedures were embedded in the organisation, led by a strong team. Staff adhered to policies and over 90% of all staff had completed training for safeguarding adults and children to level 1.
- Arrangements for managing medicines were in place to minimise the risks to patients.
- There were infection prevention and control systems in place to keep patients safe.

Requires improvement

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Our findings

Incident reporting, learning and improvement

- The trust reported a total of 1,715 incidents between 1 December 2014 and 31 November 2015. Data showed that 83% (1,422) incidents were categorised as 'no harm' or 'low harm', of the remaining 295 incidents, there were four deaths, 18 were categorised as severe harm and 271 categorised as moderate harm incidents.
- Twenty six serious incidents were recorded by the trust. Three of these incidents were connected to the prison service. All incidents fell into the category 'unexpected or avoidable death or severe harm'. The most common incidents were grade three pressure ulcers (13 incidents) and grade four pressure ulcers (five incidents). All of these were reported by community health services for adults.
- The trust was unable to provide us with the number of end of life care incidents within the last 12 months. The trust did not have a method of categorising end of life care incidents to enable themes to be reviewed and specific learning from end of life care incidents to be shared.
- In response, to the NHS England and MHRA patient safety alert: Improving Medication Error Incident Reporting and Learning (March 2014) the trust had appointed a Medicine Safety Officer (MSO) who was the Service Delivery Group Manager. They attended the trusts MSO Root Cause Analysis (RCA) challenge meetings. This helped to ensure that learning from medicine incidents were undertaken and action taken to prevent them happening again. However, the trust currently does not audit the completion of the actions.
- The trust did not always correctly apply the serious incident framework, when accessing medication incidents. This framework outlines the process and procedures to ensure that serious incidents were identified correctly. The trust's current incident reporting policy dated 22 December 2014 was not based on the most up to date advice from NHS England (March 2015).
- We found that there was an open culture of reporting and staff were encouraged to report incidents. The trust used an electronic reporting systems called Datix and all staff we met during the inspection were familiar with the system and had experience of using it
- Investigations into incidents were carried out using root cause analysis methodology. We looked at 11 investigation reports, eight which related to grade 3 and grade 4 pressure ulcers and three relating to falls. The reports showed there were structured reviews carried out and the relevant staff were involved.
- Staff in various settings were able to describe changes to the service that had resulted from learning from incidents.
- We talked to staff across the trust about how lessons are learnt and shared. Most staff members we spoke with had received some feedback if they had reported an incident. However, we found that this was not consistent across all services and learning was not always shared across teams.
- In the substance misuse service, incident reporting and learning between partner agencies was not coordinated as there had separate systems in place. Shared learning between partnership agencies relied on discussion at team meetings but we did not see that there was standing agenda for discussing and learning from incidents.

Duty of Candour

- The trust told us that face to face training had been provided to key staff via team meetings, and via sessions specifically relating to Duty of Candour requirements. It had been publicised through a safety alert to managers, amendments to relevant policies, information in the staff magazine and information on the staff intranet.
- Not all staff we spoke with during the inspection could recall receiving training or any information regarding Duty of Candour, although most were aware of the regulations and their responsibilities. Some staff we spoke with were unsure of the procedures they needed to follow.
- The electronic reporting incident form had been modified to incorporate Duty of Candour, giving staff additional fields to complete on the form regarding verbal notification to the patient. When the form is

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submitted, it triggers an automatic email to the Risk Manager. They reviews the incident and then confirm if Duty of Candour does apply and a template letter to is issued for staff to personalise and send to the patient.

- We saw the Duty of Candour was complied with and the trust met its obligations to patients.

Safeguarding

- There were 30 adult safeguarding alerts between April 2015 and September 2015. Approximately half of these were made by the adult community nursing team, with eight being made by the North East Inter Disciplinary Team. Most alerts (19 out of 30) related to lack of care, injury to the patient or patient going against advice.
- There were also 30 child alerts during the same period. Half of these were made by the school nursing service and related to poor communication between agencies or lack of communication.
- Data provided by the trust showed that 96% of all staff had completed safeguarding adults training to level one and 99% had completed safeguarding children training to level one.
- The Intercollegiate Document: 'Safeguarding Children and Young People: Roles and competencies for healthcare staff'; March 2014 published by the Royal College of Paediatrics and Child Health 2014 states that level 2 training is required for all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers. Level 3 training is required for all clinical staff working with children, young people and/or their parents/ carers and who could potentially contribute to assessing, planning, intervening and evaluating their needs where there are safeguarding/ child protection concerns.
- We asked the trust to tell us training compliance rates for level 2 and level 3 children's safeguarding. Data showed However, within CAMHS, only 32% of eligible staff were up to date with level 2 training and 41% were up to date with safeguarding children level 3 training. We also saw that only 37% of eligible community adults staff had received safeguarding children training to level 2 and 50% of eligible staff had completed safeguarding training to level 3.
- During our inspection, staff demonstrated that they were aware of their safeguarding responsibilities and safeguarding procedures were embedded in the organisation. There were robust arrangements in place for reporting adult safeguarding issues and effective links to adult social care services. The trust had arranged workshops across the trust to disseminate learning from adult case reviews.
- We saw that the trust had a strong safeguarding children team in place. There were many examples of the multi-agency working, including sharing learning from serious case reviews. The trust were visible within the wider safeguarding network. Communication structures and lines of accountability ensured that the trust board had a line of sight on safeguarding issues and they would be alerted to any concerns.

Medicines management

- Across the trust, we found efficient medicine management. A well-established pharmacy team provided good clinical services to ensure people's medicines were handled safely. Any concerns or advice about medicines were written directly onto the person's medicine records by the pharmacist or discussed with the prescribing doctor. Nursing staff we spoke with also told us that if they had any medicine queries they had access to pharmacist advice at all times.
- We found medicines were stored safely in wards and departments. We found that the temperatures of the rooms and refrigerators used to store medicines were monitored and recorded in line with trust policy so that medicines were stored in a way which maintained their quality.
- Emergency medicines were available for use and there was evidence that these were checked regularly.
- The pharmacy team used a range of methods to share medicines safety information including targeted bulletins and workshops.This helped to ensure that learning from medicine incidents within the trust and nationally was cascaded back to the ward teams.
- Anticipatory medicines are an important aspect of end of life care; they are prescribed drugs in order to control symptoms such as nausea and pain. In three prescription charts out of 16 we reviewed we saw that anticipatory medicines had been prescribed for pain, nausea, chest secretions and agitation but not for

Requires improvement

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shortness of breath which should be included. On two other prescription charts, there was no guidance provided stating the limits to frequency of dosages of anticipatory medicines.

Safety of equipment and facilities

- We saw that services were provided in appropriate clinical settings. For example, we saw that the children's speech and language therapy clinic in Telford provided in a suitably equipped and child friendly room with appropriate décor.
- Nursing and therapy staff told us that they were able to request equipment for patients such as hospital beds, pressure relieving mattresses and commodes and it was received in a timely manner. Staff told us they could access equipment from local 'satellite stores' or from a private equipment provider if equipment was needed urgently for an end of life care patient. Staff said there were no problems getting equipment quickly. District nurses in Telford told us the equipment stores delivered beds and mattresses within 48-hours of request.
- There were systems in place to ensure that equipment was regularly serviced and maintained.
- Patient-led assessments of the care environment (PLACE) 2015 results for maintenance were in line with the national average of 90% at Bishops Castle Hospital and Ludlow Hospital with Bridgnorth Hospital and Whitchurch Hospital scoring 99%.

Records management

- We looked at a wide range of patient records at different locations across the trust, held electronically and in paper format. We saw that staff had generally completed them to a high standard and there was evidence of assessments and care plans. Most of the records were accurate, complete, legible up to date and stored securely.
- However, we found inconsistencies in the quality of care records in the community hospitals. For example at Bridgnorth Community Hospital, five of the nine records we looked at were incomplete, similarly, at Ludlow, of the eight records we looked at three were incomplete. At Whitchurch Community Hospital we found an end of life care plan was incomplete and diabetes check not escalated to the GP and falls assessments not reviewed weekly. We checked five sets of patient care records at Bishop Castle. We found that records were completed correctly. Records did not always identify the time when entries had been made; signatures were missing and some entries were not legible. We highlighted the discrepancies to the nurse in charge.
- The trust's end of life care audit in February 2016 showed that 31% of dying patients (those diagnosed as having only a few hours or days to live) had been put on the End of Life care plan and that there was poor compliance with the plan when they were in place. However, there was documented evidence of discussions with the patient and family/carers in regard to 'do not attempt resuscitation' (DNACPR), this was 80% compliant.

Cleanliness and infection control

- Infection control was included in the mandatory training requirements for all staff. The target for completion was 85% of all staff. Data provided by the trust showed compliance was 93%.
- There were infection prevention and control systems in place to keep patients safe. The trust had an infection control team, with an effective link worker system in place. There was an Infection Prevention Governance Group which reported directly to the trust board.
- The ward and clinical areas we visited were visibly clean. There was sufficient provision of personal protective equipment such as gloves and aprons and hand gel and hand washing facilities were available.
- Staff consistently followed the bare below the elbow policy. During visits with community staff to patient's home, we witnessed good hand hygiene and the use of personal protective equipment when administering care to a patient.
- Observational hand hygiene audits were completed unannounced in the community hospitals. In January 2016, 100% compliance was achieved in all four hospitals and in February 2016 100% compliance was achieved in three hospitals. At Whitchurch Hospital, 90% was achieved due to a member of staff wearing jewellery. A re-audit scored 100%.

Requires improvement

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Mandatory training

- The trust had a target of 85% across all its mandatory training courses except for Information Governance, for which the target was 95% compliance.
- Average training compliance across the trust was 85%. Community dental services (92%) and substance misuse had the highest levels of training compliance, both at 86%. The lowest levels of training compliance were within community health inpatient services (74%). Data provided showed that across the four inpatient sites the staff failed to achieve the trust target in nine of the 14 courses including information governance. We saw that a performance management recovery plan was in place to improve compliance levels.
- The three training courses with the highest levels of compliance were corporate induction (95%), safeguarding adults (96%) and moving and handling (94%). The three training courses with the lowest levels of compliance were fire safety (77%), paediatric resuscitation and basic life support (75%) and adult resuscitation and basic life support (76%). The trust had met its target for six of the fourteen courses.

Assessing and responding to patient risk

- The trust had a standard operating procedure for community nursing handovers called 'SBAR'. 'SBAR' stands for 'situation, background, assessment and recommendation' and the NHS endorsed its use as a structured method for communicating critical information that requires immediate attention and action contributing to effective escalation and increased patient safety. We observed a handover between community shifts using the SBAR tool.
- We found that staff handovers were inconsistently undertaken. In South-West Shropshire, staff told us that, when possible, they had daily handovers. Two community teams said that they did not have a handover. Some staff told us and we observed they had 'informal' handovers on an individual basis. However, this meant they were not made aware of risks in neighbouring teams which they also provided cover for. One band six nurse told us they did not think the current system without handovers was safe. They had asked the team leader to re-introduce handovers to discuss patients and risks throughout the larger team and this was being considered.
- In the community hospitals we observed staff handovers to be a formal process to ensure that all staff were aware of the patients on the ward. Handover, including a safety huddle, occurred at the start and end of each shift. To ensure each patient was benefitting from the planned multi-disciplinary input, the team met daily to discuss each individual patient.
- National early warning scores (NEWS) were used for the assessment of unwell patients on the inpatient ward areas. We saw two sets of NEWS documentation completed correctly.
- CAMHS services were able to respond to deterioration in a patient's mental health via the duty system. The services did not actively monitor the waiting lists to detect increases in level of risk. Patients, families and or carers were encouraged to contact the service if risks increased. Shropshire schools for the children and young people with learning disabilities could also contact services if they felt risks were increasing.
- Only one of the minor injury units we visited had dedicated reception staff. Health care assistants or temporary (bank or agency) staff rosters as part of the nursing teams, acted as receptionists along with their healthcare role. We saw that they had a "check list" of conditions including shortness of breath or head injury that they were expected to draw to the attention of nursing staff quickly if a patient presented at reception with them.
- Although we saw there were few patients accessing minor injury services, the staff acting as receptionists were constantly diverted away to perform other duties, this meant patients may not be observed whilst waiting for treatment and if a patient's condition deteriorated it may be missed.
- All nursing staff we spoke with were aware of the risk of a deteriorating patient particular children and babies. All MIU's treated minor injuries in children and babies but none were commissioned to treat minor illness. The approach to minor illness in presenting children varied between the MIU's. Nursing staff told us they were always made aware by staff on reception when a child or baby had been booked in but the "check list" for presenting conditions did not include babies or children less than two years.

Requires improvement

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Staffing levels and caseload

- Between July and September 2015, the trust employed an average of 590 qualified nurses and had an average vacancy rate of 10.7%. During the same period, the trust employed an average of 129 nursing assistants, for which there was an average vacancy rate of 0.3%.
- Across the trust, there were 62.4 vacancies for qualified nurses. The highest number of WTE vacancies for qualified nurses were found in community health services for adults (19.5), followed by community health services for children, young people and families (16.7) and community health inpatient services (16.1).
- Some community nursing team services were below strength, due to low staffing levels, compounded by staff sickness. Staff told us that they were struggling to keep up with increasing demand for their services. The staff sickness rate across community adult services between October 2014 and September 2015 was 6.5%.
- Staff told us that staff availability to meet patients' visits was a challenge. Staff in the majority of teams told us that they regularly worked more than their contracted hours to ensure patients' visits were undertaken.
- Staffing levels in the community nursing teams were assessed using the trust's workforce planning tool, which collected data on activity to determine the required staffing levels. This identified daily demand and capacity of staff, level of risk and actions required for prioritisation of workload.
- The trust tool identified 'outstanding work load score' or OWLS. This identified any required visits that community staff were unable to undertake. We requested information from the trust about OWLS but we were told there was no outstanding community visits or workload.
- The trust had completed an audit, 'Community Nursing Capacity and Demand Audit' in October 2015. The audit identified that the majority of teams had not included time for team meetings, handovers or required supernumerary time for band 6 nurses, a variance in application of dependency score and travel time and staff were not routinely allocated time for online learning and supervision in practice. The trust had an action plan to address this and more accurately identify nursing capacity and demand, however we found the same shortfalls at the time of our visit.
- Daily staffing levels were reported to NHS England as part of the safer staffing initiative. Staffing levels and skill mix were reviewed by the ward managers in the community hospitals but we saw that staffing did not always meet the dependency of the patients on the ward.
- As at December 2015, the sickness rate on the in-patient wards was 6%.
- Staff fill rates compare the proportion of hours worked by staff to hours worked by staff. We reviewed the average fill rates for the period April to September 2015; average fill rates exceeded 200% at Ludlow Hospital and at Whitchurch Hospital, with the majority of fill rates occurring for care staff working at night. In September 2015 staffing levels were below fill rate at Bridgnorth Hospital and Bishops Castle Hospital which were told were filled with bank or agency staff.
- Bank and agency staff were used to address the qualified nurse and health care assistant vacancies. Block booking of agency staff had been arranged to ensure consistency for patients and substantive ward staff. During December 2015, 272 agency shifts were used across the community hospital in-patient areas (36 registered nurse shifts and 236 health care assistant shifts).
  We were told that staffing was in the process of being reviewed; several registered nurse posts vacancies were being converted into health care support worker roles, increasing staffing levels in order to deliver greater patient observation and basic nursing care.
- The trust told us they were experienced staffing difficulties in the minor injury units at the time of our inspection. Staff we spoke with at each of the MIU's told us the unit was short staffed and they felt levels were unsafe.
- The trust used paper rostering forms for three MIU's and an electronic format for Oswestry MIU. The trust identified the staffing levels for each shift and told us they used the West Midlands Quality Standards (WMQRS) to ensure safe staffing levels. The quality standards state that at least one registered health practitioner should be available and have competencies in a range of skills including intermediate life support (ILS) and paediatric life support (PILS).

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

- We reviewed staffing rosters for the four months December 2015 to March 2016. The rosters showed us that shifts were frequently unfilled or the WMQRS standards were not being met.
- When there were staffing shortages patients did not always get the full attention of clinical staff. For example we observed one nurse working on duty single handed for a number of hours before an agency nurse arrived to fill one of two sickness vacancies. The telephone was constantly ringing in the treatment room that nurse was seeing patients and then the agency nurse interrupted consultations with enquiries because they were not familiar with the service.
- The service did not use any recognised tools or methods to assess staffing levels. Commissioners had agreed current staffing levels with the trust. There were proposals in place to address identified staffing shortfalls. The trust was negotiating funding for these posts with commissioners.
- Across CAMHS, there were 50.7 whole time equivalent (WTE) clinical substantive staff. In the period October 2014 to September 2015, 6.14 WTE staff had left this service. CAMHS had a 13% vacancy rate. All staff said the impact of vacancies resulted in large caseloads, high stress levels and less therapeutic interventions offered to the patients.
- Caseloads for clinical staff varied. Within the two generic CAMHS teams, caseloads were within acceptable levels but two nurse prescribers on this team held a caseload of approximately 100 patients. Staff did not use any caseload management tools to monitor caseloads.
- There were 3.8 WTE psychiatry posts. Of which, 2.9 were covered by locum psychiatrists. The locums we spoke with had been in place for some time. One locum consultant psychiatrist had been in post for two years. Psychiatrists reported having 200 – 250 patients on their caseload. There was one vacant psychiatry post that had no locum cover.

Managing anticipated risks

- The trust had arrangements in place to minimise the risks associated with lone working. There was a lone working policy in place. All the staff we spoke with were aware of the policy and could describe what action they would take if a potential or actual risk was identified. Managers maintained contact lists and car details.
- Staff told us they would use both their trust mobile and also their personal mobile phone in an emergency. However staff told us that phone reception was poor in many rural areas. This meant that staff might be in a vulnerable situation and be unable to alert assistance.

Major incident awareness and training

- Staff had access to the major incident plan (dated November 2015) via the trust intranet and received training on this during their induction.
- The trust's major incident plan dated November 2015 included a response plan to commence liaison with local clinical commissioning group to identify early discharge of suitable patients in the community hospitals to increase capacity.
- There was an adverse weather policy but district nurses and community therapists told us there was no formal arrangement in place with any voluntary or statutory agencies to assist with transport in inclement weather.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

We have rated the trust as requiring improvement for effective. This is because:

- An evidence based care plan for end of life care patients had not been effectively implemented; care was variable and did not consistently follow evidence based practice.
- The outcomes for people who use services was not always monitored and participation in external audits was limited.
- Not all staff had access to regular, structured, clinical supervision. This meant the trust could not be assured that staff had the right skills and competencies to deliver effective care.
- The trust did not have a policy for children transitioning to adult services.

However we also saw that:

- Care and treatment was mostly planned and delivered in line with current evidence based guidance, standards, best practice and legislation.
- There was effective use of telemedicine systems in the community adult services.
- There was good collaborative working across all the services we visited.
- There were systems in place for the referral, transfer and discharge of patients across the services we reviewed.

Our findings

Evidence-based care and treatment

- We saw that the trust had a range of policies based on national good practice and followed national clinical guidelines where available. Guidance was available on the trust's intranet and some staff showed us they were readily accessible.
- District nurses in Telford and Wrekin, and Much Wenlock used the NHS England-recommended 'SSKIN' mnemonic to help them avoid their patients acquiring pressure ulcers. 'SSKIN' stands for surface, skin inspection, keep patients moving, incontinence and moisture, and nutrition and hydration. We saw copies of the SSKIN assessment tool, variance chart, repositioning schedule and food chart in all the sets of patient notes we looked at. We saw this tool was well used.
- A Shropshire wide, whole health economy end of life care group had developed an 'End of Life Care Plan' to replace the Liverpool Care Pathway based on current evidence based practice and national guidelines. The trust had implemented this plan but a recent audit showed that only 31% of eligible patients had been put on the End of Life care plan and that there was poor compliance with its use when it was in place. The care plan had been implemented across the trust prior to ensuring that sufficient numbers of staff had received training on how to use it.

Use of technology and telemedicine

- We saw and were told about effective use of telemedicine systems in the community adult services. The system records and stores patients' observations electronically so they are available to professionals to review and monitor their health without the need to visit the patients.
- The telemedicine service maximised the availability of specialist nurse advice across a large and mainly rural county. The tissue viability telemedicine used hi-resolution images of wounds taken by staff and transferred to a secure NHS computer. The team prioritised visits to patients and offered advice based on these photographs together with information provided on an electronic referral form.

Approach to monitoring quality and people's outcomes

- During 2014/2015, the trust participated in three national clinical audits and one national confidential enquiry covering services they provide. These were the National Audit of Intermediate Care, the Sentinel Stroke Audit and the Chronic Obstructive Pulmonary Disease (COPD) Audit. In 2014/2015, the trust undertook 42 local clinical audits. Data provided by the trust showed that the trust performed better than the average in the COPD audit but worse than similar trusts in the stroke audit.
- During 2014/2015, the trust achieved 56 out of 85 key performance indicators across a range of areas. Thirteen

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

of the KPIs were rated as "red". These included reducing avoidable grade 2 pressure ulcers, managing the proportion of delayed transfers of care and staff appraisal rates.

- The trust had seven CQUINs in place as at September 2015, three related to dementia care, one relating to the quality of end of life care.
- Between April and September 2015, there were 39 readmissions to the community hospitals. Over 40% of these (16) were to Bridgnorth Hospital. Data provided by the trust showed that 74 delayed discharges occurred across the trusts inpatient wards, within the above timeframe. Almost half of these (33) occurred at Whitchurch Hospital.
- The trust did not have a process of measuring outcomes for end of life care patients against their preferred place of death.
- ·The use of patient and clinician rated outcome measures was limited in CAMHS.
- The Diagnostic Outcomes Monitoring Executive Summary (DOMES report) is a Public Health England report measuring the outcomes for patients' receiving substance misuse services. The DOMES report for the Shropshire Community Substance Misuse Team (CSMT) showed that from October to December 2015 the service achieved good outcomes for its patients. For example, The number of opiate users who left drug treatment free of drugs of dependence, who did not return for treatment within six months, was 8.2% of the total number of those in treatment. This figure was above the national average of 7%.

Competent staff

- As at September 2015, the overall appraisal rate for the trust was 67%. The provided us with data during the inspection which showed that appraisal rates had increased to 91%. The services with the lowest appraisal rates at that time were community dental services (49%) and the community hospitals (50%). Although during our inspection of dental services, locally held data suggested that compliance rates were much higher in dental services in March 2016.
- The prescribing GP in the substance misuse service had had no formal clinical supervision since June 2015 (nine months). The UK Guidelines on Clinical Management states; that all NHS staff have an obligation to update their knowledge and skills base and to be appraised regularly. The Clinical Director had left the trust and no alternative arrangements were in place to make sure the clinical guidelines had been followed during that time.
- Staff did not receive clinical supervision in the community adult services, community hospitals and minor injury units. Clinical supervision is a review of individuals' clinical practice. Most staff we spoke with said any supervision was more likely to be informal rather than formal. Clinical supervision was well embedded in CYP services.
- One community matron told us they ran a supervision group for band 5 community nurses to overcome the shortage; this helped them to develop their practice. Arrangements for clinical supervision in the community hospitals was at the discussion stage only at the time of the inspection.
- Community nursing staff in several locations in Telford and Shropshire told us they experienced problems getting funding and time for non-mandatory, role-specific training. If they wanted to attend additional training courses for continuing professional development, they had to do so in their own time and pay for them themselves. One band 5 nurse said they had been booked to do external courses but they had been cancelled due to pressures of work.
- We found there were good arrangements for induction training for new and temporary staff.

Multi-disciplinary working and co-ordination of care pathways

- There was good collaborative working across all the services we visited.
- The multi-disciplinary meetings and discussions we observed were professionally managed; patient focussed and considered all elements of a patient's well-being.
- We saw referrals and communication networks between community nurses, social care and home service.
- There was clear evidence of good multidisciplinary team working and communication within records demonstrating joined up, holistic care planning in services for children's and young people and CAMHS.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Referral, transfer, discharge and transition

- There were systems in place for the referral, transfer and discharge of patients across the services we reviewed.
- Healthcare professionals made referrals to community teams via the single point of referral (SPOR) or directly to the teams by telephone or fax. Staff told us that professionals, the patient or their carer could contact the service for advice or a visit when required. Some patients with specific conditions were able to self-refer through the SPOR.
- District nursing services operated from 8am to 6pm, seven days a week. Between 6pm and 10pm the rapid response team provided support for patients who had unexpected needs. Outside these times, the out of hours GP service provided a response to patients with urgent needs. Community nurses in Newport told us the rapid response team and out of hours GP service provided effective cover for them outside their normal working hours and no adverse incidents had occurred.
- The trust had key performance indicators (KPI's) in place regarding referral to treatment times (RTT). All four hospitals demonstrated they had achieved or exceeded the 18 week referral to treatment time for day surgery between October 2014 and September 2015. For example, ophthalmology day surgery at Bridgnorth Community Hospital had achieved a three week RTT and general surgery at Bridgnorth Community Hospital had achieved an 11 week RTT.
- There had been six transfers to acute emergency departments in the period prior to our inspection. We reviewed the records of these patients and found there were arrangements in place to safely follow through referral and transfer to local acute ED services where appropriate and GP's and health visitors.
- We asked the Trust about the policy for children transitioning to adult services. The head of nursing and quality said that

Availability of information

- We reviewed information on the trust intranet that staff used to support their work and saw the information was clear and accessible. This also enabled staff to access information about evidence based patient care and treatment through external internet sites.
- Access to the various IT systems in use across CYP service varied in consistency and effectiveness. Management were aware and told us they were working towards to an effective IT solution for the staff.

Consent

- We found there were systems in place to establish patients' capacity and to make decisions about their welfare and care. However these were not always consistently followed and there was confusion among staff around obtaining valid consent from patients, who did not have the capacity to give it.
- We saw patients' verbal consent was obtained before care was delivered in the minor injury units but this was not recorded in the notes.
- Gillick competency and Fraser guidelines were used to ensure that young people under 16 years of age who declined to involve their parents or guardians in their treatment had sufficient maturity and understanding to enable them to provide full consent. Although we noted this was not routinely recorded in the notes of patients accessing CAMHS services.
- CAMHS patients over the age of 16 were supported to make decisions where appropriate and when they lacked capacity, staff said decisions were made in their best interests, consulting with parents and or carers and taking into account the young person's wishes, feelings, culture and history. We discussed examples with staff and saw that capacity issues were considered. However, we did not see evidence of this recorded consistently within notes. One psychiatrist felt staff needed reminding that capacity issues were decision specific and not generalised.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

We have rated this service as good for caring. This is because:

- Staff across all services treated patients with kindness, dignity and respect; we observed many examples of positive relationships between staff, patients and those close to them.
- Feedback from people using services via the Friends and Family test were above the national average.
- Staff communicated in ways that helped patients and their carers understand and were actively encouraged to be partners in their care.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.

Our findings

Compassionate care

- We observed that care and treatment of patients across all services was empathetic and compassionate. Staff promoted and maintained the dignity of all patients when they delivered care.
- Feedback from all people we spoke to during the inspection was positive about the way staff treated them.
- The trust used the Family and Friends Test as a means of receiving patient and family feedback. Results for the survey undertaken in November 2015 showed that the percentage of patients who would recommend services at the trust was higher than the England national average. Community inpatients services scored 100% and rehabilitation services scored 98%, against a national average of 95%.
- PLACE (2015) scores for privacy, dignity and well-being were above the national average of 86% at three sites ranging between 85% and 90%; Bishops Castle Community Hospital scored 76%.

Understanding and involvement of patients and those close to them

- We saw staff taking time to listen to patients' concerns and explaining care plans in clear, simple language to make sure patients understood what was going to happen. We also saw staff explaining treatment, therapy plans to patients, and talking to them about tasks they were doing in their homes to improve their safety and quality of life.
- In the CYP services we saw that staff were mindful of the needs of children and their families and care was tailored to meet their needs. For example, we saw the activities provided by an occupational therapist were specifically designed to meet the needs of the child and conversations relating to their support were specific to the patient and their needs.
- People were involved and encouraged to be partners in their care and in making decisions, with support they needed. Plans of care centred on what the patient wanted. Relatives told us that they had been consulted about decisions and understood what was happening and why.
- The trust's Admiral Nurses ran workshops for carers of people living with dementia. They provided opportunities for carers to share their experiences and discuss issues, and offered training on areas such as communication and nutrition. The workshops also featured guest speakers giving advice on legal and practical issues about caring for people living with dementia.

Emotional support

- Staff helped patients and those close to them to cope emotionally with their care and treatment. They were enabled to manage their own health and care where they could, and to maintain independence.
- We observed community staff (including nurses, occupational therapists and physiotherapists) giving holistic care including support for close relatives. During home visits with community nursing staff, we saw that staff understood the unique situation of each patient and provided tailored emotional support.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

- We heard examples from staff of families who had experienced the loss of a child being given time with staff to discuss their emotions and supported at the time of the death and over a period of time afterwards.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

We have rated this service as requiring improvement for responsive. This is because:

- Facilities in some CAMHS services did not meet the specific needs of some patients and waiting times for neuro developmental assessment were up to 12 months.
- Although services were planned and delivered to meet the needs of the local population, the admission criteria was not always complied with.
- People with complex needs were assessed; their support from specialist teams was not sufficient to support a timely discharge in to the community.

However we also saw that:

- Services were planned and delivered in a way that met the needs of the local population.
- Patients were able to access the right care at the right time and could be flexible, to take into account urgent needs.
- Waiting times were mostly managed appropriately, waiting time targets were met or exceed in a number of areas.

Our findings

Planning and delivering services which meet people's needs

- The needs of the local population were considered in how community services were planned and delivered. Commissioners, social care providers and relevant stakeholders were engaged in planning the services through meetings ensuring patient choice was considered for continuity of care. For example, the trust was part of a group looking at end of life care across the whole health economy and the trust was involved in a number of initiatives to reduce the impact on local acute services.
- However in the community hospitals we saw that systems were not always effective. Patients from one area were being cared for in hospitals many miles from their homes when the trust had similar facilities in their local area. GP's we spoke with explained that they found the admissions process frustrating as they were unable to admit patients to their local hospital and had to use the central allocation system. They told us that the system appeared to favour step down patients from acute hospitals which mean step up patients from the community had to make do with whatever bed was available in the trust rather than their local hospital. We identified that patients were admitted from 'out of area' to the community hospitals; they had subsequently been transferred nearer to home when a bed was available or their condition was suitable.
- The majority of services delivered by the community inpatient services were for people with complex needs, for example those living with dementia. Staff told us that more time would be beneficial to accommodate specific personal and social care needs of people with dementia especially time to participate in activities and social events to enhance their recovery and discharge.
- The trust was commissioned to provide three integrated community service (ICS) teams that covered Shropshire. The ICS was a pilot scheme originally planned to run until the end of March 2016, but at the time of our inspection had been extended for a further nine months. Between April and November 2015, 3,667 patients received support from ICS either following hospital discharge or for prevention of admission.
- The trust was also commissioned to provided 'Diagnostics and Access to Assessment Rehabilitation and Treatment' (DAART) clinics in Oswestry, Bridgnorth and Shrewsbury. Each DAART operated slightly differently but all provided a service to reduce hospital admission for non-urgent patients who required assessment. Between April 2015 and February 2016, they saw 2,342 patients.

Equality and diversity

- All new staff received equality and diversity training as part of their corporate induction.
- Staff told us and we saw that they had access to interpreters and that they were widely used to ensure that effective communication took place between staff, patients', families and carers.
- Disability access was available in all areas of the buildings facilities we looked at.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

- We saw that staff treated patients with respect regardless of their race, religion and sexual orientation.
- We saw information that showed the trust had a long-term equality and diversity strategy.

Meeting the needs of people in vulnerable circumstances

- A dementia-friendly environment had been promoted by the staff including the introduction of the 'Butterfly scheme' and dementia screening. The Butterfly Scheme is used on the wards for providing a strategy of dementia care, and is an opt-in scheme for patients or carers.
- Patients with a learning disability or dementia were encouraged to bring their carer with them on admission, be present during the ward round and attend care reviews.
- The Telford and Wrekin CAMHS team base was situated underneath a public gym. Staff told us that this was problematic as noise from gym equipment could be heard throughout the day. Our observations during the inspection confirmed this; we heard loud noises and felt vibrations from the gym equipment. Whilst observing one care session, we had to change rooms as the noise above one consultation room had become too much for the patient to tolerate and it was interfering with their therapy session.

Access to the right care at the right time

- Between April and September 2015, the average bed occupancy across all four community hospitals was 94.5%.
- As at September 2015, the trust had achieved all four of the KPIs in place regarding referral to treatment times.
- There were 105 delayed transfers of care in the 12 months up to November 2015. The most common reason for delayed transfers of care during the reporting period was "awaiting care package in own home" which accounted for 43% of occasions.
- Community nurses told us they responded to 'urgent' referrals within 24 hours and non-urgent referrals within 48 hours. Information provided by the trust identified 99% of urgent referrals were seen within 24 hours, against a target of 100% and 99% of non-urgent referrals were seen within 48 hours, also against a target of 100%.
- All four minor injury units had met the national response standards for urgent and emergency care during 2015/16. These included treatment times (arrival to seen time); assessment times (arrival to triage time) for arrivals by ambulance; percentage of people who leave MIU without being seen; total time in department (arrival to discharge) and unplanned re-attendances (within 7 days of discharge).
- CAMHS had target times of 18 weeks to see a priority level 2- 3 patients for assessment following referral. The average waiting time for CAMHS learning disability team was six weeks, CAMHS Shropshire was eight weeks and CAMHS Telford and Wrekin was seven weeks. The CAMHS learning disability team waiting time for treatment varied between 12 and 16 weeks.
- The waiting list for neuro developmental assessment was up to 12 months. Carers we spoke to and feedback from survey expressed concern for the length of wait. Post neuro development diagnosis support was not available to patients unless they had an additional mental health problem. Staff would refer these patients on to voluntary agencies that support children and young people with Autism.

Complaints

- In the financial year to March 2015, the trust received 72 formal written complaints. The highest number of complaints were for community health services for adults (19) and CAMHS (16). The trust executive team told us they were aware the trust does not receive a high number of complaints. They told us that staff are empowered to resolve issues before they escalate and this may be why the number of complaints is low but there was no data to support this.
- The trust told us that information for patients on how to complain was available in all community settings, but our observations did not support this. We did see CYP staff handing out complaint information leaflet during their first visit with contact telephone numbers and that information on how to complain was available to patients and carers in a variety of locations.
- The trust had a complaints policy and a Patient Advice and Liaison Service (PALS). The trust told us there had been 383 PALs contacts in the past 12 months.
- We reviewed four complaints files randomly selected from the previous 12 months. The files were disorganised and not in an auditable format. However,

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

we did note that responses were sent out in a timely manner and complainants were kept informed of progress. Letters of response showed compassion and that the complaint had been taken seriously.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

We have rated the trust as requiring improvement for well led. This is because:

- The trust had governance and quality assurance processes in place however, the operation of systems for governance and quality measurement were inconsistent and not always robust.
- There was no clear strategy for end of life care services.
- Some staff felt their managers engaged well with them, whilst others felt more could be done to actively engage with them, especially from middle management.
- Staff morale across the services we looked at was mixed. Some teams reported very high levels of morale but we were also told that morale within some teams was low.
- CAMHS staff reported they did not feel part of the development of CAMHS services. Several staff said they did not feel that the trust understood what CAMHS did and did not feel part of the trust.

However, we also saw that:

- There is a clear statement of vision and values, driven by quality and embedded in the organisation.
- Some staff
- The trust has a range of effective mechanisms in place to regularly engage with staff and the public.

Our findings

Vision and strategy

- The vision for the trust is to focus on delivering care in a way that keeps people in their own home. Staff were clear on this vision and we saw many examples as to how this is done on a day to day basis.
- The vision is underpinned by a clear set of trust values that were embedded within the organisation and reflected the NHS Constitution. Staff told us that consultation about the trust values was undertaken and that they were encouraged to provide feedback on their views
- The trust recognises that the local health economy is going through a significant change and the long term strategy of the organisation is dependent on the direction of that change. “Future Fit” is the health economy wide programme to redesign health care in the county so that care is delivered as close to home as possible, services are joined up and resources are maximised. The programme is largely acute focused in its initial phase. This left some staff unsure about the future of the organisation.
- The Future Fit programme created uncertainty about the role of the MIUs and this reflected in staffs negative understanding of their role in the trusts strategy.
- There was no overall ongoing vision or strategic overview of end of life care services. The end of life care lead attended the Shropshire wide multi- provider end of life care group. However, no end of life care strategy had been developed or timescales outlined for this to be done.

Governance, risk management and quality measurement

- The trust had a well-established audit committee and quality and safety committee. We heard that exec and non-executive directors had a programme of formal and informal visits to services.
- We noted during interview with a number of trust executives that there was a reliance on individuals providing reassurance. There was an acknowledgement of the need to triangulate the evidence but there was limited evidence as to how some of the executives achieved this. For example, through visiting services.
- Information is communicated up the organisation from operational teams through the trust’s performance dashboard. The dashboard feeds into the trust quality report and operational report which is presented to the board. The board told us they test the data through thematic reviews or “deep dives” which looks at challenging areas such as EOLC or CAMHS.
- The trust had a risk register. This identified the risks to the service. Overall, the trusts management of risk was effective, but we saw individually, some board members less clear on assurance processes.
- We saw in some cases the trust was slow to respond to some key areas of risk. For example:

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

  - There was no clear governance structure for the end of life care service. The trust had no method of categorising incidents and complaints for end of life care to enable a thematic review to take place. There was no risk register specific to the service. This meant opportunities to measure the quality and assess the risks associated with end of life care services were not in place.
  - Staff in the MIU were unclear as to the relationship of board and management governance with their operational work.
  - In the community substance misuse service, the trust did not supply naloxone hydrochloride (a drug that can reverse the effects of opiate overdose for home rescue use. We noted that the manager of Shropshire CSMT had made efforts in July 2015 to roll out a programme of supply under Public Health England guidelines for promoting wider availability. However no program was developed.

- The trust's 'Board Assurance Framework' highlighted nine areas of risk. One risk was rated high-risk, this related to Difficulty in recruiting staff to community hospitals, prisons, CAMHS and ICS.
- The director of nursing had a quality team that looked at specific services/issues that was able to look at specific areas, services or risks identified.
- Monthly meetings with the executive team were spread around the patch; senior managers told us they used these as an opportunity to see the teams and assess what was happening on the ground.

Leadership

- Many staff told us they felt valued and appreciated by their manager. We observed good relationships between managers and staff in many areas we visited. Staff said they felt supported and confident in their roles.
- We received mixed feedback about support from more senior managers; some staff felt middle managers were well engaged in their service and had a grip on the key issues. Other staff said they hardly saw middle managers and felt that they were out of touch.
- The post of MIU clinical lead had been vacant for over 6 months. We saw that the impact of the leadership vacancy in MIU was being felt by operational teams.
- Many staff were positive about the Chief Executive Officer and said she had a strong, clear vision and recognised the positive impact she has had on the culture of the organisation in recent years.

Culture across the provider

- Staff were committed to provide the best care possible for every patient. Staff from all areas of the organisation spoke with passion about their work. We observed staff that were passionate and proud about working within the service and providing good quality care for patients.
- We found staff were hard working, caring and committed to the care and treatment they provided. They demonstrated a strong patient focused culture. Staff across all adult community services were dedicated and compassionate.
- We were told by many staff at different levels within the trust that since the change in senior leadership there had been a positive shift in the culture of the organisation. Staff felt more empowered and more engaged with the trust and had moved away from a culture where there were high levels of centralised control.
- Staff morale across the services we looked at was mixed. Some teams reported very high levels of morale but we were also told that morale within some teams was low due to staff shortages and pressure on services.
- CAMHS staff reported they did not feel part of the development of CAMHS services and had concerns about the future tendering of services. Several staff said they did not feel that the trust understood what CAMHS services did and did not feel part of the trust.

Fit and proper person requirement

- All board members were aware of the principles of the Fit and Proper Person test and were aware of their responsibilities. The trust had a policy in place that was signed off by the trust board in October 2015.
- We reviewed a randomly selected sample of five executive director's personal files in relation to the Fit and Proper Person test. We found all the documentation to be compliant with the regulation.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Public and staff engagement

- Seven-hundred and twenty staff at the trust took part in the 2015 NHS Staff Survey. This is a response rate of 47%, which is average for community trusts in England. The overall engagement score was 3.83, compared to a national average of 3.82. The survey results showed that nine key findings were worse than the national average. These included, quality of appraisals (score of 2.88 compared to 3.05 nationally) and staff satisfied with the opportunities for flexible working patterns (51% compared to 67% nationally). There were also nine Key findings that were better than the national average. These included the proportion of staff
- The trust also carried out its own staff surveys to "temperature check" cultural issues and support good communication between senior managers and staff.
- The trust has programme called 'Our way of Working – Values into Action'. This programme provided structured support to teams and helped them tackle a challenge or explore ideas that will help them work differently.
- The trust used a combination of email, intranet messages and newsletters to engage with community staff. The trust published a weekly staff email newsletter, called 'Inform'. Staff we spoke with were aware of the newsletter and told us it kept them up to date with plans and developments across the trust.
- The trust's chief executive officer (CEO) wrote a weekly 'blog', which was available to all staff. It gave staff information about the CEO's activities, both at work and in their personal life, during the week. Staff we spoke to told us it was a good thing and it made the CEO more approachable.
- The trust had a monthly team brief. Staff told us that the team brief provided a summary of important events, policy updates and other occurrences within the trust.
- The trust had a 'patient and carer panel' (PCP) which met regularly throughout the year. The PCP was involved in planning services, staff recruitment, delivering training and reviewing services. The meetings took place with over 30 people attending, including some board members. Patients, volunteers and other key health and social care stakeholders were represented. A regular newsletter was produced, updating staff and patient on recent activities and developments.
- CQC held six staff focus groups to engage staff in their views of working for the trust before the inspection began. These were held at various locations and times to allow staff to attend. These were widely advertised. Across all six meetings, 20 members of staff attended from a trust staff base of around 1,600.
- Volunteers brought a range of skills and life experiences to the community hospitals including taking drinks trolleys on to the wards, managing the dementia café and being available to support patient's with advice. The trust had developed a volunteer handbook that volunteers co-designed to understand the role they may undertake.

Innovation, improvement and sustainability

- We saw a range of innovative practice in the community hospitals in relation to care for patients living with dementia and patient safety.
- The use of telemedicine within the tissue viability service addressed some challenges of working within a large and rural county whilst promoting effective patient wound healing.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Effective handover between nursing teams did not consistently take place, this did not enable staff to share key information about patient care in a systematic and safe way. • Arrangements to enable quick identification of a deteriorating patient especially children in the MIUs were not consistently in place across all four MIUs.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • Governance systems and processes were not sufficiently established and operated to enable the trust to assess, monitor and improve the quality and safety of end of life care services. • The trust did not have an overall vision and strategy for end of life care. • The approach to identifying and managing risk across the MIU's was inconsistent.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing • Staffing and skill mix levels within each community nursing team were not reviewed systematically and at regular intervals to ensure that patients' needs were met and there was sufficient capacity for staff supervision, training, team meetings and staff handovers.

This section is primarily information for the provider

Requirement notices

- Staffing levels and skill mix in the MIUs were not reviewed systematically and at regular intervals to ensure sufficiently skilled numbers of staff were on duty at all times in order to meet the needs of the service.
- There were insufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people using the service. In particular, within the CAMHS learning disability team and tier 2 staffing.
- Increased patient acuity in the community hospitals was not considered when staffing levels were planned so patients requiring support and assistance did not always receive this appropriately.

Shropshire Community Health NHS Trust

R1D

End of life care

Quality Report

Shropshire Community Health NHS Trust
William Farr House
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SY3 8XL
Tel: 01743 277500
Website: www.shropscommunityhealth.nhs.uk

Date of inspection visit: March 2016
Date of publication: This is auto-populated when the report is published

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1DHQ	Shropshire Community Health NHS Trust - HQ	End of life care	SY3 8XL
R1D25	Bishop's Castle Community Hospital	End of life care	SY9 5AJ
R1D22	Bridgnorth Community Hospital	End of life care	WV16 4EU

This report describes our judgement of the quality of care provided within this core service by Shropshire Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Shropshire Community Health NHS Trust and these are brought together to inform our overall judgement of Shropshire Community Health NHS Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Inadequate

Summary of findings

Contents

Summary of findings

Overall summary

We have rated this service overall as requiring improvement. This is because:

- Systems or processes were not sufficiently established and operated to effectively ensure the trust was able to assess, monitor and improve the quality and safety of end of life care.
- There was no risk register specific to end of life care.
- There was no method of categorising end of life care incidents and complaints to monitor themes and share learning.
- On some prescription charts, guidelines stating the limits to frequency of dosages of anticipatory medicines were not always present.
- Plans did not provide sufficient information to identify the personal wishes and preferences of patients and their families.There was a lack of assessments of patient's cultural, spiritual and emotional needs.
- There was no structured end of life care training plan or register of training to ascertain the skills of staff in different roles and teams. The trust had implemented the end of life care plan prior to ensuring sufficient numbers of staff had received training on how to use it.

However we also saw that:

- End of life care provision was caring and responsive to patients' individual needs and requirements. Relatives told us how good the care was and that staff were kind, compassionate, caring and considered the patient's dignity.

Summary of findings

Background to the service

End of life care encompasses all care given to patients who are approaching the end of their life and following death. It includes nursing care, specialist palliative care, bereavement support, and mortuary services. The definition of end of life includes patients who are approaching the end of life when they are likely to die within the next twelve months.

There is no specific palliative care team within the trust. End of life care was provided within community hospitals and by community nurses, physiotherapists and occupational therapists within patient's own homes. Specialist palliative care services were provided by two hospices within Shropshire; however these were not included in this inspection.

Shropshire Community Health NHS Trust provides a range of community-based health services for adults and children in Shropshire and Telford and Wrekin, and some services to people in surrounding areas, covering a geographical area of 1,346 square miles.

During this inspection we reviewed 30 sets of patient notes and spoke with seven relatives and 19 staff including district nurses, community matrons, occupational therapists and staff nurses.

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including: Community matrons; physiotherapists; occupational therapists; senior community nurses; community children's nurses; school nurses; health visitors; consultant clinical psychologist; palliative care consultant; nurse practitioner; head of quality; deputy director of nursing; palliative care nurse; substance misuse consultant, substance misuse nurse, CAMHS practitioner.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Summary of findings

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 7 to 11 March 2016.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a very defined period of time, however we did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, a number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held six focus groups with a range of staff across Shropshire who worked within the service. Around 20 staff attended those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

Relatives of end of life patients spoke very highly of the staff and the service they had received. Comments included, “I am confident she will be looked after when I'm not with her,” “Very gentle and caring,” and “Always treated with dignity and respect.”

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that governance systems and processes are sufficiently established and operated to so that they canassess, monitor and improve the quality and safety of end of life care services.
- The trust must establish and implement systems to assess, monitor and improve the quality and safety of the end of life care service, including a risk register.
- The trust must develop and implement an overall vision and strategy for end of life care.

Action the provider SHOULD take to improve

- The trust should ensure that end of life care plans provide sufficient information to identify the personal wishes and preferences of patients and their families.
- The trust should ensure that all eligible patients are place on the End of Life Care Plan, that staff have been trained in its use and compliance with the plan is regularly monitored.

Shropshire Community Health NHS Trust

End of life care

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as requiring improvement for safe. This is because:

- The trust did not have a method of categorising end of life care incidents to enable themes to be reviewed and specific learning from end of life incidents to be shared and services improved.
- Guidelines stating the limits to frequency of dosages of anticipatory medicines were not always present.
- The service did not have systems to ensure that staff regularly checked and documented fridge temperatures at mortuaries across all of the community hospitals.

However we also saw that:

- Care records were completed to a good standard and were accurate, legible, up to date and stored securely.
- The service had effective safeguarding and infection control procedures.
- There were sufficient staff to meet the needs of end of life care patients.

Incident reporting, learning and improvement

- Staff we talked with across the trust, community hospitals and community nurses knew how to report incidents using the reporting system. They received feedback from their line manager regarding incidents they had reported. If there was some learning involved for the individual this was not always shared across the teams. We did not find any evidence of shared learning from incidents across the organisation.
- The trust reported a total of 1,715 incidents between 1 December 2014 and 31 November 2015, 26 were classified as serious incidents. None of these incidents were attributable to End of Life Care services as the trust did not have a method of categorising end of life care incidents to enable themes to be reviewed and specific learning from end of life care incidents to be shared. The trust was unable to provide us with the number of end of life care incidents within the last 12 months. The trust response was, “Until recently concerns or incidents relating to end of life were not specifically identified by including a data field to indicate the concern or incident was specific to end of life care. Since including the data field no incidents have been reported.”

Requires improvement

Are services safe?

Safeguarding

- Staff we spoke with were knowledgeable about their role and responsibilities to safeguard vulnerable adults and children from abuse and they understood what processes to follow.
- Staff were aware of how to access the safeguarding policy on the trust intranet and were given support by the safeguarding lead.
- There was no specific palliative care team. End of life care was provided by staff within the community hospitals and by district nurses, physiotherapists, occupational therapists and community matrons within the community. Trust wide data demonstrated that 96% of staff had completed adult safeguarding training to level 1 and 99% of staff had completed children's safeguarding to level 1.

Medicines

- The end of life care lead nurse told us that guidance was available for staff to prescribe appropriate end of life medicines to manage patients' pain and other symptoms in line with national guidance and best practice. The trust used the West Midlands Symptom Management Guidelines. Two district nurses showed us their copies of these guidelines. However they were the 2007 version, which had been superseded by the 2012 version. At Bridgnorth community hospital, staff showed us the 2003 version of these guidelines. These out of date guidelines were immediately removed (on our request) and we guided them to their own guidelines.
- GPs prescribed medication for patients cared for in their own homes. Each community hospital had GPs allocated to them to prescribe medication for inpatients.
- Anticipatory medicines are an important aspect of end of life care; they are prescribed drugs in order to control symptoms such as nausea and pain. In three prescription charts out of 16 we reviewed, we saw that anticipatory medicines had been prescribed for pain, nausea, chest secretions and agitation but not for shortness of breath which ideally should be included. On two other prescription charts, there was no guidance provided stating the limits to frequency of dosages of anticipatory medicines.
- The syringe pump policy was out of date (dated 12 November 2012, due for review October 2015.) A syringe pump is a small infusion pump, used to gradually administer small amounts of fluid to a patient. This meant we could not be assured staff were following the most up-to-date guidelines.
- The trust had completed a retrospective audit of end of life care in the community teams and hospital inpatient wards in February 2016.The audit assessed compliance with the standards in, "One Chance to Get It Right" Department of Health 2015 and "Priorities for The Care of the Dying Person" as set out by the Leadership Alliance for the Care of Dying People. Results for prescriptions of 'as required medication' for the five key symptoms were: pain 83% compliance, agitation 80%, respiratory secretions 74%, nausea/vomiting 74% and shortness of breath 48% compliance.
- Staff on the wards we visited told us they routinely kept stocks of palliative care medicines both to treat symptoms and for pain relief. 'Just in case boxes' containing anticipatory medicines were kept in patients homes once they were identified as at the end of their life. Staff on the wards we visited told us they routinely kept stocks of palliative care medicines both to treat symptoms and for pain relief.

Environment and equipment

- During 2011, the National Patient Safety Agency mandated that all Graseby drivers (a device for delivering medicines by continuous infusion) should be withdrawn by 2015.The McKinley T34 syringe driver had been introduced into the trust and the Graseby pumps discontinued. Staff told us that syringe driver training was mandatory for all new employees. This was confirmed by the trust policy which also states annual updates are also required. The trust was unable to give us the number of staff trained on syringe drivers stating that this training information was held locally within individual teams.
- Nursing staff in the community told us that there were no issues with ordering or obtaining equipment promptly for patients who were receiving end of life care. Three relatives confirmed that all equipment had been supplied in a timely manner.This included pressure relieving mattresses for patients with a risk of developing pressure sores. However, we saw from one

patient's records that it took five days to obtain a pressure relieving mattress by which time the patient had developed a pressure sore. Another record showed that a bed and mattress took seven days to arrive by which time the patient had died.

- There was a mortuary situated at each community hospital we visited. The mortuary policy was out of date (dated 23rd of January 2009 due for review 22nd of January 2012.)We were informed that there was a weekly check of the mortuary at Bridgnorth Community Hospital by the Estates Department including fridge temperatures. Staff said porters usually checked the temperature of the fridge on a daily basis but there were no logs of these checks maintained. Staff told us that fridge temperatures checks had not taken place at Bishops Castle Community Hospital mortuary. When a body is preserved though refrigeration, at the correct temperature, between 2 to 4°, this sufficiently delays decomposition. The temperature control mechanism in the mortuary at Bridgnorth did not have an audible alarm to indicate if the fridge temperature was out of range.

Quality of records

- We reviewed 28 sets of community notes of patients who had died in the last 12 months and two sets of inpatient notes. Of these, ten patients had had district nurse involvement at the end of their lives. We saw that staff had generally completed them to a good standard and most of the records were accurate, legible, up to date and stored securely. Records showed that risk assessments of patients' nutrition, mobility and skin integrity had been regularly reviewed. All the records were legible and stored securely in locked cupboards at the district nurse bases.
- One of the inpatients had been put on the 'End of Life Care Plan' but sections were poorly completed. Two out of the 26 records we reviewed were not signed appropriately.
- The trust's end of life care audit in February 2016 showed that 31% of dying patients (those diagnosed as having only a few hours or days to live) had been put on the End of Life care plan and that there was poor compliance with the plan when they were in place. However, there was documented evidence of discussions with the patient and family/carers in regard to 'do not attempt resuscitation' (DNACPR), this was 80% compliant.

Cleanliness, infection control and hygiene

- There were infection prevention and control systems in place to keep patients safe. The ward areas we visited were visibly clean. There was sufficient provision of personal protective equipment such as gloves and aprons and hand gel and hand washing facilities were available. There were enough single rooms to protect people who were more susceptible to infection and to protect others.
- During a visit with community staff to a patient's home we witnessed good hand hygiene and the use of personal protective equipment, such as disposable gloves and aprons when administering care to a patient.
- Staff followed the bare below the elbow policy in both community hospitals and within patient's own homes.

Mandatory training

- There was no specific palliative care team. End of life care was provided by staff within the community hospitals and by district nurses, physiotherapists, occupational therapists and community matrons within the community. The trust provided records of mandatory training showing an average training compliance across the trust of 85% against an 85% trust target as at February 2016.
- Training on the new End of Life Care Plan was not mandatory.

Assessing and responding to patient risk

- Patient's records incorporated regular assessments of patients' needs to minimise risks and maximise symptom control. We saw that patients had been regularly reviewed.
- There was a 24-hour advice line for professionals to access out of hours. The advice was given by specialist palliative care nurses or palliative care consultants based at the local hospice.
- Staff told us they would call a 999 emergency ambulance for critical emergencies. If patients required

urgent but not critical treatment, staff accessed the GP who was responsible for the community hospital or caring for the patient at home. Out of hours staff contacted Shropdoc (the out of hours GP service.)

Staffing levels and caseload

- End of life care was provided by staff within the community hospitals and also by community nurses, physiotherapists and occupational therapists across the county. The district nursing service worked between 8 am to 6 pm, seven days a week. In the Telford and Wrekin areas a rapid response team worked between 6 pm to 10 pm. In the rest of Shropshire, an out of hours service, delivered by another provider, operated with one nurse covering the whole of the county between 7pm and midnight and one doctor between midnight and 8 am. This left a gap of one hour between 6pm and 7pm with no cover. The trust relied on the goodwill of the district nurses to cover this gap. However, staff told us they always prioritised end of life care patients to ensure their needs were met.
- District nurses were also able to refer patients to the hospice at home service which could provide assistance up to four nights a week.

Managing anticipated risks

- The trust had a winter management plan incorporated in their business continuity plan to ensure end of life care patients received a safe and appropriate level of service in adverse weather conditions. Staff gave us examples of actions taken during previous severe weather episodes: rostering staff with 4x4 vehicles during snow conditions, a service level agreement with the out of hours doctor service to provide or use the 4x4 vehicle during snow conditions and prioritisation of nursing workload to ensure availability of nurses with the appropriate skills to manage palliative care patients.

Major Incidents

- Staff had access to the major incident plan (dated November 2015) via the trust intranet and received training on this during their induction.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We have rated this service as requires improvement for effective. This is because**:**

- An End of Life Care Plan had been implemented across the trust. A recent audit showed that 31% of eligible patients (expected to die in next few hours or days) had been put on the plan and there was poor compliance with their use when they were in place. An action plan had been developed in response to the end of life care audit.
- Care plans did not provide effective information to identify the personal wishes and preferences of patients and their families. There was a lack of assessments of patients' cultural, spiritual and emotional needs.
- There was a lack of knowledge and use of Advance Care Planning for patients in the last 12 months of their life.
- There was no structured end of life care training plan or register of training to ascertain the skills of staff in different roles and teams. The End of Life Care Plan had been implemented prior to ensuring sufficient numbers of staff had received training on how to use it.

However:

- We found that patient's pain and symptom control was well managed.
- Staff had a good understanding of consent in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence based care and treatment

- A Shropshire wide, whole health economy end of life care group had been formed with representation from the local hospices, the two clinical commissioning groups (CCG's), the children's hospice, the acute trust and the community trust. The end of life care lead attended these meetings. This group was planning the end of life care strategy for Shropshire based on, "Ambitions for Palliative and End of Life Care. A national framework for local action 2015 – 2020."However, there were no timescales defined for the strategy to be developed. The end of life care lead was not clear whether any terms of reference existed for this group. Minutes of these meetings indicated ongoing planning of the EOLC strategy.
- This group had developed an, 'End of Life Care Plan' to replace the Liverpool Care Pathway. However, the trust's end of life care audit showed that 31% of eligible patients had been put on the End of Life care plan and that there was poor compliance with its use when they were in place.
- We looked at 28 care plans and saw they were mainly task focused rather than focusing on individualised, holistic assessments and plans. They did not contain enough information to identify the personal wishes and preferences of patients and their families. There was a lack of assessment of patients' emotional, spiritual and cultural needs.
- End of life care within the trust was focused on the recognition of patients who might be approaching the last few days and hours of life. However, the Department of Health's end of life care strategy (2008) and NICE quality standards for end of life care (2011) included recognition of end of life care for patients with advanced, progressive, incurable conditions thought to be approaching the last year of life. Clinical staff on the wards we visited did not demonstrate an understanding that end of life could cover an extended period, or that patients might have benefited from early discussions and care planning.
- The End of Life Care Plan had been implemented across the trust prior to ensuring that sufficient numbers of staff had received training on how to use it. The plan stipulated that a doctor must initiate the End of Life Care Plan. However, we found instances within the community and the community hospitals where nurses had implemented the plan. There was confusion regarding this amongst nursing staff who told us they were informed they could initiate the plan during their training on the End of Life Care Plan.

Requires improvement

Are services effective?

- Advance care planning (ACP) is a nationally recognised means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place in the manner of their choosing.Although staff we spoke with were aware of ACP, the end of life care lead told us that currently there was no training for staff on ACP and we did not see any evidence of its use.

Pain relief

- Patients identified as needing end of life care were prescribed anticipatory medicines. These 'as required medicines' were prescribed in advance to properly manage any changes in patients' pain or symptoms. We saw that these medicines had been administered appropriately.
- Palliative medicines (which can alleviate pain and symptoms associated with end of life) were available at all times. Ward and community nurses had adequate supplies of syringe drivers (devices for delivering pain medicines continuously under the skin) and medicines to be used with them.
- We did not see any use of pain assessment tools within patient's records we reviewed. This meant that we could not be assured that patient's pain was assessed and controlled in a consistent way. However, relatives of end of life care patients told us that staff had controlled their loved one's pain to ensure they were as comfortable as possible.

Nutrition and hydration

- The trust's end of life care audit reviewed records in relation to assessment and appropriate responses to issues around hydration and nutrition with 86% compliance. Clinically assisted hydration and nutrition had 11% compliance and evidence of ongoing review and assessment 77% compliance (within the community nursing teams) In the community hospital inpatient wards the results were 76%, 57% and 86% respectively.
- Records we reviewed did not show that staff conducted in-depth assessments or regular reviews of patients' nutritional and hydration needs.
- If patients were recognised as in need of rehydration, nursing staff within the hospitals and the community were able to provide subcutaneous fluids to help the patient absorb fluids.
- Staff had access to an up to date policy (dated January 2016) on administration of subcutaneous fluids to ensure they were following the most up-to-date guidance.
- The end of life care lead acknowledged that more staff training was required in relation to nutrition and hydration.

Patient outcomes

- The trust did not have a process of measuring outcomes for patients against their preferred place of death.
- The trust's end of life care audit concluded that there was good evidence of care provision in the records they reviewed but that this would have been improved by the consistent and full use of the End of Life Plan across all teams and settings.Even when the plan was in place there was poor documentation in relation to spiritual needs and discussions about these. A basic action plan had been developed in response to the audit. These actions included to roll out the end of life plan across all teams, disseminate the results of the audit to teams and to conduct a re-audit. However, there was no clear strategy as to how this was to be achieved other than to use the end of life care operational group to drive this forward.
- We observed care being delivered in the community. We saw staff made every effort to ensure that people's needs were met, including medicines being delivered, equipment being provided and support for relatives being put in place.

Competent staff

- There was no structured, end of life care training plan. Staff were able to access courses on end of life care provided by the local hospices. However, there was no register of training to ascertain the skills of staff within different roles and teams. The end of life care lead told us that they had trained 350 staff on the End of Life Care Plan. However, they had no method of knowing the percentage of staff trained within different teams to ascertain future training needs or whether it was safe to use the plan within teams.

Requires improvement

Are services effective?

Multi-disciplinary working and coordinated care pathways

- As there was no specific palliative care team within the trust, specialist services were provided by two hospices within the Shropshire area. Records demonstrated and relatives of patients confirmed that there had been effective multidisciplinary team working between district nurses, occupational therapists, physiotherapists and hospice at home service when providing care.
- District nurses attended meetings at GP surgeries to discuss the ongoing needs of patients. MacMillan nurses, the hospital outreach team and community matrons also attended these meetings.

Referral, transfer, discharge and transition

- Access to all inpatient beds or community nurses for all patients across Shropshire was managed by a single point of access. GPs made direct referrals (via this system) to the district nursing teams. The community hospitals received referrals from GPs or the acute hospitals.
- All the trust community hospitals stated they provided end of life care but there were no designated end of life care beds.
- Some patients at the end of their life were identified and fast tracked for discharge if they wished to transfer their care to their home or to an alternative service. One bereaved relative told us that their loved one was discharged to die in their own home at their request with speed, and with all the appropriate equipment care and support needed.
- Staff told us that there were sometimes delays due to trying to access care packages for patients. The trust did not monitor how quickly rapid discharges were completed. Responding to patient's choice for their preferred place of care is part of national best practice guidance.

Access to information

- Community staff had access to patients' risk assessments and care plans as these records were left in individual patient's homes and inpatient staff had access to both nursing and medical records within the community hospitals. This meant care and treatment could be planned and delivered in a timely way.
- The district nurses notified the out of hours services of any patients that were at the end of their life. This meant that a red flag would come up on the out of hours computer screen to alert them if the patient or family contacted them.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- Nursing staff were knowledgeable about processes to follow if a patient's ability to give informed consent to care and treatment was in doubt. Staff demonstrated a good understanding of consent in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards. We observed community staff gaining informed consent appropriately prior to carrying out any procedures during a home visit.
- We reviewed seven do not attempt cardio pulmonary resuscitation (DNA CPR) forms and found five out of seven were completed accurately. Of the two forms which were not completed correctly, One form had the 'capacity' box ticked as "no" with an explanation of, "Capacity not assessed due to deafness." The 'Summary of communication with relatives section' stated "None today". Another form had the sections on 'communication with patient' and 'evidence of discussion with family' left blank.This meant that we could not be assured that all patients were having their capacity to consent appropriately assessed prior to decisions being made. 'Deafness' does not indicate lack of mental capacity.
- The trust end of life care audit reviewed DNA CPR forms to ensure there had been evidence of discussion with the patient and family in relation to DNA CPR and that there was an appropriate form was present in the patient records. The community hospital inpatient wards 100% compliance.
- The trust informed us that there was currently a DNA CPR audit taking place across the trust.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We have rated this service as good for caring. This is because:

- Relatives spoke very highly of the staff saying they were caring, gentle and always treated people with dignity and respect.
- Relatives said they were kept fully informed and were involved in decisions about care.
- Staff provided emotional support to patients and their families. One relative said, “They have shown kindness and care to all of the family.”

Compassionate care

- Six relatives of patients spoke very highly of the staff and the service that their loved ones had received.
- They said staff were very caring and gentle and always treated people with dignity and respect.
- Ward staff told us that, whenever possible, end of life patients were nursed in side rooms to preserve dignity and privacy for them and those visiting them.
- We observed that nurses were attentive to an end of life care patient, nursed in a side room and responded quickly when they were in pain.
- One relative told us, “Happy, kind, caring staff who are respectful and make me feel very welcome.”Another relative said, “They have shown kindness and care to all of the family.”
- The Friends and Family test results for community inpatient services (November 2015) showed very positive feedback with 100% of responders extremely likely/likely to recommend the trust.

Understanding and involvement of patients and those close to them

- Patients and those close to them were involved with their care.Relatives told us that they had been consulted about decisions and understood what was happening and why.One family member had been invited to a multidisciplinary meeting with staff to discuss future care needs for their relative.
- Relatives and partners said that staff kept them fully informed of their loved ones condition and any changes to their care.One relative explained that when they had had to leave and their mother had been unsettled, the staff nurse had taken the time to phone them at home to confirm that she had now settled.
- One relative told us that the nurses explained what they were doing and that the GP had gone through the End of Life Care Plan with them.They said, “I have read the End of Life Care Plan and totally agree with it.”

Emotional support

- All the relatives we spoke with said that staff had been very supportive and understanding. Chaplains are attached to each community hospital.
- One relative told us, “The staff also give me great emotional support.”
- Another relative explained how the district nurse and hospice nurse had visited them, to provide support, following the death of their loved one.
- District nurses told us that, where possible, they tried to double up on end of life care visits to enable one nurse to manage the physical needs of the patient and the other nurse to provide emotional support to the patient and their family.
- Staff told us that there were no chaplains attached to the community hospitals.However, they had good relationships with local clergy who were willing to come in and see patients.
- We reviewed 14 thank you cards sent to the community teams which all contained very positive feedback. Comments included: “Comforting that you were calling in every day,” and “Thank you for your kindness, compassion and love.”

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We have rated this service as good for responsive. This is because:

- The trust engaged with the wider health economy in planning and coordinating end of life care services.
- Arrangements were in place for services to respond to the additional needs of vulnerable people or people from minority groups.
- A rapid discharge system was in place to enable patients to die at home. We saw staff made every effort to ensure that patient's needs were met, including medicines being delivered, equipment being provided and support for relatives being put in place. District nursing services were responsive to end of life care patients.
- Facilities and arrangements were in place in the community hospitals for relatives wishing to stay overnight. This included recliner chairs, pull-down beds, en-suite facilities and an area where relatives could prepare drinks for themselves.

Planning and delivering services which meet people's needs

- The end of life care lead attended the Shropshire whole health economy end of life care group to plan a strategy for end of life care based on evidence-based practice.
- The trust did not currently have their own bereavement information leaflets but used those supplied by Age UK. They were planning on gaining feedback from a patient group, to ascertain what information they should include when developing end of life care and bereavement information leaflets.
- Staff in the community hospitals facilitated rapid discharge to enable patients to return home if they wished to die there.One relative told us, "All in all I couldn't speak more highly of the whole team, they were wonderful and my partner got their wish to die at home."
- We saw an example in a patient's records where the rapid response team cared for a complex, distressed, dying patient, enabling them to die at home.They stayed with the patient for four hours providing symptom control and support to the family.
- A palliative care suite had been developed at Bishops Castle community hospital.This consisted of a room adjacent to a relative's room which had ensuite facilities.Reclining chairs were available if relatives wished to stay overnight.Tea and coffee facilities were also available.There was a small landscaped garden with seating area which relatives could access.

Equality and diversity

- Translation services were available for patients at the end of life and their relatives.
- The community hospitals we visited had good access for disabled patients and had disabled toilet facilities.
- Staff treated patients with the utmost respect regardless of their race, religion and sexual orientation. Relatives confirmed that they and their loved ones were shown dignity and compassion throughout their care.

Meeting the needs of people in vulnerable circumstances

- A learning disabilities trained nurse from the hospice had developed easy read materials for patients with learning disabilities and training for staff.They attended both the health economy wide end of life care and the operational end of life meetings to share best practice in relation to caring for patients with learning disabilities.
- The trust employed three Admiral Nurses who were qualified in mental health to support patients living with dementia.However, due to commissioning arrangements, they only covered the Telford/Wrekin area of the county and the remainder of Shropshire had no access to these nurses.

Good

Are services responsive to people's needs?

Access to the right care at the right time

- The trust did not monitor how rapidly patients were discharged from inpatient services if they wished to be cared for at home or how many patients achieved their goal of dying in their preferred place.
- Community staff told us that end of life patients were always prioritised within their workload to ensure they received a timely and appropriate service.
- Community nurses told us they responded to 'urgent' referrals within 24 hours and non-urgent referrals within 48 hours. Information provided by the trust identified 99% of urgent referrals were seen within 24 hours, against a target of 100% and 99% of non-urgent referrals were seen within 48 hours, also against a target of 100%.

Learning from complaints and concerns

- The trust had no method of categorising or monitoring complaints for end of life care to enable a thematic review to take place.This meant that trust wide learning from complaints was not possible to improve the quality of care.
- Community and inpatient staff that we spoke with told us they had not received any complaints in relation to end of life care.
- We did not see posters or leaflets displayed on how to make a complaint within any of the community hospitals.

Inadequate

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We have rated this service as inadequate for well-led. This is because:

- Systems or processes were not sufficiently established and operated to effectively ensure the trust was able to assess, monitor and improve the quality and safety of the end of life care service.
- There was no overall vision or strategic overview of end of life care.
- There was no clear governance structure for end of life care.
- There was no risk register specific to end of life care. There was no method of categorising end of life care incidents and complaints to monitor themes and share learning.

Service vision and strategy

- There was no overall ongoing vision or strategic overview of the service. The end of life care lead attended the Shropshire wide multi-provider end of life care group. However, no trust wide end of life care strategy had been developed or timescales outlined for this to be done.
- The end of life care lead had recently developed an end of life care operational group, (within the last few months), with representatives from the district nursing teams and community hospitals. The aim was that the end of life care link nurses would disseminate best practice back to their individual teams. Staff confirmed that they had attended these meetings and were feeding back to their teams. However, not all teams had assigned a representative or were aware of the group.

Governance, risk management and quality measurement

- Systems or processes were not sufficiently established and operated to effectively ensure the trust was able to assess, monitor and improve the quality and safety of the end of life care service.
- There was no clear governance structure for the end of life care service. The end of life care lead had developed an end of life care operational group with representatives from the district nursing teams and community hospitals. The aim of this group was to discuss the recent audits of end of life care, NICE guidelines, any actions from the Shropshire wide group and develop and improve the end of life care service. However, this group did not feed into any other quality structures within the trust.
- The Director of Nursing (DoN) informed us that their role included the remit for the executive lead for end of life care. There was also a non-executive lead for end of life care. The DoN stated that the end of life care operational group was the strategy group which reported to the quality and safety committee and from there to the board. However, the end of life care lead was unaware of this structure or that the DoN was the executive lead for end of life care. Minutes of the quality and safety committee between November 2015 and January 2016 did not reflect any reports on end of life care discussed. The only reference to end of life care was within the January 2016 minutes which stated that end of life care had been highlighted as a potential priority to be put on the trust's quality account.
- The trust had no method of categorising incidents and complaints for end of life care to enable a thematic review to take place. This meant that learning from end of life care incidents and complaints was not happening to improve the quality of service.
- There was no risk register specific to end of life care. The community health service divisional register stated, “End of Life Pathway not fully embedded across local health economy.” There was a rudimentary action plan in relation to the end of life care audit. Actions include: to roll out the End of Life Plan across all teams and ensure consistent use and to disseminate the results of the audit to all teams. However, there was no specific

strategy or plan as to how this would be achieved or performance managed. There was no trust wide policy or guidance on how the End of Life Care Plan would be implemented across the trust.

- The Shropshire wide providers (including the acute trusts, hospices, CCG's and community trust) had agreed to implement the End of Life Care Plan. However, staff told us that some GPs were refusing to use the plan. The end of life care lead had asked the community nurses to report when this occurred through the incident reporting system. They were then planning to report back to the clinical commissioning groups to improve compliance with use of the End of Life Plan. This issue was not on any risk register to ensure senior management oversight and monitoring of the risk.

Leadership of this service

- The end of life care lead was committed to improve the end of life care service and had gained quite a high profile across the trust for their end of life care role in the year they had been in post. However, they had no designated time dedicated to end of life care within their role as an adult consultant nurse.
- Most of the community and inpatient staff were aware of the operational end of life care group and some teams had representatives who fed back on issues relating to end of life care. However, none of the staff we spoke with knew that the DoN was the executive lead for end of life care.

Culture within this service

- Staff we spoke with in the community hospitals and in the community were committed to providing high quality end of life care.
- Staff told us they worked in very supportive teams where they learned from each other. They conducted peer debriefs when patients died to provide support for each other.
- District nurses were able to describe good lone working practices to ensure staff safety and had access to the loan working policy on their intranet.

Public and staff engagement

- There was no survey for relatives in relation to end of life care.
- The end of life care lead told us that they would like to conduct a survey of recently bereaved relatives.They had contacted the local hospice to see if there were any existing patient groups to find out what information they would like and to find the best method of gaining feedback from the recently bereaved.
- The results of the end of life care audit had been sent to the DoN, commissioners and individual teams within the community and community hospitals.
- There was a consultation before the End of Life Care Plan was finalised, with staff and a patient panel. The plan was revised as a result of feedback.
- The end of life care operational group had been formed to share best practice relating to end of life care and disseminate learning amongst individual teams.

Innovation, improvement and sustainability

- The end of life care lead acknowledged that improvements were required to governance and staff training to improve the consistency and quality of the implementation of the End of Life Care Plan.

Shropshire Community Health NHS Trust

R1D

Community health services for adults

Quality Report

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Date of inspection visit: March 2016
Date of publication: This is auto-populated when the report is published

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1DHQ	Shropshire Community Health NHS Trust – HQ	**Community health services for adults**	SY3 8XL
R1D22	Bridgnorth Community Hospital	**Community health services for adults**	WV16 4EU
R1D21	Ludlow Community Hospital	**Community health services for adults**	SY8 1QX
R1DX5	Oswestry Health Centre	**Community health services for adults**	SY11 1GA

This report describes our judgement of the quality of care provided within this core service by Shropshire Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Shropshire Community Health NHS Trust and these are brought together to inform our overall judgement of Shropshire Community Health NHS Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Summary of findings

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Summary of findings

Overall summary

We have rated this service as requires improvement. This is because:

- Staffing levels were below establishment and capacity to meet demand was stretched. Staff availability to meet patients' visits was a challenge. This also meant that there was not always sufficient time for handover and team meetings, and staff were not always able to share information in a systematic and safe way.
- There was inconsistent information regarding the outcomes for people who use services, data was collected but not regularly collated and analysed.
- Staff were supported to maintain and develop skills but accessing training could be problematic due to funding and work pressure issues. Staff did not have access to timely and meaningful clinical supervision.
- There was a lack of consistency in staff's understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- The vision and strategy was not clear to some staff and they were unable to see their role in the future development of the service. Governance systems and processes were in place, including recording of risks but not all risks were identified or had action taken to mitigate them.
- Staff told us they felt supported at a local level but team leaders felt less well supported and some teams described working in isolation. Staff were passionate about the service they delivered but were concerned that resources were stretched and this was impacting on staff morale.

However we also saw that:

- Staff treated patients with kindness, dignity and respect. Feedback from people using services was positive and staff helped patients and those close to them to cope emotionally with their care and treatment.
- Staff understood their responsibilities to raise concerns and report incidents and staff told us they received feedback, safeguarding was embedded in the service and medicines were stored, managed and administered appropriately and safely. Records were complete and up to date and maintained to a good standard.
- Care and treatment was planned and delivered in line with current evidence based guidance.
- There was effective use of telemedicine, enabling staff to support patients who wished to remain at home.
- We saw good examples of multidisciplinary working across teams and sectors.
- Services were planned and delivered in a way that met the needs of the local population. Patients were able to access care in a timely way, waiting times for appointments and treatment were managed appropriately.
- The values for the service were well developed and encompassed compassion, respect and dignity.

Summary of findings

Background to the service

Shropshire Community Health NHS Trust provides a range of community-based health services to approximately 306,100 people in a geographical area of 1,346 square miles, covering Shropshire, Telford and Wrekin and surrounding areas.

There were eight community interdisciplinary teams (six in Shropshire and two within Telford and Wrekin), five integrated community services (Shrewsbury, Whitchurch, Oswestry, Bridgnorth and Ludlow), one community neurology team (Shrewsbury), three 'diagnostics and access to assessment rehabilitation teams' (DAART) (Shrewsbury, Oswestry and Bridgnorth). A team of Admiral Nurses based in Telford provided dedicated, specialist support to patients living with dementia and to their families. The trust also provides a range of other specialist services such as Enablement and Falls Prevention.

There were 21,723 new patient referrals to community nursing (Interdisciplinary teams) within Shropshire Community Health NHS Trust between 1 February 2015 and 29 February 2016.

For adult community services, we inspected the regulated activities across a number of locations and community nursing teams. We inspected services the trust provided in people's own homes, residential homes and within clinics. We spoke with 78 patients, 27 carers and relatives, and 117 staff across a range of roles within the trust. We looked at 53 sets of patient records.

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including: Community matrons; physiotherapists; occupational therapists; senior community nurses; community children's nurses; school nurses; health visitors; consultant clinical psychologist; palliative care consultant; nurse practitioner; head of quality; deputy director of nursing; palliative care nurse; substance misuse consultant, substance misuse nurse, CAMHS practitioner.

The team also included other experts called Experts by Experience as members of the inspection team. These people had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 7 to 11 March 2016.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a defined period, however we did contact

Summary of findings

Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, a number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis. We also met with service managers and leaders, and clinical staff of all grades.

Before the visit, we held six focus groups with a range of staff across Shropshire who worked within the service. Around 20 staff attended those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how staff cared for people, talked with carers and/or family members, and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

How we carried out this inspection

What people who use the provider say

One patient said the trust's staff were a "Highly commended team, they are all so good to me". They also said, "They will always phone if they unable to visit or they are going to be late."

One relative said, "All the team are very good and they ask about both of our health".

"I previously had had numerous admissions to hospital each year. However, since the community matron has seen me I have had just two admissions in 2015".

"The care is wonderful".

One relative said, "This service is amazing. I could not have got through the last six months without it".

Good practice

Photographs of pressure ulcer and skin damage were reviewed which enabled the tissue viability nurses to provide timely advice on required treatment to prevent further harm to the patient.

The tissue viability service had demonstrated that changes to two layer compression bandaging did not compromise wound healing, gave increased patient comfort and provided cost savings to the trust.

The diabetes patient education programme provided excellent patient outcomes for the management of their diabetes.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must develop a clear vision and strategy for the service that is communicated to staff in a way they understand and they are able to see their role in the future development of the service.
- The trust must review community staffing and skill mix within each community team to ensure that staffing meets patients' needs and provides capacity for staff supervision, training, team meetings and staff handovers.

Summary of findings

- The trust must ensure that effective handover and team meetings are allowed to enable staff to share key information in a systematic and safe way.
- The trust must ensure that all risks are identified and action is taken to mitigate them.

Action the provider SHOULD take to improve

- The trust should review the arrangements for clinical leadership of physiotherapy and occupational therapy.
- The trust should have a specific policy for ensuring patients' needs are met during adverse weather conditions.
- The trust should review arrangements for obtaining feedback from patients and their carers.
- The trust should ensure there are suitable arrangements in place to ensure that staff receive regular supervision.
- The trust should ensure that information regarding the outcomes for people who use services is collected, collated and analysed so that improvements in patients outcomes can be measured.

Shropshire Community Health NHS Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as requires improvement for safe. This is because:

- Staffing levels were below establishment and capacity to meet demand was stretched. Staff availability to meet patients' visits was a challenge
- Sufficient time for handover and team meetings had not been allowed. This meant staff could not share key information in a systematic and safe way.
- The trust did not have a specific policy for ensuring patients' needs were met during adverse weather conditions.
- Staff were up to date with level 1 safeguarding adults and children training, however compliance with levels 2 and 3 training was inconsistent.

However we also saw:

- Staff understood their responsibilities to raise concerns and report incidents and staff told us they received feedback.
- Medicines were stored, managed and administered appropriately and safely.
- Records were complete and up to date and maintained to a good standard.

Safety performance

- The trust completed information for the NHS Safety Thermometer. The Safety Thermometer allows us to establish a baseline against which we can track improvement. The actual numbers of incidents resulting in harm identified fluctuated. The average incidence of monthly pressure ulcers, falls with harm and urinary and catheter infections for the trust between 1 November 2014 and 30 November 2015 were 58 pressure ulcers, 55 falls with harm and 12 urinary infections. This was trust-wide information.
- One nurse showed us how information for the thermometer was completed. Staff told us the trust collected the information on one day each month and it was a day's snapshot of the number of pressure ulcers, falls, infections and venous thrombosis such as deep vein blood clots or pulmonary embolism blood clots. It did not take account of other occurrences throughout the month.

Requires improvement

Are services safe?

- In all the community-nursing bases we visited, we saw information about pressure ulcers, falls and infections that had occurred within the team.

Incident reporting, learning and improvement

- From 1 December 2014 to 1 December 2015, the trust reported 17 serious incidents within community services for adults. These involved 12 grade 3 pressure ulcers and five grade 4 pressure ulcers.
- Staff we spoke with said that they were able to report incidents and were able to access incident reporting systems. The trust used an electronic incident reporting system. Some staff said they were also able to report incidents using their trust-issued 'smart phone' when they were out of the office. Staff told us the system acknowledged when they submitted incidents.
- Two band 5 district nurses in Shropshire told us that incident reporting, including near misses, was positively encouraged. One of the nurses gave us an example of a medicine error that they had reported. They said their manager supported them through the process and they felt there was a 'no blame' culture.
- Staff in other teams told us they regularly received feedback on and saw results from incidents they reported.
- Community physiotherapists in Telford told us they used the trust's electronic reporting system to record incidents and near misses, but that they did not always receive feedback on their reports. However, some staff told us that they had not reported a recent incident in relation to a lack of communication by another care provider, which had put the patient at risk of harm. This meant that staff might have missed a valuable opportunity to improve communication.
- A district nurse from Telford told us about an incident she had reported which had resulted in a change in practice. A patient living with diabetes had been added to their visit list at very short notice, after the nurse had left their base for the day, and the visit had been missed. The nurse reported the incident and the trust put a policy in place to ensure that nurses were informed of any late additions to their visit lists. Two staff in teams based at other locations also mentioned this event when telling us about learning from incidents.
- We looked at five investigations (called root cause analysis) of serious incidents, which related to grade 3 and grade 4 pressure ulcers. We found that the service investigated the incidents, highlighting lessons learnt and drawing up action plans to address any shortfalls. The investigations clearly identified whether the pressure ulcer was avoidable or not. A senior tissue viability nurse reviewed the investigation. The director of nursing then signed off the final report. Team leaders told us that managers shared lessons learnt with their respective teams. The team leaders then passed these on to staff during team meetings or in person. This demonstrated that there were suitable systems in place to learn from and address patient harm incidents. These staff had had training on completing root cause analyses.
- The trust's tissue viability team reviewed all pressure ulcer notifications and any concerns staff had about skin damage. Photographs of the pressure ulcer or skin damage were reviewed which enabled the tissue viability nurses to provide timely advice on required treatment to prevent further harm to the patient. The tissue viability nurses shared information throughout the trust to prevent or reduce the incidence of pressure ulcers to improve patient safety.
- Staff told us they discussed incidents, and learning from incidents, during handovers and team meetings. However, staff said that not all teams had regular team meetings so not all senior staff shared this information.
- A team leader told us that previously staff had no time allocated to review and update patients' care needs. However, following a serious incident community nurses now had allocated time to review and update care records.
- We saw alerts circulated around community nursing teams from outside organisations such as the and Healthcare Products Agency, alerting staff to incidents that had happened in other organisations.
- There were no never events reported in the last year by the trust. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Duty of Candour

- The 'Duty of Candour' regulation came into force in November 2014 as part of the Health and Social Care Act. It required that the patient or their representative receive verbal and written notification of the harm and an apology when they suffered moderate or more severe harm because of the care provided. It defined moderate harm as harm requiring a moderate increase

in treatment. All pressure ulcers (grade 3 and above) will require additional treatment, so Duty of Candour will apply if the care delivered contributed to the development of the pressure ulcer.

- Information provided by the trust identified there had been two incidents to which Duty of Candour applied within community health services for adults. A team leader from the Integrated Community Service demonstrated a good understanding of Duty of Candour and gave us an example of an incident where it had been applied. A patient had developed a pressure ulcer while under the team's care; the trust had apologised to the patient and their spouse in writing and face-to-face and carried out a root cause analysis (RCA). Managers shared the written outcome of the RCA with the team. As a result of the investigation the team had changed the amount of time planned for visits to some patients.
- We saw letters of apology with a summary of concerns included and when possible managers made an apology either in person or by telephone.
- Staff we spoke with, told us they had not received any training on Duty of Candour regulations. Whilst most staff we spoke with understood what Duty of Candour was, they told us they did not understand the process, or what would trigger this.

Safeguarding

- Staff we spoke with were aware of their responsibility to keep people safe and, when needed, report any safeguarding concerns they had. Staff were able to identify safeguarding leads within the organisation for both adults and children. Team leaders told us they discussed any learning from safeguarding incidents during team meetings. However not all teams had regular team meetings.
- The trust had a target that 85% of all staff received safeguarding training. Information provided by the trust showed that this target had been achieved by the service. Compliance with safeguarding adults level 1 training was 97% and for safeguarding children level 1 training was 100%. Staff told us they had safeguarding (adults and children) training as part of their initial induction followed by updates every three years.
- The Intercollegiate Document: 'Safeguarding Children and Young People: Roles and competencies for healthcare staff'; March 2014 published by the Royal College of Paediatrics and Child Health 2014 states that level 2 training is required for all non-clinical and clinical staff who have any contact with children, young people and/or parents/carers. We asked the trust to confirm compliance with level 2 and 3 safeguarding training for children. They told us that 37% of eligible community adults staff had received safeguarding level 2 training and 50% of eligible staff had safeguarding level 3 training. The trust provided us with a 'performance recovery plan' which demonstrated they had plans in place to ensure that community adults staff had appropriate safeguarding children training. In February 2016, the trust updated its requirements for safeguarding training to reflect the published standards.
- We asked the trust to confirm compliance with level 2 and 3 safeguarding training for adults but they were unable to provide us with data.
- Staff at the integrated community service in Much Wenlock told us they had done level 2 safeguarding children training, and had done safeguarding adults training. They were not sure what level the adults training had been.
- A district nurse team leader in Telford told us their staff had completed safeguarding training at level 2 for adults and children, and completion rates stood at 86%.
- Two band 5 nurses district nurses in Shropshire told us they had had level 2 safeguarding adults training via e-learning. They explained the safeguarding referral process to us and could name the trust's safeguarding lead.
- The trust used the 'Safeguarding adults: multi-agency policy and procedures for the West Midlands' document, written by the West Midlands Safeguarding Adults Policy and Procedure Group. This ensured staff followed the same processes regardless which local authority and clinical commissioning group area they worked in.
- Between April and September 2015 staff working within community adult services reported 27 safeguarding incidents, most of which were about the protection of vulnerable adults.
- A district nurse from Oakengates gave us an example of a safeguarding referral they had made about a patient who was not able to care for themselves at home. The nurse attended safeguarding team meetings and was involved in the process. The patient and their spouse were eventually provided with accommodation in a residential care home.

Requires improvement

Are services safe?

Medicines

- We accompanied community nurses on visits to patients' homes and observed that they administered medicines, which included medicated wound dressings, safely and appropriately. We also noted that community nurses completed a record of each medicine they administered.
- We saw patient medicine documentation which included a comprehensive list of prompts to ensure staff could administer medicines safely. Staff told us these forms had recently been introduced to replace an older version, and they felt the new forms were more holistic, easy to use and helped to keep patients safe.
- We saw medicine administration charts and medicine stock balance sheets in several of the sets of patients' notes we looked at. All of the administration charts and stock records were legible and were accurately completed.
- Staff told us that there was a new electronic system for ordering dressings. Staff said that the trust had reduced the dressing 'formulary' (the number of different dressings available for specific wounds) but suitable dressings were available to meet patients' needs. Staff also told us that if they required an 'off formulary' dressing they had to get authorisation from the tissue viability nurse specialist. This ensured that patients had safe and effective use of dressings that promoted wound healing.

Environment and equipment

- Staff saw patients in a wide variety of locations throughout the trust ranging from health centres, residential homes and in their own homes. The trust maintained and safety checked equipment we looked at such as specialist pressure relieving mattresses and hoists (in patients' homes).
- Nursing and therapy staff told us that they were able to request equipment for patients such as hospital beds, pressure relieving mattresses and commodes and it was delivered in a timely manner. Staff told us they could access equipment from local 'satellite stores' or from a private equipment provider if equipment was needed urgently for an end of life care patient. Staff said there were no problems getting equipment quickly. District nurses in Telford told us the equipment stores delivered beds and mattresses within 48 hours of request.
- Community physiotherapists in Telford told us they had an excellent equipment ordering process, staff in their equipment stores were helpful and accommodating and equipment was readily available, often on the same day as it was ordered. We visited the equipment store during our inspection and saw that it held sufficient quantities of a range of equipment community staff used to support patients in their own homes.
- Community nursing staff carried a small stock of consumable equipment such as dressings, catheters and gloves to allow them to deal with any unexpected patient needs without having to return to their bases. They carried this equipment in a plastic box, fitted with a lid which could be secured. This kept the equipment clean and separate from the staff members' personal property.

Quality of records

- We looked at 53 sets of patient records at different locations including patients' homes, residential care facilities and trust premises. Staff had completed them to a high standard. We saw they contained evidence of initial assessments, care plans, pressure ulcer risks, falls risks, nutrition assessments and requirements, consent and next of kin details. They also showed evidence of care and treatment provided by trust staff and of care plan reviews. We saw that staff had regularly reviewed and updated care plans when patients' needs had changed.
- However, we looked at two sets of notes for patients being cared for by nurses from the Shifnal and Albrighton team and found sections on medication administration, advanced directives, reassessments and consent had not been completed. One patient's care plan had been set up for three visits per week but a healthcare assistant had changed it to two visits per week. We were told that the healthcare assistant would have discussed the change with a qualified nurse however there was no record of that discussion in the notes.
- Community nursing staff used paper records which were held in patients' own homes, this enabled staff from different teams to contribute their own entries and be aware of what care or treatment other teams had provided. Other professionals such as physiotherapists and occupational therapists kept separate paper patient records. Staff told us that this could be problematic if therapists were not at the same community base and

they needed information or advice in relation to ongoing treatment or patient management. We observed that limited information was available electronically which mainly identified the date and reason for the visit. However, staff did tell us that the use of electronic records, which would be available in 2017, would address this.

- We observed that when staff were required to carry patients' records from one place to another they used a secure bag to transport the documents. This gave assurance that patient confidential information was safe and secure.
- We looked at 12 sets of physiotherapy records while accompanying community therapists on patient visits. The records all recorded that consent had been obtained from the patient, and met the Chartered Society of Physiotherapy's record keeping standards, however there was no list of standard abbreviations. This meant that staff who were unfamiliar with physiotherapy abbreviations might not have been able to understand the notes properly.
- In part of the integrated community team's base at Much Wenlock, a whiteboard with lists of patients' names was visible from outside the office, through a window. We raised this issue with the team leader at the time of our visit and action was taken immediately to ensure that patient details could not be seen from outside.
- Community nursing staff in Newport told us they had protected time to complete electronic or paper patient records. After patients were discharged from their care, records were retained on site for a year. These records were stored in a locked cupboard, and the key for the cupboard was secured in a key safe.
- Clinical practice teachers carried out documentation audits and fed results back to staff in team meetings. We saw minutes of team meetings that included this item.
- Email referral forms completed by staff at the single point of referral service (SPR) contained protected fields and used drop-down menus to ensure that only correct referrals were made and that information was only sent to approved locations. Staff saved electronic referral forms using a strict naming convention including the patient's name, NHS number, priority and the initials of the staff member who dealt with the referral. Electronic referral forms were stored on a shared drive, in folders organised by date and community team. This allowed staff to find saved forms if queries were raised and made audits of completed forms more effective.
- The SPR manager kept daily records of the number of referrals taken by the service. At 3.30pm each day, they cross-checked the number of referrals received against the number sent out to community teams, to ensure none were missed.

Cleanliness, infection control and hygiene

- Staff in community settings demonstrated good infection control practices such as the use of personal protective equipment and regular hand washing pre and post-patient care. Staff followed the trust's infection control policy. We observed that staff were 'bare below the elbow' while delivering patient care. This complied with the National Institute for Health and Care Excellence (NICE) guideline CG139: Healthcare-associated infections: prevention and control in primary and community care and the Department of Health's "Community staff had alcohol gel, to allow them to carry out effective hand cleansing while away from their base.
- Information provided by the trust showed that 96% of all staff were up to date with their infection control training.
- We saw district nurses in Telford and Shropshire using effective aseptic techniques while changing a patient's wound dressing.
- Staff told us that they had a hand washing assessment by a senior nurse as part of the annual observation in practice, which forms part of the staff appraisal. The assessment checked that their handwashing met the required standard and protected patients from the risk of cross infection. The trust did not provide us with overall compliance rates for the assessment. A district nursing team leader in Telford also told us they did audits on handwashing and had undergone a peer review on their team's aseptic techniques. We requested copies of the audits and peer review, however the trust did not provide these.
- We observed staff cleaned equipment appropriately after they used it. For example, we saw that community nurses cleaned thermometers and equipment used to take patients' blood pressure.
- We saw that staff safely and appropriately disposed of dressings, needles and syringes.

Requires improvement

Are services safe?

- Staff told us that each team had an infection control link nurse. The link nurse's role included attending infection control meetings and providing feedback to their team.

Mandatory training

- The trust target for mandatory training was 85% apart from information governance which was 95%. Information provided by the trust (1 March 2016) identified that 86% of community adults' staff had completed all required mandatory training. The service had met or exceeded the 85% target in all subject areas with the exception of annual fire safety training (77%) and mental capacity training (84%). Compliance with information governance was 91%.
- Staff accessed mandatory training through e-learning, although some which had a practical element such as moving and handling, was delivered face to face.
- A team leader told us they had experienced challenges in getting staff to complete their training and as a result staff were now given protected time to do so. The team leader showed us an electronic record of their team's compliance with mandatory training, which was colour coded to show courses still to be completed. Team leaders used the record during staff appraisal meetings to ensure staff were aware of any training they needed to complete.

Assessing and responding to patient risk

- Community-based staff demonstrated awareness of key risks to patients such as urgency of patient visits and arrangements for further support when required, such as the supply of additional equipment.
- Senior nurses triaged and prioritised first assessment appointments based on individual risk and patient need. Staff told us they would see urgent cases within a few hours with less urgent patients seen within a few days.
- Staff raised concerns about the single point of referral process. Staff said it was difficult for patients and health professionals to access this service and frequently information provided (such as the need for the visit and the patient's contact details) were unclear or inaccurate.
- Information we received from the trust identified that staff should attend a weekly handover (when staff on duty discussed patients, needs, risks and visits) and they should complete handover sheets daily. We found that some but not all teams achieved this.
- The trust had a standard operating procedure for community nursing handovers. We were shown a copy of this document, which included sections on staff skill mix, risk flagging, documentation and 'SBAR'. 'SBAR' stands for 'situation, background, assessment and recommendation' and the NHS endorses its use as a communication tool for important clinical information. We observed a handover between community shifts using the SBAR tool.
- We found that staff handovers were inconsistently undertaken. In south-west Shropshire, staff told us that, when possible, they had daily handovers. Staff told us that this enabled them to know and understand patients' needs and risks. It also provided a good opportunity for junior staff to share any concerns with more senior staff. Two community teams said that they did not have a handover. A health care assistant told us that patient's details were in a folder they could check before they visited. One team said they had been told when the electronic monitoring system was introduced they no longer needed to have handovers. Some staff told us and we observed they had 'informal' handovers on an individual basis. However, this meant they were not made aware of risks in neighbouring teams which they also provided cover for. One band 6 nurse told us they did not think the current system without handovers was safe. They had asked the team leader to re-introduce handovers to discuss patients and risks throughout the larger team and this was being considered.
- We asked team leaders at two district nursing bases to locate the trust's pressure ulcer management policy. Both initially told us they knew where it was on the trust's intranet but on checking could not find it. One team leader contacted the trust's governance office who told them that the policy had been withdrawn to be updated.

Staffing levels and caseload

- Staffing levels in community nursing teams were assessed using the trust's workforce planning tool, which collected data on activity to determine the required staffing levels. This identified daily demand and capacity of staff, level of risk and actions required for prioritisation of workload. Activity was described as

level 1 (desirable work that could be cancelled) through to level 4 activity (treatment plans that cannot be changed without causing substantial harm to the patient).

- Information provided by the trust identified that there were 19.5 (10%) whole time equivalent vacancies for qualified nurses and 1.9 (10%) whole time equivalent for unqualified nurses. At the time of our inspection, 15.6% of allied health professional posts in community services for adults were vacant.
- The highest number of WTE vacancies for qualified nurses were for the north east Shropshire interdisciplinary teams (5), Shrewsbury and Atcham north interdisciplinary teams (4.1), community nursing team 4 (2.9) and north west Shropshire interdisciplinary teams (2.2).
- We found some community nursing team services were below strength, due to low staffing levels, compounded by staff sickness. Staff told us that they were struggling to keep up with increasing demand for their services. We found the staff sickness rate across community adult services between October 2014 and September 2015 was 6.5%. This is above the national average of 4.1%.
- Community nursing teams in Telford were made up of a total of 47.4 whole time equivalent (WTE) nurses (bands 3, 5, 6 and 7), one phlebotomist, 1.3 WTE administration staff, two team leaders and one clinical practice teacher. Staff were split into Telford north and south teams, then allocated to a number of community bases.
- We were shown a copy of a capacity and demand analysis for the Telford south community nursing team, which had been completed in January 2016. The analysis identified a possible imbalance in the staffing levels between the north and south teams, according to their respective workload. The report recommended moving some staff and relocating the workload from some GP surgeries to even out the caseload for each team. This showed that managers were monitoring each team's workload and making plans to ensure that each had a similar amount of activity.
- Staff told us that staff availability to meet patients' visits was a challenge. Staff in the majority of teams told us that they regularly worked more than their contracted hours to ensure patients' visits were undertaken. Staff told us part time staff could claim for extra hours payment. Full time staff could have time off in lieu but this was not always possible as that would leave the team short staffed and so full time staff worked additional hours without payment.
- Staff told us they frequently covered for other teams. However, staff working in the south- east Shropshire team said there were occasions when all teams were short staffed which meant they came on duty early and did not finish until 7pm, where they should have finished at 6pm.
- Community staff, particularly in rural areas, said that they felt that the trust did not fully recognise distance and travel time between patients. Some staff said that a need for relocation into one community base for several teams would put additional time constraints on them to ensure that all patient visits were undertaken. This was not on the trust's risk register.
- Community nurses told us that community nursing service hours were between 8am and 6pm. They told us that another provider delivered cover from 7pm until 8am. There was no nursing service from that provider from midnight onwards. They said that staff sometimes went out after 6pm to ensure their patients received timely care rather than waiting for the evening provider to start and visit the patient.
- The trust tool identified an 'outstanding work load score' or 'OWLS'. This identified any required visits that community staff were unable to undertake. We requested information from the trust about OWLS but they told us there were no outstanding community visits or workload.
- The trust had completed an audit, 'Community Nursing Capacity and Demand Audit' in October 2015. The audit identified that the majority of teams had not included time for team meetings, handovers or required supernumerary time for band 6 nurses. It also evidenced a variance in application of dependency score and travel time and showed staff were not routinely allocated time for online learning and supervision in practice. The trust had an action plan to address this and more accurately identify nursing capacity and demand, however we found the same shortfalls at the time of our visit.
- Staff told us the number of band 6 nurses within the trust had been greatly reduced. Staff told us there had been one band 6 nurse as 'case holder' for each GP practice with a caseload of around 80 patients. However,

staff told us this was no longer the situation and some teams did not have a band 6 nurse on duty on some shifts to ensure that support was available for junior staff.

- One team told us that they had previously had 20 band 6 nurses, this had now reduced to eight and the trust was reducing this further. Another team told us they had a band 6 nurse vacancy but the trust would replace the post with a temporary band 5 nurse. The trust told us this was because the commissioner for that service had served notice. Staff told us they were concerned about the loss of experienced community nurses.
- Community physiotherapy teams in Telford used staffing guidance endorsed by the 'Agile Standards working group', a professional network group recognised by the Chartered Society of Physiotherapy, to calculate their staffing numbers. This guidance recommended one community physiotherapist should be employed per 10,000 population in the area served.
- The respiratory care team had a caseload of 650 patients in Telford and Wrekin and 700 patients elsewhere in Shropshire, who were covered by 10.35 whole time equivalent (WTE) qualified nurses, 4.9 WTE healthcare assistants, 4.5 WTE physiotherapists and one rehabilitation technician who works in pulmonary rehabilitation. As stated in NHS Improvement's 'Framework for commissioning community nursing', staffing levels in community teams cannot be calculated solely on patient numbers, but involve a number of factors ultimately leading to beneficial outcomes for patients. Staff in the respiratory care team told us their numbers were sufficient to provide a safe service for their patients.

Managing anticipated risks

- We observed and were told that most home visits were carried out by a lone worker, although staff did say there were occasions when two staff could attend. We also saw this during our visits to patients' homes.
- The trust had a lone working policy in place. The policy identified staff should ring into the 'triage nurse' when they started and ended their working day. Senior staff had a record of all visits each staff member would undertake. Team leaders had a record of the registration and the colour, make and model of staff cars if required in an emergency.
- All of the community nurses we spoke with were aware of these procedures and told us they used them and they were effective. Staff knew what action they should take if a potential risk to a colleague was identified. Staff told us they would use both their trust mobile and also their personal mobile phone in an emergency. However staff told us that phone reception was poor in many rural areas. This meant that staff might be in a vulnerable situation and be unable to alert assistance.
- The community physiotherapists in Telford listed the ID numbers of patients they planned to visit on a whiteboard in the office at the start of each day. They also used a buddy system to confirm they were home safe at the end of their shift. While we were observing one physiotherapist on a home visits an extra, ad hoc, visit was added in while they were out of the office without the board being updated. Staff told us they used common sense when deciding whether patients were safe to visit alone.

Major incident awareness and training

- District nurses in Shropshire told us the trust had an adverse weather policy and adverse weather appeared on their risk register. The policy identified that staff should make every effort to attend work at their normal starting time. Several staff had four-wheel drive vehicles, which they used out of goodwill. Community physiotherapists in Telford told us they were not aware of any formal plans for dealing with adverse weather, but said they would just "use common sense", "do their best to get there" and prioritise those patients most in need of treatment.
- We asked the trust for its adverse weather policy; however, in response we were only given its 'Policy and Procedure on Special Leave (Time Off)' which included reference to staff being allowed paid leave if they were unable to get in to work because of severe weather. We were not reassured that the trust had any plans in place to ensure that its patients continued to receive care during periods of inclement weather.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We have rated this service as 'good' for effective. This is because:

- Care and treatment was planned and delivered in line with current evidence based guidance.
- There was effective use of telemedicine, enabling staff to support patients who wished to remain at home.
- Staff had the skills and experience to carry out their roles effectively.
- We saw good examples of multidisciplinary working across teams and sectors.
- Referral and discharge were effectively managed.
- Staff could access all the information they needed most of the time.

However we also saw:

- There was limited information regarding the outcomes for people who use services in some service areas, data was collected but in some services it was not regularly collated and analysed.
- Staff were supported to maintain and develop skills but accessing training could be problematic due to funding and work pressure issues.
- We found there was a lack of consistency in staff understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.

Evidence based care and treatment

- We saw that the trust had a range of policies based on national good practice and followed national clinical guidelines. Guidance was available on the trust's intranet and some staff showed us it was readily accessible. In addition, staff could access the trust's intranet and policies using their 'smart phones' when they were away from their base. This meant staff had access to policies and procedures when required.
- We saw a range of evidence-based practice being used across the service. The community neurology team used 'stroke pathways' to provide evidence-based care. Treatment provided by staff on the respiratory care team followed guidance from NICE and the British Thoracic Society. We also saw evidence-based practice used for patients who had catheters.
- All clinical staff at the trust had access to the online version of the Royal Marsden Manual of Clinical Nursing Procedures.
- District nurses in all the locations we visited assessed patients for pressure ulcer risk in line with guidance from the European Pressure Ulcer Advisory Panel, and used photographs of pressure damage, with consent from patients, to monitor changes in the wounds they treated.
- District nurses in Telford and Wrekin, and Much Wenlock used the NHS England-recommended 'SSKIN' mnemonic to help them avoid their patients acquiring pressure ulcers. 'SSKIN' stands for surface, skin inspection, keep patients moving, incontinence and moisture, and nutrition and hydration. We saw copies of the SSKIN assessment tool, variance chart, repositioning schedule and food chart in all the sets of patient notes we looked at.
- An audit dated September 2015 by the Oswestry Diagnostics, Assessment and Access to Rehabilitation and Treatment (DAART) unit showed the team managed patients with suspected deep vein thrombosis appropriately based on national best practice evidence.
- Staff told us and we saw physiotherapy services in Telford followed the NICE guidelines and the Chartered Society of Physiotherapy's 'Quality Assurance Standards'.

Pain relief

- We observed that staff discussed pain relief and pain management plans with patients and their relatives. Several staff told us and we observed that strong pain relief was administered alongside other pain relief which kept patients comfortable. One patient told us that community nurses had respected their wishes not to have strong pain relief to ensure they remained alert.

- During home visits, we saw physiotherapists assessing people's pain and giving advice about therapy to reduce pain. Where needed, physiotherapists contacted patients' GPs to request additional or different pain relief.
- Extended scope practitioners in the Telford Musculoskeletal Service were able to administer a number of pain-relieving medicines by injection for joint therapy, under patient group directions (PGDs). We were shown PGDs for three medicines authorised for use in this way, all of which were in date and completed properly.
- We saw staff giving patients 'pain toolkit' booklets. The booklets gave guidance on pain management techniques, medicines and sources of information and help.

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool (MUST), which is a recognised assessment tool to assess nutritional risk. We saw that a nutritional risk assessment was in place that identified risks to the patient's dietary intake and actions required to ensure they had sufficient food intake.
- We observed nursing staff and therapists discussing diet to promote the person's health and wellbeing and to promote wound healing if appropriate.
- Community nurses were able to explain what actions they would take if a patient's MUST score indicated they were at risk. They were able to refer patients to dieticians in their teams for further assessments and treatment.

Technology and telemedicine

- Telemedicine is a system that records and stores patients' observations electronically so they are available to health professionals to review and monitor their health. Community matrons were able to arrange for patients to use 'telemedicine' in their homes. We looked at the records of two patients who had telemedicine to manage a long-term condition. We saw that the patient or their carers checked and recorded observations such as temperature, pulse, blood pressure and respiration rate on identified days or if they felt unwell. The patient or their carer submitted observations electronically to the community matron for review. If needed, the community matron would contact or visit the patient and provide further advice to manage their condition. The use of this equipment meant that the community matron and nurses were able to support the patient's wish to remain at home.
- We saw one community matron discussing blood sugar recording with a patient. The community matron discussed the use of telemedicine with the patient to give consistency of blood monitoring. The community matron agreed to set this up with the consent of the patient.
- The telemedicine service maximised the availability of specialist nurse advice across a large and mainly rural county. The tissue viability telemedicine used hi-resolution images of wounds taken by staff and transferred them to a secure NHS computer. The team prioritised visits to patients and offered advice based on these photographs together with information provided on an electronic referral form. The team had plans to use live video streaming to improve this service further. Following the start of treatment, the tissue viability nurse could review further images to monitor the patient and their wound or skin problem. This provided effective use of the tissue viability nurse specialist to promote timely and effective wound healing. Use of still photographs and video was governed by the trust's clinical photography guidelines, which ensured images were kept secure and patient confidentiality was maintained.

Patient outcomes

- The trust had taken part in the National Chronic Obstructive Pulmonary Disease (COPD) clinical audit of pulmonary rehabilitation services in England and Wales in 2015. The trust performed better than the average with times to arrange patient assessment (an average of 36 days compared to 52 days from enrolment to discharge) and from initial assessment to discharge assessment (49 days compared to 65 days). The audit also identified that 72% of patients' difficulty in breathing and fatigue had improved.
- The community neurology team provided domiciliary stroke care (within patients own homes) and submitted data to the Sentinel Stroke audit 2015. The audit identified that the service performed worse than similar trusts for times from referral to initial triage review (14 days compared to 12 days) and referral to treatment (30 days compared to 20 days) for similar domiciliary services nationally.

Good

Are services effective?

- The trust provided data to the National Audit of Intermediate care 2015 in relation to its re-ablement services. Re-ablement services are community-based services provided to people in their own home or care homes. The aim of the service was to help people recover skills and confidence to live at home, maximising their level of independence so that their need for ongoing home care support can be minimised. Information showed that this service had an above average cost for each person accepted (approximately £2,440 compared to an average cost of £1,484) although the duration of the service was shorter (30 days compared to national 34.5 days).
- Staff from the integrated community service (ICS) at Much Wenlock told us they had performance targets for a number of areas of their work including delayed transfer of care, assessment of newly referred patients and admission avoidance. The trust provided details of the team's performance, which showed they achieved seven out of 11 of their targets between May 2015 and January 2016. For example, the trust had a target that readmission rates for ICS should be less than 20%. Information provided by the trust identified that from 01/04/2015 – 29/11/2015 the team met this target (15.6% to 17.5%).
- The tissue viability service had demonstrated improvements to leg ulcer dressings. Changes from four-layer compression bandaging to two-layer compressions had proven to be cost effective and improved patient comfort and cosmetic appearance without compromising healing rates. An audit of one caseload of 18 patients who had leg ulcers had shown to have reduced the number of patient appointments each week and time during each visit with a cost reduction from £656 to £150 per patient over a 12 week period.
- The diabetes nurse specialists ran courses to increase awareness of diabetes and its management for people living with diabetes. Information provided by the trust showed 323 patients had attended this course between 1 March 2015 and 17 March 2016. Information showed that patient empowerment scores had increased by 15.8% and blood tests demonstrated that patient's long-term diabetes control had slightly improved.
- The integrated community service at Much Wenlock monitored and reported on the length of time patients stayed on its caseload and on the outcomes for patients discharged from the service. We were shown examples of the summaries from these reports, which highlighted trends and individual patients who might need additional care. Data for the reports was submitted to the local authority, which produced and circulated reports. We saw a copy of the report for January 2016. It included details of patient outcomes such as patient readmission rates (17.3%, better than the target of 20%), and numbers of patients discharged from the service with no further need for support (75.2%, better than the target of 65%).
- Physiotherapists told us that they used the 'Tinetti' score to monitor patients' balance and gait outcomes to assess the benefits of treatment. They told us they recorded the score in patients' notes before and on completion of treatment, but that the trust did not ask for this information.
- Community matrons told us it was their role to prevent hospital admissions. One community matron told us that on average they prevented four patients each month being admitted to hospital. Community matrons also told us that due to their ongoing advice for and management of patients with long term conditions, their patients had fewer admissions to hospital on a year on year basis. At the time of inspection, no trust wide data was available to demonstrate the reduced numbers of patient admissions to hospital.
- Therapists working in the Telford Musculoskeletal Service completed clinical outcome forms after each episode of treatment. Details from the forms were input onto the trust's electronic patient record system. However, a senior manager told us the data was not audited so no information about how effective the service was could be provided. A senior manager in community services was unable to explain the audit process or give examples of any audits carried out by teams in their service.

Competent staff

- We observed clinical practice, attended staff multidisciplinary team (MDT) meetings and saw that staff working across adult community services were competent and knowledgeable.
- New staff received induction training and were supernumerary for at least one week. Staff we spoke with were positive about the induction they had received. Team leaders told us that the induction period might be extended if staff were not confident in their role or tasks they were required to perform.

Good

Are services effective?

- Staff told us that they had competency assessments for catheterisation and using a syringe driver. Team leaders also told us that, as part of the staff appraisal, they would assess staff practice.
- Staff mostly told us they did not receive clinical supervision. Clinical supervision is a review of individuals' clinical practice. The majority of staff said that any supervision was informal rather than formal. One team leader told us there were insufficient numbers of trained supervisors to ensure all staff had access. Information we received from the trust identified that there were 36 trained supervisors across the whole service. One community matron told us they ran a supervision group for band 5 community nurses to overcome the shortage; this helped them to develop their practice.
- At Dawley Medical Centre, a team leader told us they carried out annual clinical supervision (referred to as 'observation in practice') for their staff. We saw records of these sessions which showed all staff in the team had had clinical supervision within the last 12 months. We also saw evidence that all staff on the team had had an appraisal within the same period.
- The community neurology team told us they had formal and recorded supervision every six weeks. Staff told us that funding had been approved to provide external supervision for the psychologist, however at the time of inspection the supervision was not in place.
- Some therapists we spoke with said they did not have clinical supervision. However, one physiotherapist told us that they had arranged clinical supervision from a physiotherapist from another trust. One occupational therapist said they received supervision from a band 7 physiotherapist but not from an occupational therapist.
- Community physiotherapy staff in Telford told us they did not receive any formal clinical supervision; however, physiotherapists in the reablement team at Halesfield told us they received clinical supervision every two weeks.
- Team leaders told us they received supervision as a manager but not for clinical practice.
- The appraisal rate for community services for adults' staff was 99.8% (as of 7 March 2016). Team leaders told us that staff appraisal rates had improved in recent months and information we received from the trust confirmed this. Team leaders told us that at the time of their appraisal staff also had a review of their competency to undertake their role. This involved a senior community nurse assessing and judging them to be competent in identified procedures. Staff needed to have both had their competency assessment and appraisal interview before their appraisal was completed.
- Two band 5 community nurses in Shropshire told us a clinical practice teacher accompanied them for a day of 'direct observation of practice' before they had their annual appraisals. The observations from that day formed part of their appraisals. They also told us they had opportunities to attend external courses and gave us an example of palliative care training that one of them had completed.
- A clinical educator in Telford provided bespoke training packages according to needs identified in staff appraisals, for example pressure ulcer care and patient care planning for community nurses and heart failure and central venous catheter management for community matrons.
- A rehabilitation technician at Much Wenlock told us they found it easy to access training they wanted to do. They also said some of their colleagues in the same role were doing an access course to allow them to study for a degree.
- The trust supported the release of four community nurses per year to train as specialist practitioners, which involved 40% of their time spent in observed clinical practice. During this time staff were used to backfill the students' core roles. Specialist practitioner training developed staff for leadership roles and gave them skills to deliver care for patients living with complex conditions.
- Staff told us they sometimes struggled to attend training due to staffing levels and workload. One band 5 nurse said they had been booked to do external courses but they had been cancelled due to pressures of work. They said it was hard enough to ensure that required mandatory training was undertaken. A band 6 district nurse in Telford told us they found it difficult to keep up with e-learning due to staffing levels and workload pressure.
- There was inconsistency in how much funding and protected time or opportunities were available for staff to access training courses. Some staff told us it was a balance between meeting the demands of the service and current capacity. Staff in several locations in Telford and Shropshire told us they experienced problems getting funding and time for non-mandatory, role-

specific training. If they wanted to attend additional training courses for continuing professional development, they had to do so in their own time and pay for them themselves.

- Staff told us protected time for developmental training was an issue due to staffing constraints. One member of staff said, "We need more staff so we can access training. For example we have just one nurse prescriber in the team and we need an ear syringe update".
- Two community specialist students were very positive about development opportunities within the trust. They told us the trust funded four students each year to undertake this course. A rehabilitation assistant (band 4) told us they were undertaking a foundation degree which had been supported by the trust.
- A Community Practice Teacher (CPT) told us that there were now two CPTs (previously four) in the trust but a further two had been appointed. They told us their role was to support the Community Specialist Practitioner students to assess and develop their practice. In addition, when possible they supported team leaders in reviewing staff practical competencies.
- Staff told us that there was no occupational therapy or physiotherapy lead for the organisation. Staff told us that this meant that there was no review of current practice and they missed out on professional development opportunities.
- There were five community matrons in Shropshire with an additional new community matron post in Ludlow. In Telford there were four but their management arrangements were different and were in an overall community matron team. The professional lead for community matrons was the nurse consultant.
- One community matron told us that they had regular training and supervision of practice from general practitioners. They told us that this support was also available from the nurse consultant within the trust.

Multi-disciplinary working and coordinated care pathways

- We saw good collaborative working across all community services. We saw referrals and communication networks between community nurses, therapists and general practitioners. District nurses in Newport told us they had good working relationships with specialist nurses and allied health professionals such as occupational therapists, physiotherapists, health visitors and speech and language therapists.
- We observed two multi-disciplinary meetings which included community nursing team members, occupational therapists and physiotherapists. Staff discussed all new referrals and current occupational therapy and physiotherapy caseloads during these meetings, and agreed which patients should be seen. During one multidisciplinary team (MDT) meeting a general practitioner came with an urgent referral, which was accepted by the team.
- Community physiotherapists in Telford accepted referrals from GPs, the local acute hospital, and other Shropshire Community Health teams such as community matrons, tissue viability specialists, continence nurses, the enablement team and community nurses. Physiotherapists could also refer patients to any other team within the trust. They also told us district nurses, occupational therapists and the manual handling team accompanied them on visits when a multidisciplinary approach was necessary. The team also had weekly meetings with the integrated community team to share information about patients they were looking after.
- Staff told us that pathways between Interdisciplinary team (IDT) and the integrated community team (ICS) were not clear for either patients or professionals. One physiotherapist working within IDT told us that they may have already been working with a patient but following an admission to hospital the patient was then being referred to a physiotherapist within ICS. They told us that ICS staff might then refer this patient back to the IDT team. This meant the person's needs were assessed by staff each time they transferred between services and it was not an effective pathway for the patient.
- One community matron told us that they worked effectively with both secondary (the acute hospital services) and primary care (general practice and community staff). They told us that they were able to refer patients into secondary care when needed.
- Community matrons focussed on patients with long-term conditions and complex needs. They held regular meetings with their patients' GPs to discuss and agree their care and treatment.
- The respiratory care team held fortnightly multidisciplinary meetings involving GPs, consultants, community matrons and their own team. Healthcare professionals who attended the meetings discussed care and treatment of any patients they shared.

Good

Are services effective?

Referral, transfer, discharge and transition

- Healthcare professionals made referrals to community teams via the single point of referral (SPR) or directly to the teams by telephone or fax. Staff told us that professionals, the patient or their carer could contact the service for advice or a visit when required.
- Some patients with specific conditions were able to self-refer to the SPR service. This meant they could make direct contact with the community teams who were caring for them, rather than having to go via their GP surgery.
- We found staff discharged patients appropriately although some patients were reluctant to be seen by GP practice nurses. This meant they required visits by community nurses and put additional demand on the service. From Monday to Friday, non-housebound patients should go to the practice nurse within their GP practice, however, staff felt the policy was unclear to support them with regard to only seeing truly housebound patients. One team had a complaint about this and community nurses felt vulnerable.
- One community matron told us they were case managers for patients with long-term conditions. They visited following patient requests when they became unwell. They provided a treatment plan and when the patient became more stable they then stood down.
- One team were split between two bases. One part of the team was based in Craven Arms and the other in Ludlow. The Ludlow team had a 'triage' nurse on duty to review and prioritise all referrals. At Craven Arms an administrator answered the telephone and reviewed the referrals. Staff said this person had had this role for some time and would immediately contact the team leader should they have any concerns, and a community nurse would contact or visit the patient urgently. They said this also freed qualified staff whilst in the office to complete their records and undertake urgent visits. This was an effective use of staff.
- District nursing services in Telford and Wrekin operated from 8am to 6pm, seven days a week. Between 6pm and 10pm the rapid response team provided support for patients who had unexpected needs, for example with syringe drivers or catheters. Outside these times, the out of hours GP service provided a response to patients with urgent needs. Community nurses in Newport told us the rapid response team and out of hours GP service provided effective cover for them outside their normal working hours and no adverse incidents had occurred.
- A nurse from the rapid response team in Telford told us they accepted referrals from the ambulance service, the SPR and direct from other community teams. The rapid response team also provided a proactive 'in-reach' service to the emergency department in the local acute hospital. A nurse from the team attended the emergency department each day to assess patients and advise hospital staff about those who community teams could care for at home.
- The hospital in-reach service provided by the respiratory care team enabled patients to see the same nurse before and after discharge, in their homes. This provided effective continuity of care for the patient. The out of hours GP service informed the trust's respiratory care team if they had contact from or visited any of the team's patients. This allowed the respiratory care team to follow up the treatment given to their patient.

Access to information

- Staff at all the locations we visited showed us where they could find the trust's policies and procedures on the intranet. Staff could also access these away from trust locations via the 'staff zone' of the trust's internet site. We reviewed information on the trust intranet and saw the information was clear and accessible. This enabled staff to access information about evidence-based patient care and treatment through external internet sites.
- Community matrons in Telford and Wrekin had 'smart phones' that allowed them to access their emails while away from base locations. However, other staff did not have access to similar devices and were only able to access emails when at trust premises, or had access to smart phones but only used them for voice calls.
- A 'single point of referral' service (SPR) based in Telford dealt with referrals for community health services. The SPR team received telephone calls, secure emails and faxes from other providers such as GPs and acute hospitals, transcribed them into a standard format and passed them on to appropriate community teams by secure email.
- Some community staff told us they experienced difficulty contacting the SPR service by telephone. A SPR

manager told us they were aware of this problem and had submitted a capital bid for a new telephone system, to include call queuing and live performance monitoring.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- In every location we visited, we saw staff consistently gaining consent from patients before carrying out any assessment or treatment; and recording this in patients' notes.
- During our inspection, we found that staff had a mixed understanding of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Some community staff we spoke with were clear regarding their role and responsibilities of assessing patients' mental capacity and gave us several examples of patients who had not provided consent to treatment. One member of the rehabilitation team in particular demonstrated an in-depth understanding, explained the meaning, the process of carrying out an MCA assessment and what action to take if a patient did not have capacity to consent to treatment.
- District nurses in Newport demonstrated a good understanding of DoLS and told us that the local authority usually completed the process. The patients seen by the community nursing team were normally in their own homes or in residential care. The nurses told us, because of that, it was unlikely they would ever have to complete a DoLS application, however their understanding of the process allowed them to challenge any inappropriate deprivation of liberty they saw.
- However, a senior manager in Telford told us they felt their staff did not have good knowledge or understanding of the MCA and DoLS, and were not able to carry out MCA assessments.
- District nurses in Much Wenlock and Newport told us that if they had concerns about a patient's mental capacity they would ask social services or the patient's GP to assess them and make a plan. Mental capacity assessments are only valid at the point they are completed and cannot be done in advance, therefore this was not an appropriate method of assessing capacity to consent to or refuse treatment. The local authority provided MCA training for this team.
- We asked one community physiotherapist about their understanding of DoLS. They told us they had never heard of the term and knew nothing about it.
- A district nursing team leader in Telford located the trust's Mental Capacity Act policy on the intranet when we asked them. The policy included an assessment form; however, the team leader told us they could not remember it ever being used.
- The trust told us that training on the Mental Capacity Act 2005 was mandatory every three years for all front line staff with a care management responsibility. Information provided by the trust showed that 84% of staff working within community adult services had undertaken this training. This was slightly below the trust target of 85%.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We have rated this service as good for caring. This is because:

- Staff treated patients with kindness, dignity and respect; we observed many examples of positive relationships between staff and patients.
- Feedback from people using services was positive.
- Patients and their carers were actively encouraged to be partners in their care.
- Staff communicated in ways that helped patients and their carers understand.
- Staff helped patients and those close to them to cope emotionally with their care and treatment.

Compassionate care

- We observed that care and treatment of patients across all services was empathetic and compassionate. Staff promoted and maintained the dignity of all patients when they delivered care.
- We accompanied community staff on over 78 home and residential home visits to patients. In every case, we saw staff provided compassionate and kind care and treated patients with dignity and respect.
- Feedback from all people who used the service and those who were close to them was positive about the way staff treated them.
- Patients told us they received excellent care particularly from the community nurse services. One person said, "The care is wonderful". Another person said, "I have found the service to be excellent. I can't fault them". One community physiotherapy patient told us they had had "excellent care from the physiotherapist, fantastic support". Another said, "the team are amazing".
- One patient told us the support they received from the respiratory care service made them "feel secure".
- We saw patients were reassured throughout their treatment. For example, we observed patients who required dressings to extensive and painful leg ulcers. We saw nursing staff removed the dressings carefully to ensure they were not stuck to the wounds whilst also explaining to the person what they were doing and checking they were not in discomfort.
- The trust used the Family and Friends Test as a means of receiving patient and family feedback. The trust target for people who recommended the service was 90%. In January 2016 there were 1190 friends and family test responses received (from a possible 23021) which equated to a 5.2% response rate. Of the responses received 19 related to community nursing services and 424 rehabilitation and therapy services 440 were either extremely likely of likely to recommend the service they received. This meant that 98% of people would recommend community services.

Understanding and involvement of patients and those close to them

- We saw staff taking time to listen to patients' concerns and explaining care plans in clear, simple language to make sure patients understood what was going to happen. We also saw staff explaining treatment and therapy plans to patients, and talking to them about tasks they were doing in their homes to improve their safety and quality of life.
- Staff asked patients and their carers if they had any questions, and treatment plans were summarised to ensure patients understood. Where appropriate, staff asked people about their personal goals and what they wanted to achieve such as greater mobility or independence.
- We saw staff from the Enablement Team clearly explaining different types of equipment available to assist patients with their mobility and safety, and allowing patients to decide what was best for them. Staff made sure they used clear, non-technical language that their patients, relatives and carers could understand.
- We saw a district nurse in Telford supporting the spouse of a patient who was unable to communicate. The nurse discussed options for changing the patient's pain medication to a form that was easier to administer. The

nurse also talked about providing a 'just in case' box of breakthrough pain medicine to use should the patient's condition change suddenly. The nurse offered to speak to the patient's GP about the change on behalf of the family.

- People were involved and encouraged to be partners in their care and in making decisions, with the support they needed. Plans of care centred on what the patient wanted. One person and their husband told us, "all the nurses have been brilliant and they all explain things". One relative told us, "They ask about both of our health". Another relative said, "This service is amazing, we are lucky to have had it. I could not have got through the last six months without it".
- The trust's Admiral nurses ran workshops for carers of people living with dementia. They provided opportunities for carers to share their experiences and discuss issues, and offered training on areas such as communication and nutrition. The workshops also featured guest speakers giving advice on legal and practical issues about caring for people living with dementia.

Emotional support

- Staff helped patients and those close to them to cope emotionally with their care and treatment. They were enabled to manage their own health and care where they could, and to maintain independence.
- We observed community staff (including nurses, occupational therapists and physiotherapists) giving holistic care including support for close relatives. Where appropriate, they gave patients and their carers details for support groups. For example, we saw community physiotherapists in Telford checking the welfare and emotional wellbeing of a patient's spouse as well as the patient. Staff paid particular attention to how the spouse was coping with the change in circumstances that meant they had to act as carer for the patient during their rehabilitation. Staff offered support to the patient's spouse and it was clear that the offer was appreciated.
- We saw a district nurse in Telford talking to a patient's family about extra support for them in preparation for deterioration in the patient's condition. The nurse told the patient's family about support services available for them and gave them contact details.
- We saw a community nurse from Much Wenlock providing advice and support for a patient's relative who was struggling to cope with the patient's condition. The nurse was patient, empathetic and understanding.
- During home visits, staff demonstrated knowledge of people and their unique situations and provided tailored emotional support.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We have rated this service as good for responsive. This is because:

- Services were planned and delivered in a way that met the needs of the local population.
- Staff took equality and diversity needs into account when delivering care.
- The service was responsive to the needs of people living with dementia and we observed good examples of staff responding to the needs of vulnerable patients.
- Patients were able to access care in a timely way, waiting times for appointments and treatment were managed appropriately.
- When complaints were made they were taken seriously and there was evidence that improvements were made to services as a result of concerns.

Planning and delivering services which meet people's needs

- The trust had three integrated community service (ICS) teams that covered Shropshire. The ICS was a pilot scheme originally planned to run until the end of March 2016, but at the time of our inspection had been extended for a further nine months. The integrated service meant that the same team could assess patients for health and social care needs. The team's role was to support early hospital discharge as well as prevent hospital admissions. The team provided a short-term input and then 'signposted' patients to other services when needed.
- The trust received a weekly average of 36.6 referrals for patients following hospital discharge, which was below the weekly target of 45 per week but within an agreed range. The service also had a weekly average of 11.8 patients referred to prevent hospital admission, this was below the expected weekly level of 31 patients per week.
- Between April and November 2015, 3,667 patients received support from ICS either following hospital discharge or for prevention of admission.
- We found that where ICS teams worked alongside interdisciplinary teams, coordinated care packages that met people's needs were not always provided. Patients and other health professionals were frequently unsure of the role of each team and which team they should contact.
- Some of the ICS staff at Much Wenlock operated as a 'START' team. START stands for 'short term assessment and re-ablement team'. The team provided care for vulnerable patients receiving treatment for acute illnesses such as chest or urinary tract infections, allowing them to remain in their homes rather than being admitted to hospital.
- The trust provided 'Diagnostics and Access to Assessment Rehabilitation and Treatment' (DAART) clinics in Oswestry, Bridgnorth and Shrewsbury. Each DAART operated slightly differently but all provided a service to reduce hospital admission for non-urgent patients who required assessment. This might include blood tests, diagnostic treatment for deep vein thrombosis and x-rays. Between April 2015 and February 2016, they saw 2,342 patients. However, staff at the other locations told us they felt the service was under-utilised. During the same period, 366 patients attended Bridgnorth DAART and 708 patients attended Oswestry DAART.
- Several staff told us there was no up-to-date community nursing specification in place. They told us this meant they were unclear whether they should only be seeing housebound patients. We asked the trust for information about the service specification for community nursing. The trust sent us a copy of a service specification dated May 2007. However, this policy did identify that home visits were primarily for patients who were unable to leave their home without substantial support and gave examples of which patients this may include.

Equality and diversity

- All new staff received equality and diversity training as part of their corporate induction.
- We saw information that showed the trust had a long-term equality and diversity strategy. The strategy

included staff training on equality and diversity that would commence in spring 2016. 'Everyone Counts' equality and diversity workshops had taken place during staff away days.

- Staff told us they identified communication needs of their patients at the time of the initial contact with them. Staff told us they had access to an interpreter if needed. The trust could also send out information in different languages if needed.
- Physiotherapy staff in Telford told us they had access to an interpreter service for patients whose first language was not English. However, they also told us they normally used family members to translate for them. Using family members as translators is not best practice as it is not possible to check levels of understanding and it may affect patient confidentiality.
- The trust had a 'Patient and Carer Panel' (PCP) which provided an opportunity for users of services to highlight their own experiences of using the trust's services. We saw that the PCP had regular sessions on equality and diversity. For example, a visually impaired patient of the diabetes service told the story of their care at the 'Celebrating Success' staff event in October 2015.

Meeting the needs of people in vulnerable circumstances

- District nurses in Telford could refer patients who were living with dementia to the trust's team of specialist Admiral Nurses. Admiral Nurses specialise in supporting patients living with dementia and their families, and have close links to Dementia UK, a charity that offers guidance for patients, relatives and carers. Admiral Nurses were not available in Shropshire.
- The trust was a member of Shropshire Dementia Action Alliance. This allowed the Admiral Nurses to work closely and share good practice with voluntary organisations, other services and NHS trusts.
- Community staff had access to on-line dementia awareness training. Staff we spoke with told us they had completed this training and it had given them a good understanding of the issues affecting patients living with dementia, their carers and families. However, we were not reassured that the availability of this training was widely known. Three community nurses across two different teams told us the trust did not provide any dementia awareness training.
- Community physiotherapists in Telford told us physiotherapy services for adults living with learning disabilities had been decommissioned. Other local services such as GP surgery services were still sending referrals to the physiotherapy team, however they could not respond to the requests as specific training was required to care for patients in this group. This meant that adults living with learning disabilities might not have received physiotherapy when they needed it. The team had escalated this situation to their manager and the divisional manager.
- One community matron told us that they would attend significant consultant appointments to ensure that their patients had the correct treatment quickly. Because of this, one patient with 'brittle' or unstable asthma had an agreement to go directly to the respiratory ward at the local hospital to ensure they received timely treatment. Another patient had difficulty hearing and understanding. The community matron accompanied this patient on a hospital visit. The community matron was able to explain their treatment so the patient was able to choose the best option and outcomes for themselves.
- We visited one patient who had difficulty getting out of their chair. An occupational therapist identified that the person required a different chair. We observed the staff member arranged for the chair to be delivered later the same day. This meant the person was not confined to their chair and the risk of skin damage was reduced.
- Community staff in Newport told us they were aware of the problem of patients feeling or becoming isolated in rural areas. They had contact details for a local 'befriending service', a voluntary transport service and for Age Concern and encouraged patients to make use of these services if isolation was an issue.

Access to the right care at the right time

- The trust had a target of 18 weeks referral to treatment time (RTT) for 95% of non-admitted patients and referral to treatment for incomplete pathways. Information provided by the trust identified that the majority of its services met the 18-week target although waiting times

were starting to increase. The trust gave us data showing therapy services in Telford and Wrekin had seen over 96% of their patients within the 18-week referral to treatment target, between March 2015 and February 2016.

- Community nurses provided a service between 8am and 6pm. Staff told us that there was at least one member of staff on duty between these times for each community team. However, staff told us that the out of hours service provider was not available until 7pm. Teams told us that this gave them a challenge, as there was a gap in service provision. One team told us they would only answer the phone until 5pm although visits were undertaken until 6pm. Others teams told us that they frequently went out after 6pm to ensure their patients received timely and appropriate care. A rapid response nursing team provided a service 8am until 10pm, seven days a week for Telford residents only.
- Community nurses told us they responded to 'urgent' referrals within 24 hours and non-urgent referrals within 48 hours. Information provided by the trust identified 99% of urgent referrals were seen within 24 hours, against a target of 100% and 99% of non-urgent referrals were seen within 48 hours, also against a target of 100%.
- One community matron said they accepted patients with 'complex' medical health problems from the acute services. This provided patients with support to manage their long-term condition and reduce the risk of ill health.
- The Telford Musculoskeletal Service had targets of screening patients within 48 hours of referral and seeing patients within a week for urgent referrals and four weeks for non-urgent. At the time of our inspection a manager told us initial screenings were not being done until 48-72 hours after referral and non-urgent referrals were taking up to six weeks to be seen. Non-urgent rheumatology patients were waiting up to 10 weeks to be seen. Urgent referrals were being seen within the one-week target.
- The trust gave us data showing therapy services in Telford and Wrekin had seen over 96% of their patients within the 18-week referral to treatment target, between March 2015 and February 2016. Staff told us they had a maximum waiting time of four weeks from referral to first appointment for patients with long-term conditions.
- Patients with chronic obstructive pulmonary disorders (illnesses that had a long-term effect on their breathing) had a dedicated telephone number to contact the out of hours GP service. If they required care or advice outside the trust's respiratory care team's operating hours this number gave them direct access to a clinician.

Learning from complaints and concerns

- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally and how to escalate when required. Staff we spoke with were aware of the complaints procedure and told us where possible they would try to resolve patients' concerns themselves.
- There had been 19 formal complaints about adult community services between 17 October 2014 and 16 October 2015. Of these, seven were fully upheld and two were partially upheld.
- Most of the staff we spoke with told us they could not recall having had a complaint. A manager from the respiratory care team told us about a complaint they had received about a patient who had been kept waiting in a clinic. Because of this, the team had introduced a process of ensuring that patients would be informed if clinics were running more than 15 minutes late.
- Written information on how to complain was not widely available for people who used the service. Patients and their relatives we spoke with said they would speak to the nurse but were unclear how they would make a complaint otherwise. One person we spoke with said they were unsure how to raise concerns. Community nurses said they discussed how to raise complaints as part of the initial assessment of the patient's needs.
- One team leader told us that although they did not have many complaints most patients expressed a preference to see the same nurse. They told us that because of this feedback they had responded by implementing 'named

Good

Are services responsive to people's needs?

nurses'. The named nurse would be normally be a band 6 nurse who was a caseload holder for each GP practice, who would be supported by a small team to aid patient continuity of care.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We have rated this service as 'requires improvement' for well-led. This is because:

- Governance systems and processes were in place, including recording of risks but not all risks were identified and had action taken to mitigate them.
- Staff told us they felt supported at a local level but team leaders felt less well supported and some teams described working in isolation.
- Staff were unclear of the future for the integrated community service.
- Staff were passionate about the service they delivered but were concerned that resources were stretched.
- Staff morale was mixed, morale within some teams was low due to staff shortages.
- There was a limited approach to obtaining feedback from patients and their carers.

However we also saw:

- The values for the service were well developed and encompassed compassion, respect and dignity
- The trust had mechanisms in place to communicate with staff on a regular basis and staff told us they felt engaged.

Service vision and strategy

- The trust values were: improving lives; everyone counts; commitment to quality; working together for patients; compassionate care; respect and dignity. Staff told us that consultation about the trust values was undertaken and that they were encouraged to provide feedback on their views. We saw staff provided high quality care and we received positive feedback from both patients and carers about the care staff provided which demonstrated these values.
- There had been 'away days' for staff to consider the trust strategy. Staff were invited to attend an away day during which the strategy and values of the trust were discussed.
- Staff were unclear of the future for the integrated community service (ICS). Staff told us that ICS staff had temporary contacts until 31 March 2016 but did not know where they would be working after this, however a team leader did confirm that the service had been extended by another nine months.
- The trust did not have a professional lead for allied health professionals. Allied health professionals include staff such as physiotherapists, occupational therapists and speech and language therapists. Several members of this staff group told us they felt they did not have a voice in the organisation and, because of this, there was no strategic vision for rehabilitation services.

Governance, risk management and quality measurement

- Team leaders told us and we saw that incidents and any learning from incidents were discussed at senior management team meetings. Any learning from the incident or meeting was then discussed during community team meetings. One team manager gave us an example of how practice had changed following a serious incident. They told us that previously community nurses had not been allocated time to review care needs including pressure ulcer prevention care. They told us that now staff had time allocated to review patient's care needs within the system.
- Adult community services maintained a risk register that then fed into the corporate register so that the board had oversight of the main areas of risk for the service. The community health service divisional registers identified 18 risks. Of these risks, two were described as high risk (current risk score of 15 or above), and related to the use of 'high cost' agency staff, and not meeting the Trust Development Authority (TDA) requirements regarding agency staff usage. However, information provided by the trust identified that community adult services did not use agency staff and this was also confirmed by staff. We saw no risk recorded relating to a lack of staff handovers, team meetings or a lack of supernumerary time for senior nurses. This may mean that the trust were not fully sighted on risks and staff concerns.

Requires improvement

Are services well-led?

- We were given copies of the risk registers for the ICS and for the Telford Musculoskeletal Service (TeMS). The ICS risk register had 10 entries, nine of which were recorded as medium risk and one as low risk; the TeMS risk register had six entries, all of which were medium risk. All of the entries on both documents recorded action that had been taken to control or reduce the risks in question, and all had been reviewed or updated within the six months preceding our inspection.
- The team leader at the ICS based at Much Wenlock collated data on their activity and performance and submitted it to local authority analysts weekly. The analysts provided weekly performance data for the team on areas such as delayed discharges and patients who were under their care longer than planned. The team leader shared this information with all of the team members during the weekly board round.
- A member of staff in the reablement team told us they had started to collect data to address inappropriate referrals from one agency, but said there were no formal audits in place in the service.
- Team leaders told us the trust had an electronic system that monitored staffing and caseloads within the teams. Team leaders we spoke with told us that the trust updated systems daily to enable senior managers to review activity and actions needed to ensure that essential visits were undertaken.
- Staff in all but two community teams told us about delays in staff recruitment. They told us that frequently there was a delay of several weeks after a post holder had left before a senior manager gave agreement for the post to be advertised. One team leader told us there had been a delay of over 13 weeks before one vacant post in their team had been advertised. Another team leader said it frequently took a senior manager four months before they approved a post.
- We asked the trust for a copy of its pressure ulcer management policy. The copy we were given had been due for review in November 2011and had a note attached saying “This policy is under review and due for approval at the Clinical Policies Group on 18 April 2016 but has been reviewed as relevant for clinical use by Tissue Viability in March 2016. Additional pressure ulcer guidance is available on Royal Marsden Manual Online”. We were not reassured that the trust was ensuring that its pressure ulcer management policy was regularly reviewed, or that staff had been told the trust’s policy had been withdrawn and they should be using the online guidance.

Leadership of this service

- Staff said they felt supported by their team leaders and band 6 supervisors. One team said they only saw their team leader once a week and would like to see them more often. Some but not all team leaders had clinical duties. One team leader managed staff working from three community bases and worked clinically two days a week. They said that they were not always able to see staff as much as they would like.
- Community physiotherapy staff in Telford told us they felt they had very little support from their manager and were left to manage their own caseload without supervision.
- Two band 5 nurses in Newport told us their team leader was approachable and visible, and had effected positive changes. They told us the team leader had made changes, which improved the nurses’ access to equipment for patients.
- Community staff in Newport told us they worked in isolation but did not feel isolated. During team meetings, their team leader fed back information from other areas of the trust, and community staff regularly had the opportunity to attend other teams’ meetings to share learning and good practice.
- North Shrewsbury team band 6 nurses had two protected management days each week. However, other teams we spoke with said that band 6 staff did not have or rarely had any supernumerary time due to staffing challenges within the team.
- We received mixed feedback about support from more senior managers. One band 6 nurse said they had never met the community services manager although they had been in post for more than 12 months. However, staff in another area said they received good support from their senior managers who they had worked with for some time.
- Community nurses in four community teams said that they felt that senior trust managers did not listen to them and lacked awareness of the challenges of working in a rural area. They said that travel time

between visits and the community base was longer. They also said there was a lack of awareness of how community nurses liaised with other organisations and professionals and acted as advocates for their patients.

- Staff gave us examples of what they considered was poor communication from senior managers. These included annual leave and personal development requests that had not been responded to.
- One leader told us they felt isolated and unsupported since being appointed. They told us they had escalated concerns about their service to the trust's executives but had not had any feedback. Staff said they would like more communication from the senior management team as they were not visible.
- Two team leaders in Telford told us that the trust's chief executive was visible and made visits to community bases, often accompanied by other board members. However, another team leader and a band 6 nurse in Telford told us the trust board were visible to senior managers but not to junior staff.
- The trust told us that the senior management team visited each team approximately every six months. During these visits, staff were able to discuss any concerns. We were told about one example where staff had fed back concerns about the physiotherapy waiting list. Consequently, a new physiotherapist was appointed and would commence employment in April 2016.

Culture within this service

- We found staff were hard working, caring and committed to the care and treatment they provided. They demonstrated a strong patient focused culture. Staff across all adult community services were dedicated and compassionate.
- The team leader for Oswestry ICS said they were proud of the team. Another said, "I am proud of my staff as they go the extra mile". One community matron told us, "I love my role it gives me flexibility to respond to patients in a crisis". Staff told us they felt proud of the care they provided; promoting peoples' independence and the end of life care given. Another staff member said, "Holistic care is good and we get really positive feedback from patients".
- Some staff told us that colleagues were leaving the service because of pressure of work and the reducing opportunities for progression.
- We were also told that morale within some teams was low due to staff shortages. Team leaders said that, when possible, exit interviews were undertaken. One staff member said, "I wish that someone would ask about the reason why staff are leaving".
- Many services appeared to run on the good will of staff working additional hours unpaid, and missing breaks. Staff told us their concerns in relation to working in a rural location and that the senior management team did not consider time taken between patients visits. One staff member said, "The board do not have a true picture of what we do".
- A manager in Newport told us there was a culture of openness at team level, with staff members' immediate supervisors, but felt this was not reflected at senior manager level.
- A team of allied health professionals in Telford told us they worked in isolation, and communicated with the single point of referral service by email. They told us they had a culture of not challenging, and not being challenged. They told us they were happy to be left alone.
- Staff we spoke with said they would raise concerns and would 'whistle blow' if needed.

Public engagement

- Patients could access information about services, the locations they were provided from and contact details where they could find further information on the trust website.
- Staff told us they did not formally collect feedback from patients and relatives. They told us they saw 'thank you' cards and verbal feedback as evidence of positive experiences. The notice boards in all the community locations we visited displayed thank you cards.
- The trust had a 'patient and carer panel' (PCP) which met regularly throughout the year. The PCP was involved in planning services, staff recruitment, delivering training and reviewing services.
- The respiratory care team based at Halesfield carried out patient satisfaction surveys twice a year. Patients

who responded said they wanted a seven-day service, better communication and continuity of care. As a result of this, each nurse on the team had been given their own caseload of patients and a duty nurse role had been introduced. The duty nurse answered calls from other healthcare professionals and dealt with urgent referrals. We saw action plans produced by the team leader following these surveys.

Staff engagement

- The trust used a combination of email, intranet messages and newsletters to engage with community staff. The trust published a weekly staff email newsletter, called 'Inform'. Staff we spoke with were aware of the newsletter and told us it kept them up to date with plans and developments across the trust.
- The trust's chief executive officer (CEO) wrote a weekly 'blog', which was available to all staff. It gave staff information about the CEO's activities, both at work and in their personal life, during the week. Community adults staff in Telford were all aware of the blog and, while not all of them read it, all of the staff we spoke to told us it was a good thing and it made the CEO more approachable.
- The trust had a monthly team brief. Staff told us that the team brief provided a summary of important events, policy updates and other occurrences within the trust.

Innovation, improvement and sustainability

- Managers told us they had a cost improvement plan for their service. They told us this included a reduction in community bases and the skill mix of teams. However, managers said they were concerned as the number of referrals to services had increased and the trust had not acknowledged this.
- The trust had highlighted high spending on wound dressings. Following a review of practice, the trust had a new system for ordering dressing and availability of types of dressings.
- The tissue viability nurse service had shown that improvements to leg ulcer dressings (from four-layer compression bandaging to two-layer compression) was cost effective and had reduced staff costs and improved patient comfort without compromising healing rates. As a result of this initiative the tissue viability service had been shortlisted for two awards from The Journal of Wound Care and been accepted for abstract at European Wound Management Association in Germany in May 2016.
- The use of telemedicine within the tissue viability service addressed some challenges of working within a large and rural county whilst promoting effective patient wound healing.

Shropshire Community Health NHS Trust

R1D

Community health inpatient services

Quality Report

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Website: www.shropscommunityhealth.nhs.uk

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1D34	Whitchurch Community Hospital	**Community Health Inpatient Services**	SY13 1NT
R1D25	Bishops Castle Community Hospital	**Community Health Inpatient Services**	SY9 5AJ
R1D21	Ludlow Community Hospital	**Community Health Inpatient Services**	SY8 1QX
R1D22	Bridgnorth Community Hospital	**Community Health Inpatient Services**	WV16 4EU

This report describes our judgement of the quality of care provided within this core service by Shropshire Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Shropshire Community Health NHS Trust and these are brought together to inform our overall judgement of Shropshire Community Health NHS Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Summary of findings

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Summary of findings

Overall summary

We have rated this service as 'requires improvement'. This is because:

- Although services were planned and delivered to meet the needs of the local population, the admission criteria was not being complied with and the community hospital vision was not fully implemented.
- Patient's discharge were delayed due to social care arrangements being locally restricted.
- People with complex needs were assessed yet their support from therapist teams was not sufficient to support a timely discharge into the community.
- Dementia friendly environments had been developed to support in patients; we identified and staff told us the need for diversional therapies was required to offer specialist intervention.
- Staffing levels were reported monthly but the patient acuity and dependency was reported bi-annually which meant that staffing levels were not adjusted to meet the needs of the patients on a regular basis.
- Recommendations following external audits had not been fully achieved.
- Not all staff felt valued or listened to with the management of staff in some areas not supportive.
- Patient records were not always kept secure.
- Nursing staff received no formal clinical supervision. Clinical skills were not observed by managers to gain assurances of the staff competencies.
- We saw several examples of poor outcomes for patients including lack of support during meal times and personal hygiene issues not promptly addressed (Whitchurch Hospital).

However we also saw that:

- Infection control and prevention processes delivered low rates of infection.
- Patient safety was promoted through individual risk assessment from admission and their safety was monitored as part of the individual care plan including appropriate pain relief.
- The hospitals followed local and professional guidance and most of the staff were familiar with the policies and procedures.
- The Friends and Family Test (FFT) scores showed patients and carers were consistently satisfied with the care and treatment they received.
- Patients told us they were treated well by the staff in a kind and compassionate manner.
- Link nurses met with relatives of patients diagnosed with dementia to review consent and discuss the butterfly scheme which was promoted on the ward.

Summary of findings

Background to the service

Shropshire Community Health NHS Service has four community hospitals located around the county providing inpatient services for up to 97 patients. Each hospital provides post-operative support and a rehabilitation service to meet the needs of local people. Bridgnorth Hospital has day surgery facilities where minor operations and simple procedures are performed. There are 16-beds at Bishop's Castle Community Hospital, 25 beds at Bridgnorth Community Hospital, 24 beds at Ludlow Community Hospital and 32 beds at Whitchurch Community Hospital.

Patients are admitted to the community hospitals in a variety of ways which could be directly from home, in order to avoid an acute hospital admission or transferred from the local acute NHS hospitals. A multidisciplinary team approach included the integration of therapy, medical and social care professionals.

During the inspection we visited inpatient wards and facilities at each of the four hospitals. We spoke with 50 patients and relatives of people using the service and observed interaction between patients and nursing staff. We spoke with 73 members of staff, ranging from student nurses, nurses of all grades, physiotherapists, occupational therapists, domestic staff, doctors and consultants. We looked at the medical and care records of 20 patients, observed four staff handovers, attended two multidisciplinary team meetings and reviewed data held at ward level.

We spoke with two of the GPs who provided medical care for patients on the wards.

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including:

Head of quality; deputy director of nursing; consultant nurse; clinical quality manager, community matrons; nurse team managers; senior community nurses; occupational therapists; physiotherapists; community children's nurses; school nurses; health visitors; palliative care consultant; palliative care nurse; sexual health nurses and specialist dental advisors.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

Summary of findings

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 7 to 11 March 2016.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a much defined period of time, however we did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held six focus groups with a range of staff across Shropshire who worked within the service. In total, around 20 staff attended all those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

We carried out unannounced visits on 13 and 24 March 2016.

What people who use the provider say

People told us they were satisfied with the level of care offered to their relatives who were currently using the service. We heard that the nurses were lovely and looked after the patients very well, although they were very busy.

Patients told us that the staff answered the call bell in a timely manner. One patient told us they had received very little physiotherapy and their progress was slow.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must review the admission criteria for community hospitals or ensure it is complied with and that the vision for community hospital's is revisited
- The trust must ensure that when local social care arrangements are required for a patient's discharge further collaborative working is required; an increase in therapist teams to support patients with complex needs is needed to promote timely discharge
- The trust must ensure that increased patient acuity is considered when staffing levels are planned so that patients requiring support and assistance receive this appropriately

Action the provider SHOULD take to improve

- The trust should review arrangements for provision of dementia friendly diversional therapies.
- The trust should ensure that all recommendations following external audits are revisited.
- The trust should ensure that patient records are fit for purpose and kept secure at all times.

Summary of findings

- The trust should ensure that nursing staff are able to access regular, formal clinical supervision.

Shropshire Community Health NHS Trust

Community health inpatient services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as requires improvement for safe. This is because:

- Staffing levels were reported monthly but the patient acuity was infrequently considered which meant that staffing levels were not regularly adjusted to meet the needs of the patients.
- Patient records were not always kept secure and the quality of record keeping was inconsistent. Re-audit of the concerns from 2013/14 had not been undertaken.
- The service had not met the trust targets for compliance with mandatory training for staff in nine of the 14 subjects.
- Risk assessments were completed on admission but had not always been reviewed as per trust policy.

However we also saw:

- Staff were encouraged to report incidents and most staff members had received some feedback.
- Infection control and prevention processes were in place; recorded rates of infection were low.
- NHS Safety thermometer data was displayed and used to measure 'harm free' care with outcomes consistently reported over 98% for no new harm to patients admitted in to the community hospitals.
- Patient safety was promoted through individual risk assessment being completed on admission.
- The importance of referral for safeguarding issues was understood. Staff understood their role in reporting and told us they were confident to raise issues and were up to date with training.

Safety performance

- Ward safety performance was clearly displayed on notice boards in all hospitals. We reviewed the safety data from December 2014 to December 2015. Harm free days and no new harm are reported in the NHS to evidence the delivery of safe inpatient care. Data, in line with the national average, showed that harm free care and no new harm recorded were an average of 1% during that period. The occurrence of falls, pressure ulcers and catheter and urinary tract infections occurrence was less than 1%.

Requires improvement

Are services safe?

- The number of new pressure ulcers reported by the trust, peaked in January 2015 (9 cases reported) and April 2015 (8 cases reported). In total 57 pressure ulcers were reported between December 2014 and November 2015. The trust told us only one of these occurred in the community hospital. Fifty four falls were reported between November 2014 and October 2015 which had averaged at four per month.
- The trust had robust internal mortality review processes that ensured patient safety, clinical effectiveness and user experience formed the core practice and principles of services. This included a trust-wide mortality review group chaired by the medical director. We saw the meeting minutes which demonstrated the group undertook reviews of all deaths and reported findings and recommendations to the quality and safety operational group. These were reported to the quality and safety committee and the trust board as part of the assurance around management of risk within the trust.
- Between April 2014 and March 2015 there were three unexpected deaths reported.

Incident reporting, learning and improvement

- Between December 2014 and November 2015 there were five inpatient incidents reported to the Strategic Executive Information System (STEIS) of these, one was related to a death, one to a pressure ulcer and three related to slips/trips/falls. Serious incidents were also reported to the (NRLS) with around 80% reported as 'no harm' or 'low harm' to the patient.
- No Never Events were reported between December 2014 and February 2016.
- Evidence showed that the number of incidents with harm being reported had reduced over time. For example in June 2015, 31 incidents were reported as moderate harm and this had reduced to two in December 2015.
- Between March 2015 and February 2016 there were five cases of Clostridium Difficile reported which were all diagnosed 72 hours after admission. The manager at Bridgnorth Community Hospital showed us the root cause analysis for the latest case under review; an 'episode of care form' was completed which showed a synopsis of what had been done well, what had not been done and any lasting impact. Meeting minutes showed attendance from the infection, prevention and control lead, pharmacist, hotel services, the GP, clinical services manager and the ward staff with the next meeting planned in March.
- Staff were encouraged to report incidents and most staff members had received some feedback. All levels of staff were encouraged to report 'no harm' incidents. Staff told us they occasionally got to hear about incidents that occurred in other wards or departments in ward meetings but not often demonstrating that a valuable 'lessons learned tool' was not being fully utilised.
- We found that there was an open culture of reporting medicine incidents, which were recorded directly onto an electronic incident reporting system. Staff gave an example of learning from a particular type of incident and what changes to practice had been introduced to minimise the error occurring again. Learning from incidents was cascaded down to ward staff at briefing meetings through targeted learning documents.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of'certain notifiable safety incidents'andprovide reasonable support to that person
- When incidents had occurred, staff told us that the patient and their relatives were spoken with at the time or asked to attend a formal meeting, where explanations in line with Duty of Candour were offered and apologies given. For example, we read a letter which had complied with DoC that had been sent to the relative of a patient who had suffered a stroke and their transfer from the community hospital to an acute hospital had been delayed.

Safeguarding

- Three safeguarding alerts were reported to adult safeguarding from the community hospitals in the last 12 months; two related to Bridgnorth Hospital and one related to Whitchurch Hospital. There were no safeguard alerts open.
- Ninety one percent of staff had completed safeguarding adults training to level one and 87% of staff had completed safeguarding children 'level one' training; the trust compliance target rate was 85%.

Requires improvement

Are services safe?

- Staff understood their role in reporting and told us they were confident to raise issues with the safeguarding team promoting patient safety and avoiding harm where possible. Staff described the process and showed us how they accessed the form to complete.
- Patients told us they felt safe and well cared for by the staff. We saw that all patients were observed to have their call bells to hand; we heard and saw call bells answered promptly on most occasions. At Ludlow Hospital we saw the use of wireless call bells being used to ensure all patients could call for assistance.

Medicines

- Clinical pharmacists were actively involved in all aspects of patient's individual medicine requirements, including a falls review of medication. A falls risk review was carried out by a clinical pharmacist on the medication being prescribed to a patient. Certain medication can increase the risk of a patient falling. They may recommend for example a reduction in dosage, a change to an alternative in medication or if it's a great risk to the patient stop the medication all together. It was documented on the patients prescription chart in green pen.
- A pharmacy technician ensured that all the patients' medicines were available for discharge.
- Medicines, including controlled drugs, were stored securely. At the time of our visit, medicines were stored at suitable temperatures to maintain their quality and appropriate arrangements in place to ensure these were maintained. However, there was not always a robust system in place for the checking of expiry dates of some medication. We found one medicine at Bridgnorth Community Hospital was available for administration after it had expired and another medication was due to expire at the time of the inspection.
- Appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The sixteen records we looked at showed patients were getting their medicines when they needed them. If patients were allergic to any medicine, this was recorded on their prescription chart.
- A pharmacy audit undertaken between May and September 2015 showed that there were 334 omitted doses reported on the electronic incident reporting system. Staff stated that there had been a change in practice since September 2015 which had reduced the number of omitted medicine doses, including checking the medication charts during handover.

Environment and equipment

- All areas we visited were clean, well maintained and free from trip hazards including corridors, quiet rooms and bathrooms.
- Signage was clear and well positioned to ensure patients and visitors were able to source the appropriate area and wards safely.
- Patient-led assessments of the care environment (PLACE) 2015 results for maintenance were in line with the national average of 90% at Bishops Castle Hospital and Ludlow Hospital with Bridgnorth Hospital and Whitchurch Hospital scoring 99%.
- Security staff were not employed at the hospital sites. Staff told us that they generally felt safe working in the hospital at night; they followed a 'lock down' procedure to ensure that windows and doors were secure. Staff followed local procedures which had evolved relative to the location of their ward. For example Bishop Castle hospital consisted of only one ward. There were no other NHS staff available to assist. Staff worked with the adjacent care home to alert each other if they experienced any suspicious activity. They also had a good relationship with the local police who made periodic visits.
- Portable equipment was electrically tested on an annual basis and all the equipment we looked at was in date. Re-test date stickers were in place.
- Domestic staff were available seven days a week and an evening service was in place. Those domestic staff we spoke with were aware of their responsibilities relating to the safe storage of their trolleys and cleaning fluids and should an accident occur, they had access to data relating to Control of Substances Hazardous to Health (COSHH).
- Waste management was handled correctly and staff described different types of waste disposal in the ward environment. Foot operated bins were in place in all areas.
- Staff told us they had access to the specialist equipment they required. Bariatric equipment was available and staff told us specific training was delivered.

Requires improvement

Are services safe?

Quality of records

- An active nursing record was stored on each patient's bedside locker; the medical records were securely stored in a ward trolley. We saw one set of medical notes and a patient handover sheet left unsecure at Whitchurch Hospital, which were removed immediately when we brought it to the attention of staff.
- An admission checklist was completed when patients were admitted to the wards. We saw that this had not always been completed or signed. The patient history, individual needs and plan of care was recorded and additional support when necessary was arranged such as physiotherapy.
- To ensure compliance with the relevant national, professional and local clinical record keeping requirements, records of active patients or those recently discharged from the community hospital were audited by the service. In the 2013/14 audit, six areas of non-compliance were identified. These areas included lack of patient and health care professional identification, insufficient evidence of gained consent and patient discussions within case note entries and poor completion of discharge summaries.A seven point action plan which listed the recommendations from the audit had been signed as achieved by May 2014.
- A re-audit was due to be carried out
- There was therefore no assurance that the procedures to address the concerns raised in 2013/14 had been completed.
- During our inspection, we found inconsistencies in the quality of care records we looked at. For example at Bridgnorth Community Hospital we looked at nine sets of records. Of those five were incomplete; two manual handling assessments had not been completed, two manual handling assessments had not been reviewed weekly and one diabetes check had not been completed. AtLudlow Community Hospital, for example of the eight records we looked at three were incomplete; a diabetic checklist was not signed or dated, falls assessment had not been completed weekly and a bed rail assessment had not been reviewed. At Whitchurch Community Hospital we found an end of life care plan was incomplete and diabetes check not escalated to the GP and falls assessments not reviewed weekly. Records did not always identify the time when entries had been made; signatures were missing and some entries were not legible. We highlighted the discrepancies to the nurse in charge. We checked five sets of patient care records at Bishop Castle. We found that records were completed correctly. They contained risk assessments relevant to the needs of the patients, these had been completed correctly and where appropriate updated or amended as patients' needs changed. Patients who required barrier nursing had their care records outside their room, this provided an opportunity for unauthorised access to personal and private information. Patient records must be kept secure at all times.

Cleanliness, infection control and hygiene

- Standards of cleanliness and hygiene were maintained across all the hospital sites by the in-house domestic staff. They supported the care staff in protecting people from a healthcare associated infection. Observational hand hygiene audits were completed unannounced. In January 2016, 100% compliance was achieved in all four hospitals and in February 2016 100% compliance was achieved in three hospitals. At Whitchurch Hospital 90% was achieved due to a member of staff wearing jewellery. A re-audit scored 100%.
- Staff adhered to handwashing procedures and the use of hand gel. We saw that nursing and medical staff washed their hands and used hand gel between patients; they adhered to the bare below the elbow policy and wore personal protective equipment (PPE) such as aprons and gloves. Signage reminded people to wash their hands to protect patients, relatives and staff from cross infection.
- Staff received level one infection control training. The training records compliance was above the trust target of 85% in all areas except Bishops Castle Hospital which was 81%. Gaps in the training were generally due to long term sickness.
- PLACE (2015) results for cleanliness were above the national average of 98% scoring no lower than 99% in all four hospitals.
- Patients were screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) on admission. Zero cases had been reported between March 2015 and February 2016.

Requires improvement

Are services safe?

Mandatory training

- The trust mandatory training target was 85% for all training courses except for information governance which was 95%. Data provided showed that across the four inpatient sites the staff failed to achieve this in nine of the 14 courses including information governance.
- The lowest training compliance rates were seen in fire safety (50% - 63%), health and safety (19%-81%), conflict resolution (20% - 71%), fraud (19% - 75%) equality, diversity and human rights (31%-75%) and adult basic life support (44%-73%).

Assessing and responding to patient risk

- National early warning scores (NEWS) were used for the assessment of unwell patients; simple observations detected when a patient's condition required a more intense observation and further investigation. Staff told us they used NEWS to identify and respond appropriately to deteriorating health of patients including medical emergencies. We saw two NEWS completed correctly.
- A trust 'sepsis bundle' was implemented by medical and nursing staff to identify early signs of infection and initiate prompt treatment.
- At Ludlow Community Hospital we saw patients left unattended by staff for over 15 minutes during an emergency situation. We witnessed all the staff respond to the emergency bell leaving patients in one-half of the ward entirely unsupervised.
- We observed staff handovers to be a formal process in all of the hospitals, this ensured that all staff were aware of the patients on the ward. Each member of staff was provided with an 'up to date' print out of the patients names, status and plan of care to ensure that they had the information they needed. Handover, including a safety huddle, occurred at the start and end of each shift. To ensure each patient was benefitting from the planned multi-disciplinary input, the team met daily to discuss each individual patient.
- Staff were aware of the importance of patient safety to ensure that their independence was promoted whilst protecting their safety. Patients were individually risk assessed on admission. The assessments clearly stated for 'weekly review' or 'following an incident'. Assessments that we looked at had not been correctly reviewed in the care records which was brought to the attention of the nurse in charge.
- Medical, nursing and multi-disciplinary records were reviewed on the weekly ward round to assess the progress of each patient, to plan the week ahead and review the estimated discharge date. Treatments and therapies were arranged to accommodate the individual needs of each patient including mobility assessments and social care reviews.
- Preventing venous thromboembolism (VTE) in community hospitals' policy was in place. Patients were assessed on admission. VTE management included the use of prescribed anti-embolism stockings.
- At Ludlow hospital we observed a 'safety huddle' prior to the patient handover; the ward manager informed the staff of any events that had occurred on the ward, highlighted patients with high risk scores and reviewed the ward safety thermometer data. The staff told us this huddle had raised their awareness of patient risk.
- We spoke with physiotherapists and occupational therapists (OT) who told us they told us they felt part of the ward team. We heard examples whereby their time was limited with each patient as the dependency of the patients had increased, which required greater input to achieve the planned discharge dates.
- During the unannounced inspection at Whitchurch Community Hospital we were informed that a patient had fallen during the early hours. We looked at the patient's records to find that they had been assessed by the nurse in charge, the risk assessment had been reviewed, a Datix incident report had been completed and they had been regularly assessed with the recording of neurological observations. However, this event had not been reported to the medical provision on call which meant that the patient had not been medically reviewed. This was actioned immediately when highlighted to the staff.

Staffing levels and caseload

- The nursing staff on each ward at each hospital were supported by daily GP attendance. They carried out a weekly ward round to review their patients; staff were also able to contact them within normal working hours to review their patients when needed.
- Staffing levels were reported to NHS England as part of the safer staffing initiative. Staffing levels and skill mix were reviewed by the ward manager however we were told and saw evidence that the staffing did not always meet the dependency of the patients on the ward. We were told that dependency or acuity assessments were

undertaken bi-annually; but we were unable to locate evidence to support this. To ensure patients received safe care and appropriate treatment at all times, their dependency should be recorded in line with a relevant tool and supporting guidance.

- We looked at minutes of the trust quality and safety committee meeting held in January 2016 where the trust chairman raised concerns about the dependency of patients in the community hospitals including the high level of enhanced patient supervision that was required at Whitchurch Hospital during December 2015. The director of operations advised that this was unusually high and a discussion followed whereby it was decided that the case for additional staff should be referred to the commissioners as a funding issue.
- To maintain safe care and treatment during December, 272 agency shifts were used across the community hospital in-patient areas (36 registered nurse shifts and 236 health care assistant shifts). We were told that staffing was in the process of being reviewed; several registered nurse posts vacancies were being converted into health care support worker roles, increasing staffing levels in order to deliver greater patient observation and basic nursing care.
- Staff fill rates compare the proportion of hours worked by staff (Nursing,Midwifery and Care Staff) to hours worked by staff (day and night). All health trusts are required to submit a monthly safer staffing report and undertake a six-monthly safe staffing review by the director of nursing to monitor and ensure staffing levels protect patient safety. We reviewed the average fill rates for the period April to September 2015; average fill rates exceeded 200% at Ludlow Hospital and at Whitchurch Hospital, with the majority of fill rates occurring for care staff working at night. In September 2015 staffing levels were between 90% and 100% at Bridgnorth Hospital and Bishops Castle Hospital; which we were told were filled with bank or agency staff.
- Bank and agency staff were used to address the qualified nurse and health care assistant vacancies. Block booking of agency staff had been arranged to ensure consistency for patients and substantive ward staff. Between July and September 2015, 1,582 shifts were covered by agency staff across the four community hospitals. Of these 1,582 shifts, 524 were for registered nurses, while 1058 were for health care assistants. The number of agency staff decreased during the months, from 690 in July 2015, to 487 in August 2015, and 405 in September 2015. There had also been a reduction in the use of registered nurses from agencies, with 297 booked in July 2015, 125 in August and 102 in September 2015.
- We saw evidence that managers took appropriate action to ensure all staff worked to an acceptable level. We saw where standards had not been met, action was taken to keep patients safe and where required; to support staff.

Managing anticipated risks

- Potential risks were discussed at the quality and safety meetings including the planning of services whilst considering seasonal fluctuations in demand, the impact of adverse weather, or disruption to staffing. Monthly management meetings were held to review the 'quality and safety' action plans whilst considering potential and new risks.
- During 2015 a number of risks were identified and action taken across inpatient services;

1. Safer staffing in-patient bed configuration took place in Ludlow Hospital; two wards were combined in to one ground floor ward. Staff and the 'league of friends' had been involved in the discussions prior to the changes being made.
2. Issues were identified at Bishop Castle hospital with regard to fire safety. Evacuation routes were improved to ensure bedded patients could be moved to safe locations without staff having to move beds across grassed areas. Internal dividing walls were improved to prevent fire transferring between areas in false ceiling voids providing essential fire breaks.

Major Incident

- Local arrangements were in place to respond to emergencies and major incidents. The policy stated that when community hospital staff became aware that the trust had declared a major incident they should call their normal place of work to give their availability. Staff told us they were aware as it was discussed at induction and that their role would be to prioritise 'safe early discharge' of suitable patients to support the acute trust with their plan. However, none of the staff could recall practicing a major incident situation.

Requires improvement

Are services safe?

- Major incident plan dated November 2015 included a response plan to commence liaison with local clinical commissioning group to identify early release of suitable patients to increase capacity.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We have rated this service as good for effective. This is because:

- All four hospitals demonstrated they had achieved or exceeded the 18 week referral to treatment time.
- The hospitals followed local and professional guidance and staff were familiar with the policies and procedures.
- Patients were risk assessed and their safety was monitored as part of the individual care plan including appropriate pain relief.
- We observed good multi-disciplinary (MDT) working in the hospitals.
- Inpatient staff appraisal compliance ranged between 83% and 98% as of February 2016, against a trust target of 85%.

However, we also found that:

- Nursing staff did not receive any formal clinical supervision.
- Not all staff we spoke with demonstrated a clear understanding of the Mental Capacity Act.
- We saw several examples of poor outcomes for patients including lack of support during meal times and personal hygiene issues not promptly addressed (Whitchurch Hospital).

Evidence based care and treatment

- We saw that the nursing staff had access to The National Institute for Health and Care Excellence (NICE) guidelines on the intranet. National guidance had been incorporated in to the trust policies and procedures. For example, we were shown the catheterisation policy which referred to NICE Guidance.
- A 'falls and injury risk screening and management plan' was completed on all patients aged 65 or older. Patients aged 50 to 64 who were judged by a clinician to be at higher risk of falling because of an underlying condition were also screened, following NICE guideline 161.

Pain relief

- Pain scoring and recording charts were included in each individual care plan; each pain record we looked at had been appropriately dated, signed and reviewed.
- Patients told us they had received adequate pain relief and staff had returned to check on its effectiveness. They told us when they had experienced pain the staff responded promptly with painkillers on most occasions and they did return to ask if they had been effective.

Nutrition and hydration

- Meal times were protected from medical and nursing intervention being carried out on the ward at that time. Patients were encouraged to eat their meals in the dining rooms if appropriate. Relatives were encouraged to visit to offer support and assistance.
- A trust nutritional screening tool was implemented when patients were identified to be malnourished, at risk of malnutrition, or obese. We saw that the staff had used the current guidelines to develop individual patient care plans on admission with a planned weekly review. These reviews were completed in those records we looked at but had not always been signed off weekly as the policy suggested.
- Menus were given to the patients to allow choices to be made. Meals were served from a hot trolley on the ward; portion sizes varied depending on the patient's request. Patients told us the food quality ranged between good and satisfactory. PLACE (2015) results for 'ward based food' scored above the national average of 89% in three sites ranging between 93% and 100%; Bishops Castle Community Hospital scored below the national average at 52%. However, at the time of our inspection patients at Bishop Castle told us the food was very good. We observed meals being served and patients being offered choices.
- For example at Whitchurch hospital we observed several patients waiting either for their meal or sat with their meal in front of them with no staff available to assist them. There was no offer of hand-washing prior to or after meals, no condiments offered and plates were not covered whilst being served.

Good

Are services effective?

- Red trays were used to identify patients that needed support with their meals. At Bishop Castle, we observed that patients were provided with support. At the other three community hospitals, although staffing numbers met the planned levels, the acuity of the patients at meal times (those requiring assistance and feeding) could not be met by the staff available. We observed patients who required support were left unattended with their meals.
- Hot drinks were offered throughout the day and night and water jugs were refreshed at least twice daily.
- Fluid balance charts, to monitor patient's fluid intake and output had been commenced when deemed necessary. We saw that patient intake had been recorded more precisely than outputs which meant that the purpose for the chart was not always fully understood by the staff and the data from the charts could be misleading.

Patient outcomes

- The Commissioning for Quality and Innovation () payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For example, we reviewed the inpatient scheme for patients with dementia or delirium during episodes of emergency, unplanned care. Dementia and delirium - find, assess, investigate, refer and inform (FAIRI) in January 2016 had achieved 60% compliance. This was to be revisited in May 2016 to see if the target of 90% compliance had been achieved through evidence of liaison and communication with carers, the care home and the GP.
- Between June and December 2015, 33 patients were readmitted to a community hospital within 90 days of discharge.

Competent staff

- The ward managers had a responsibility to ensure their staff had the right skills and knowledge to do their job. We saw variances between hospitals relating to staff performance; staff at Ludlow Hospital and Bridgnorth Hospital were managed through competency tests but no such tests were completed at Whitchurch Hospital or Bishops Castle Hospital. All staff told us they had been supported to improve their skills when they felt less confident or less competent but that it was difficult to be released from the ward environment.
- Through appraisal, staff learning needs for were identified. The hospital appraisal compliance rate for non-medical staff ranged between 29% (Bridgnorth Community Hospital) and 79% across the four sites in September 2015. We were told that appraisals had been prioritised since then to be line with the trust target of 85% and compliance had improved by February 2016.
- Nursing and care staff told us they considered the training sufficient to meet their learning needs. However, e-learning had caused difficulties with the introduction of smart cards to log, at the time of our inspection many staff were still waiting for their cards to be issued to them. We were told that ace to face training was difficult for many staff to access due to the wide geography of the trust.
- All new staff took part in the trust induction programme which was signed off by local managers when completed. We spoke with one newly recruited nurse who had not signed an induction booklet at Whitchurch Hospital, which meant that assurances had not been gained from the manager regarding their ward based and trust wide knowledge including policies, procedures and competencies. New nursing staff followed a preceptorship programme. They were assigned an experienced nurse to mentor them, given a period of time during which they were supernumerary and they observed practice without being expected to participate. An induction workbook was also completed.
- An induction pack had been developed specifically for student nurses to orientate them to the ward areas.
- We spoke with link nurses for infection control, tissue viability and continence. They were aware of their responsibilities to attend link meetings and cascade their knowledge and new information to the rest of their team.
- The ward managers arranged support for their staff when necessary; informal one-to-one meetings were arranged as needed. No formal clinical supervisions sessions were currently arranged; plans to commence clinical supervision in line with revalidation for nurses were at the discussion stage only.

Multi-disciplinary working and coordinated care pathways

- We observed multi-disciplinary (MDT) working in the hospitals. The MDT meetings and discussions were patient focused and considered all elements of a patient's progress and discharge arrangements.

Good

Are services effective?

- Medical cover on the wards was provided by General Practitioner (GP) services. At Bishop Castle a GP attended the ward each day, reviewed new patients, and examined any patients who were escalated by the nursing team or those who required follow-up examinations. Care records were updated to reflect any changes or new treatments.
- Dieticians, speech and language therapist (SALT) also worked with patients on the ward but we did not meet with any of the team during the inspection.
- Patients' records had a detailed therapy assessment showing good MDT review, progress and future plans.

Referral, transfer, discharge and transition

- The trust had key performance indicators (KPI's) in place regarding referral to treatment times (RTT). All four hospitals demonstrated they had achieved or exceeded the 18 week referral to treatment time for day surgery between October 2014 and September 2015. For example, ophthalmology day surgery at Bridgnorth Community Hospital had achieved a three week RTT and general surgery at Bridgnorth Community Hospital had achieved an 11 week RTT.
- ShropDoc provided the 'out of hours' service for community hospitals. Medical and nursing staff told us that generally the response to 'out of hours' support was satisfactory, however if there was a significant delay when patients required emergency transfer to an acute setting they dialled 999.
- The trust was currently performing worse than anticipated with data showing they were above the target of 3.5% for delayed transfer of care with the main reason for this being access to care in the community. The health economy were working together to improve patients flow and to ensure that care was provided in the most appropriate environment.
- Bed occupancy from October 2014 to September 2015 ranged between 91% and 97% with the highest level of occupancy (97%) recorded at Bridgnorth Community Hospital.

Access to information

- Staff told us they had access to relevant patient information and their records whenever they needed them.
- Access to trust wide policies and procedures were available on the intranet.
- We identified an 'acting up' file on a shelf in the ward corridor at Whitchurch Hospital which held the personal contact details of each member of staff. We were told it was there for convenience so staff could contact other staff when the ward was short staffed. This was removed immediately to protect employee's private information being available to the public.
- Nursing staff told us that, when patients were transferred between wards or from another hospital they received a handover about the patient's medical condition but the doctors were not included in the discussion. This meant that the doctors were not always aware of the patient being on the ward or knowledgeable of their medical condition.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- NICE guidelines for dementia care were followed, highlighting the need for staff to gain valid consent from people with dementia; we saw staff checking that the patients understood what they had been asked.
- The trust target for staff completing training in Mental Capacity Act was 85%. Data provided by the trust showed that none of the four community hospitals had achieved this target. Bridgnorth Hospital was the poorest performer (48%) and Ludlow Hospital (78%) was the best performer, Bishop's Castle Hospital achieved 60% and Whitchurch Hospital achieved 75%.
- We saw evidence that when people lacked mental capacity to make decisions about their care, staff arranged for 'best interests' decisions to be made in accordance with legislation. Patients requiring review under the Mental Health Act (MHA) were protected by the MHA Code of Practice including early referral.
- Not all staff we spoke with demonstrated a clear understanding of the Mental Capacity Act, mainly because they had yet to undergo training. However, they understood how to recognise when a patient was unable to make informed decisions and explained that they would seek assistance from colleagues or senior staff regarding how to support them.
- Deprivation of Liberty (DOL's) champions were identified on each ward. Between 87% and 98% of staff had received the safeguarding (adults) training - Level one. The trust target for compliance was 85%.

Good

Are services effective?

- There had been six DOL's safeguard applications between May 2015 and August 2015. Two applications were made from Ludlow Hospital and Whitchurch Hospital and one each at Bridgnorth Hospital and Bishop's Castle Hospital.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We have rated this service as good for caring. This is because:

- The Friends and Family Test (FFT) scores showed patients and carers were consistently satisfied with the care and treatment they received.
- Patients told us they were treated well by the staff in a kind and compassionate manner.
- We saw that patients and those close to them were involved in the plan of care and discharge planning.

Compassionate care

- The community hospitals received 122 compliments during 2015; Bishop's Castle Community Hospital received 27, Bridgnorth Community Hospital received 36, Ludlow Community Hospital received 33 and Whitchurch Community Hospital received 26.
- Patients received appropriate care and their privacy and dignity was protected. We saw staff drawing the curtains to give personal care and they ensured the patient had the call bell when they had attended to them.
- PLACE (2015) scores for privacy, dignity and well-being were above the national average of 86% at three sites ranging between 85% and 90%; Bishops Castle Community Hospital scored 76%.
- Patients told us that staff took time to interact with them when able but they were very busy; staff told us they wished they had more time to help the patients and felt the patients required more interaction with them to promote independence; they had not raised this as an issue to senior staff.
- We saw staff offer discreet support in a sensitive manner.

Understanding and involvement of patients and those close to them

- Patients told us they understood why they were in hospital and some were able to tell us when they were due to be discharged.
- Staff ensured that patients and those close to them were able to ask questions about their care and treatment including during visiting times. Relatives told us that they had plenty of opportunities to ask the nurses and doctors for updates on the plan of care plans and discharge arrangements.

Emotional support

- During the MDT meetings the staff considered the long term social support that may be required to discharge the patients in to the community.
- Patients were given appropriate and timely support; occupational therapists and physiotherapists worked with the patients to encourage them and offer reassurance.
- Staff offered emotional support to patients including the involvement of relatives and those close to them.
- We observed how staff dealt with a confused visitor to the ward in Bishop Castle. Although they were not a patient, they provided reassurance and support and demonstrated a caring approach.

Requires improvement

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We have rated this service as requires improvement for responsive. This is because:

- Although services were planned and delivered to meet the needs of the local population, the admission criteria was not always complied with.
- People with complex needs were assessed; their support from specialist teams was not sufficient to support a timely discharge in to the community.
- Physiotherapists had limited time available for each patient and there was no provision at weekends.
- We saw dementia friendly environments had been developed to support inpatients; but we identified and staff told us the need for diversional therapies was required to offer specialist intervention.

However, we also saw that

- Assessments were completed on admission to plan the patient care and review the therapies required.
- Quiet rooms had been funded by the volunteers and were used for staff to speak with relatives or for private visiting times.
- We saw patients encouraged to use day rooms and to socialise with other patients.

Planning and delivering services which meet people's needs

- The needs of the local population were considered in how community services were planned and delivered. Commissioners, social care providers and relevant stakeholders were engaged in planning the services through network meetings ensuring patient choice was considered for continuity of care. However we saw that these systems were not always effective. Patients from one area were being cared for in hospitals many miles from their homes when the trust had similar facilities in their local area.
- GP's we spoke with explained that they found the admissions process frustrating as they were unable to admit patients to their local hospital and had to use the central allocation system. They told us that the system appeared to favour step down patients from acute hospitals which mean step up patients from the community had to make do with whatever bed was available in the trust rather than their local hospital.
- We identified that patients were admitted from 'out of area' to the community hospitals; they had subsequently been transferred nearer to home when a bed was available or their condition was suitable.
- Nursing staff and GP's who visited the hospitals told us that the patient mix was roughly 80% step down from acute hospitals and 20% step up from the community. This demonstrated that the majority of patients were transferred to the community hospitals from local acute hospitals rather than from their home in the community.
- Physiotherapy and OT services were only available Monday to Friday 9am to 5pm. At Bishop Castle physiotherapy services were available four days per week.
- The therapists documented exercises for the patients to complete during the evening and weekends, with the support of the nursing staff when time allowed. Therapists told us that nursing staff often unable to follow all the therapy advice provided due to how busy they were.
- Patients required extensive support to enable a safe discharge in to the community. It was acknowledged by the staff, some patients and their relatives that the service did not offer sufficient therapy services that were appropriate for the acuity of the patients. Staff told us this lack of support and motivational therapy may delay progress in independence and did not always promote early discharge.
- Patients estimated discharge dates and social arrangements were discussed during board rounds and referrals to social services were considered on admission to avoid delays in length of stay. Between June and December 2015 there had been 74 delayed discharges recorded.
- The facilities and premises were appropriate for the services that were planned and delivered. The wards had been upgraded within the existing buildings.

Requires improvement

Are services responsive to people's needs?

Equality and diversity

- Equality and diversity issues were considered on admission and patients that required any form of assistance were managed with the appropriate support, for example we saw evidence of translation service contact details and bariatric equipment in use.
- Disability access was available in all areas of the buildings including accessible toilet facilities.
- Wards were well signposted with clear directions. Dementia friendly colours had been used in some areas including pictorial signage.

Meeting the needs of people in vulnerable circumstances

- Services were commissioned to provide rehabilitation services for local people. The majority of services currently delivered care to people with much more complex needs, for example those living with dementia. A dementia-friendly environment had been promoted by the staff including the introduction of the 'Butterfly scheme' and dementia screening. The Butterfly Scheme allowed staff to identify people whose memory was permanently affected by dementia and provided them with a strategy for meeting their needs. The butterfly scheme was used on the wards for recognition of dementia.
- Health care staff told us that more time would be beneficial to accommodate specific personal and social care needs of people with dementia especially time to participate in activities and social events to enhance their recovery and reduce their boredom on the ward. At Ludlow Hospital the staff had organised an activity week during the previous month; the staff told us that the patients had benefited emotionally and socially from the activities and relatives had commented on the positive atmosphere on the ward.
- Assessments were completed on admission to plan the patient care and review the therapies required. However, we did not see any regular activities being offered to patients in the ward area especially for those that were identified to display behaviour that challenged. Staff told us that an activities co-ordinator would add great value to the patient experience on the ward.
- Patients with a learning disability or dementia were encouraged to bring their carer with them on admission, be present during the ward round and attend care reviews.
- We saw patients encouraged to use day rooms and to socialise with other patients. Patients in the television lounge at Bishop Castle were provided with a remote call bell so that staff could be summoned if required.
- Patient day rooms and quiet room were decorated and furnished to a high standard. The quiet rooms had been funded by the volunteers and were used for staff to speak with relatives or for private visiting times.
- We saw that patients had their call bells to hand; Call bells were answered promptly on almost all occasions.
- Patient information leaflets were available in all wards and waiting areas. Advice leaflets and posters were placed on notice boards throughout all hospitals.
- The trust website assisted patients and their relatives to find out relevant information about available services and support.

Access to the right care at the right time

- The 'admissions and transfers to community hospital' policy offered guidance for staff on the admission and transfer criteria of patients. This policy, approved in 2014, clearly stated that patients who were medically stable could be admitted to the community hospitals.
- We heard from medical and nursing staff that patients were not always medically stable and medical agreement was not always achieved. This had not been raised through incidents or added to the risk register. GP's at two hospitals commented that they believed 15% to 20% of patients who were transferred from acute hospitals to the community hospitals should have remained in the acute hospital due to the acuity of their condition. The trust told us that they were aware that patient's co-morbidities increased the acuity of patients. They told us they would be completing a patient acuity audit in June 2016.

Learning from complaints and concerns

- Between October 2014 and October 2015 five hospital complaints were received. Four complaints were received at Ludlow Community Hospital with two of those partially upheld relating to communication, record keeping and discharge arrangements, two were not upheld. One complaint was partially upheld at Bridgnorth Community Hospital which related to the

Requires improvement

Are services responsive to people's needs?

response to patient requests. Each complaint had been recorded explaining the reason for the complaint, the outcome of the investigation and the improvements to be made to avoid further occurrences.

- We did not hear any examples of wider learning from complaints; staff at one community hospital would not know of any complaints at other community hospitals.
- Patient advice and liaison service (PALS) leaflets were available on reception desks but not clearly displayed throughout the hospitals. We did not see any 'how to make a complaint' notices displayed.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We have rated this service as Good for well led. This is because:

- Patient and carer panel meetings took place; there was a designated patient experience and engagement lead.
- Staff felt valued and listened to in many areas of the service; however, in certain areas, staff told us their manager was less supportive.
- Staff were kept informed through regular staff meeting and newsletters.

However, we also found that:

- The community hospital vision was not fully implemented.
- Recommendations following external audits had not been fully achieved.

Service vision and strategy

- The trust vision was to "…deliver care as locally and conveniently as possible for patients..." . This vision was not fully embedded in the community hospitals service. We heard that patients were not always from local areas with the main reason being due to bed capacity issues in acute hospitals from another region.
- The trust quality report identified five priorities to be actioned which all linked in to community hospitals. Priorities included giving patients relevant contact details on discharge should they have any queries, telephoning patients 48 hours after discharge to ensure all is well and to discharge patients before 11am in to the community. We saw evidence on the wards that the priorities were being considered and implemented; staff understood their role in achieving them.

Governance, risk management and quality measurement

- Bishops Castle, Whitchurch and Ludlow Community Hospital managers held joint meetings monthly to discuss performance and quality and safety with the heads of department. At Bridgnorth community Hospital monthly heads of department meetings were held with bi-monthly quality and safety meetings.The community services managers completed a monthly dashboard which was discussed at the quality and safety meetings. Not all staff we spoke with had seen board members on the wards, however staff did say they had seen board members, the chief executive and the senior nursing staff from time to time.
- The board assurance framework itemised service and team specific issues which were discussed at each board meeting. Currently patient falls, potential laundry cross infection and one to one supervisions were the top three issues being addressed through risk assessments and monitoring.
- Community hospital and outpatients risk register itemised individual risks including cause, effect and impact.Registers were reviewed monthly at the quality and safety meetings. Ward staff were not aware what was on the risk register for their ward. The two current 'high risk' entries related to lack of agency staff to meet staffing levels and the trust development agency proposal to not use national framework agencies, reducing staffing overspend. These remained on the monthly review agenda.
- Monthly staffing levels were published for community hospital wards, including agreed establishment and actual staffing levels. Acuity of patients was not reviewed monthly. Staffing levels were presented and challenged at board level, by ward staff and through commissioning. Staffing was assessed shift-by shift to meet agreed establishment rather than to meet the current patients need or the demand on the service.
- At Bridgnorth Community Hospital we saw that quality rounds were completed weekly. These rounds carried out by the ward manager observed ward cleanliness, standard of record keeping and staff conduct including the ward appearance, care plan completion, patient admission screening and ward performance boards. The trust told us these are also carried out at Ludlow Hospital.
- To provide improved patient facilities at Whitchurch Community Hospital and safer staffing within one ward at Ludlow Community Hospital a reconfiguration programme started during March 2015. Whitchurch Hospitals limited space between in-patient beds had

Good

Are services well-led?

been highlighted during the previous two PLACE assessments; reconfiguring the ward allowed a greater space between beds.. The LOS at Whitchurch, traditionally higher than the rest of the community hospitals, had reduced from 27.4 days in 2013 to 20.9 days in 2015. Through different ways of working including a greater focus on timely discharge LOS reduction had exceeded the CQUIN set by Shropshire CCG which requested a phased reduction in LOS to 25 days in 2014 and 23 days in 2015.

- An external audit carried out by West Midlands Quality Review Service (WMQRS) in May 2014, identified issues between the acute and community trust which with improved collaboration could be resolved. One example was that community hospitals did not receive a 'transfer of care' letter when patients were discharged from the acute trust. All 'transfer of care' procedures started again when a patient was admitted to a community hospital, rather than community hospitals taking over from the point which had been reached in the acute trust. During our inspection we heard that patients continued to arrive without this document.
- The WMQRS report also identified that the type of patients accepted and model of care expected in the community hospitals was not clear. They found little evidence of proactive management of patients through their hospital stay and lack of systems to 'drive' the pathway through to discharge. During our inspection we heard examples that this issue continued due to lack of therapy time allocated for each patient. The reviewers noted in 2014, as we did during our CQC inspection, that that the multi-disciplinary input should be increased to ensure an active programme of rehabilitation was provided.
- The WMQRS report of May 2015 reflected on areas for improvements, for example the reduction of documentation duplication and again the need to develop a medical model to support patient flow more effectively. A re-audit was planned for mid-2016.

Leadership of this service

- Many staff told us they felt valued and appreciated by their ward manager and could not imagine working elsewhere. Ward leadership at Bridgnorth Community Hospital was praised by the staff as being supportive, innovative and based on compassionate care. Ward leadership at Bishop Castle was very strong. We observed excellent relationships between the ward manager and nursing staff and also between the ward manager and the operations manager. The ward manager understood her staff and was aware of their individual strengths and weaknesses. Staff said they felt supported and confident in their roles.
- In the quality strategy report (January 2016) it stated that maintaining good leadership within the hospitals was a constant process of listening, learning and acting upon any issues in a timely way. During 2016/17, the management aimed to strengthen the leadership development for managers and enable them to discharge their responsibilities with skill and compassion.
- At one community hospital location, ward staff felt that the management were not aware of the pressures the staff were under to meet the needs of the patients. We heard examples of how the management were unsupportive when they asked for advice or assistance, especially at meal times. Four senior nurses had recently resigned from the ward and the vacancies were being addressed.
- Managers were visible, supportive and encouraging at three of the four hospitals we visited. Some staff told us that they felt listened to and their suggestions were taken seriously. We were told that senior management were not regularly seen at the hospitals but when they visited they were approachable. The majority of staff told us they had not seen the executives or boards members on the wards or in any of the departments.
- GP's had mixed views of the managers. They described excellent relationships with local managers and in some case were extremely complimentary of the executive team, giving examples of where executive managers had become involved in identifying solutions to issue they had raised. However they were less complimentary of middle management; describing them as unapproachable and inflexible.

Culture within this service

- Staff told us that they enjoyed working for their local community hospital offering dignified care for the elderly. We heard that staff morale fluctuated; sometimes it was low as patient's dependency increased and the workload was heavy and demanding. Staff told us that in those circumstances that felt they did not get regular breaks.

Good

Are services well-led?

- Some staff told us they felt able to suggest and promote new ways of working to enhance the delivery of care such as encouraging patients to socialise in the day rooms.

Public engagement

- Patient and carer panel meetings took place with open discussions about hospital care. Up to 30 people attended the meetings including some board members. Patients, volunteers and other key health and social care stakeholders were represented.
- The trust had a designated patient experience and engagement lead. The trust website displayed contact details and patient/ carer advice.
- Between January 2015 and September 2015 the Friends and Family Test (FFT) response rate ranged between 82% and 100%. The current community hospitals score for the FFT was 98%. Positive responses were received from 1190 people that had used the service demonstrating they were extremely satisfied with the clinical treatment and quality of care they had received.
- We saw evidence of the recently developed 'you said, we did' strategy from patient and visitor feedback. This demonstrated that the trust listen to what patients tell them and make changes to services as a result of the comments. For example, local road signage had been made clearer.
- Volunteers brought a range of skills and life experiences to the community hospitals including taking drinks trolleys on to the wards, managing the dementia cafe and being available to support patient's with advice. The trust had developed a volunteer handbook that volunteers co-designed to understand the role they may undertake.

Staff engagement

- Staff meetings took place monthly; the details and minutes were emailed to all staff to ensure that they were aware of the dates and those who did not attend were updated. The minutes of the meetings showed that actions from previous meetings were addressed. The 2014 NHS staff survey showed that 72% felt satisfied with the quality of their work and care delivered, compared to 75% nationally. 35% of staff reported having well-structured appraisals in the last 12 months, compared to 38% nationally. 68% of staff agreed that they would feel secure raising concerns about unsafe clinical practice, compared to 72% nationally. A staff forum had commenced in January 2016; staff were encouraged to attend from all the community hospitals to raise their concerns, discuss good practice and hear news from other areas.
- A trust newsletter was distributed to all staff each month with current issues and future plans. Staff were encouraged to send in information/news when they thought it appropriate.
- The chief executive newsletter was distributed to all hospital sites to inform the staff of their plans and any actions carried out.

Innovation, improvement and sustainability

- Each hospital had developed their dementia environment including a café in Bridgnorth where patients, carers and visitors could drop in and meet friends and volunteers. Previous patient relatives were known to continue to visit the café for support and advice.
- Coffee mornings were held at Bridgnorth Community Hospital, to welcome relatives and visitors on to the ward.
- Two link nurses met with relatives of patients who were newly diagnosed with dementia in Bridgnorth. They reviewed patient consent and discussed the butterfly scheme promoted on the ward.
- At Whitchurch hospital we saw that a patient was wearing a safety bracelet on their wrist to alert the staff to their movement and protect their safety.

Shropshire Community Health NHS Trust

R1D

Community dental services

Quality Report

Shropshire Community Health NHS Trust
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Tel: 01743 277500
Website: www.shropscommunityhealth.nhs.uk

Date of inspection visit: March 2016
Date of publication: This is auto-populated when the report is published

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1DHQ	Shropshire Community Health NHS Trust - HQ	Community Dental Services	SY3 8XL

This report describes our judgement of the quality of care provided within this core service by Shropshire Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Shropshire Community Health NHS Trust and these are brought together to inform our overall judgement of Shropshire Community Health NHS Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

We have rated this service as good. This is because:

- Services were effective, evidence based and focused on patients' needs.
- The continuing development of staff was seen as integral to providing high quality care and all staff received professional development appropriate to their role and learning needs.
- The service was responsive to patients' needs; people could access services in a timely way that suited them.
- Effective multidisciplinary team working and links between clinics ensured patients received appropriate care at the right times and without avoidable delays.
- Patients from all communities could access treatment if they met the service's criteria.
- The local management team were visible and the culture was seen as open and transparent.
- Systems for identifying, investigating and learning from patient safety incidents were in place.
- Infection control procedures were in place, equipment was clean and well maintained.
- We saw good examples of staff providing compassionate and effective care.

Summary of findings

Background to the service

The core clinical services of Shropshire Community Dental Services are special care and children's dentistry services who need specialised dental care approaches that are not available in general dental practices. These services included oral health care and dental treatment provision for patients with impairments, disabilities and/or complex medical conditions, it also included those patients suffering spinal injuries. This provision extended to patients with physical, sensory, intellectual, mental, medical, emotional or social impairments or disabilities including those who are housebound.

Shropshire Community Dental Service uses the standard NHS dental contract currency of Units of Dental Activity (UDA) to measure the outputs of the service. When a patient accesses the service, the dentist determines the amount of dental work required. The patient then starts a course of treatment. Depending on the complexity of the treatment, each course of treatment represents a given number of UDA. These are monitored through the year to ensure delivery of the contracted activity. We saw end of year data that showed that overall the service delivered 103% of its contracted activity for the year 2014-15.

Shropshire Community Dental Service also provides urgent care dental services through the dental access centres, community dental practices providing a range of continuing care dental services, and the out of hours emergency dental services. The service also undertook domiciliary visits for those patients who were house bound. At the time of our visit the service had delivered around 434 domiciliary courses of treatment for the year 2014-15.

The service offered inhalation conscious sedation in selected clinics when treatment under local anaesthetic alone was not feasible. The service also provided general anaesthesia as necessary for the very young, the extremely nervous, patients with special needs and patients who need multiple extractions.

At the time of our visit the service had delivered 332 sedation courses of treatment for the year 2014-15.

During our inspection we visited two community dental service locations; Dawley Dental Clinic and Shrewsbury Dental Access Centre.

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including: Community matrons; physiotherapists; occupational therapists; senior community nurses; community children's nurses; school nurses; health visitors; consultant clinical psychologist; palliative care consultant; nurse practitioner; head of quality; deputy director of nursing; palliative care nurse; substance misuse consultant, substance misuse nurse, CAMHS practitioner and senior dental practitioners.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

Summary of findings

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 7 to 11 March 2016.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a very defined period of time, however we did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held six focus groups with a range of staff across Shropshire who worked within the service. Around 20 staff attended those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

We saw the collated results of the patient satisfaction survey of the three special care and children's dentistry sites at Dawley, Oswestry and Shrewsbury between December 2015 and February 2016. This revealed a high degree of satisfaction of the service. Comments included, 'from a terrified person, thank you for terrific treatment', 'we are so grateful to have been sent to this clinic, the service is excellent, staff pleasant, caring and efficient. My daughter has no fears of coming to the dentist', 'Couldn't ask for a more friendly, helpful and accommodating staff, a visit to the dentist to enjoy'.

Shropshire Community Health NHS Trust

Community dental services

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as good for safe. This is because:

- The dental service used the trust electronic incident reporting system to identify, investigate and learn from patient safety incidents.
- Staffing levels ensured patients were kept safe at all times during their care and treatment.
- Radiography and infection prevention control equipment was maintained at each of the locations we visited, by specialised technicians from the Trust or external companies.
- Dental service staff received adult and child safeguarding training and were confident in their knowledge of how to escalate concerns.
- Systems and processes were in place to protect people from the risk of infection.

Incident reporting, learning and improvement

- The service reported 17 patient incidents in the 12 months up to December 2015. Two were categorised as low harm and 15 were no harm. The service did not report any serious incidents in the same period.
- Safety was managed through the effective reporting of incidents. The trust had an incident reporting and investigation policy and this was embedded within the service. The trust used an electronic reporting system to record all incidents.
- Every member of staff we spoke with, at all levels and grades, could explain the reporting process and felt confident incidents were dealt with robustly and in a timely way.
- The dental service reported incidents using the trust electronic reporting system. Staff we spoke with demonstrated to us how the system worked. Staff reported that the system would always acknowledge the receipt of the particular incident reported. We were told by staff that the service managers or the Clinical Director would always follow up issues resulting from reported incidents.
- Staff meeting minutes we saw showed that incidents were discussed to facilitate shared learning. There were also standing agenda items relating to infection control, safety alerts, risk management issues and clinical audit.

Good

Are services safe?

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff were aware of their responsibilities under Duty of Candour regulations. The staff we spoke with described a culture which encouraged candour, openness and honesty.

Safeguarding

- Dental staff we spoke with were aware of the trust's safeguarding policy and received training in child and adult safeguarding to a level dependant on their grade. Data provided by the trust during the inspection showed that 98% of staff had completed safeguarding training for adults to level 1 and 100% had completed child protection training to level 1. Locally held data showed that the relevant staff, such as dentists who specialise in paediatric dentistry, had completed level 3 training.
- The staff we spoke to were able to demonstrate knowledge and an awareness about safeguarding issues in relation to the community they served.
- All of the dentists we spoke to were aware of how safeguarding concerns could impact upon the delivery of dental care. This included children who presented with high levels of dental decay which could indicate that a child was suffering from neglect and patients who did not attend for treatment.
- The service had an information sharing system where they would alert and share information with other professionals such as social workers, health visitors, school nurses and learning disability teams. Sharing information occurred when children presented with possible signs of neglect and poor clinic attendance.

Medicines

- A comprehensive recording system was available for the prescribing and recording of medicines. Local anaesthetics, antibiotics and high concentrate fluoride toothpaste when prescribed were clinically justified. A sample of six clinical records we saw showed the details of the prescription were recorded in full.
- We found medicines for emergency use were available, in date and stored correctly.
- The emergency medicines were all in date and stored securely, with emergency oxygen, in a central location known to all staff. A dental nurse monitored the expiry dates of the emergency medicines using a checklist at each location we visited. This checklist was signed by the responsible dental nurse on a weekly basis.
- Dental nurses used a checklist for monitoring the expiry dates of the emergency medicines. We saw that this was signed by the responsible dental nurse at each location we visited. This was carried out on a weekly basis.

Environment and equipment

- We noted that the dental clinics we visited were in a good state of repair and suitable for the provision of dental care to all of the patient groups seen by the service.
- We observed that dental equipment was visibly clean and well maintained. We noted that at each clinic we visited there was enough dental equipment and materials to provide the appropriate level of care.
- The service had a named Radiation Protection Adviser and Radiation Protection Supervisors ensuring that the service complied with legal obligations under IRR 99 and IRMER 2000 radiation regulations. The ionising regulations require periodic examination and testing of all radiation equipment, a radiological risk assessment, contingency plans, staff training and the quality assurance programme. The named Radiation Protection Supervisor at each location was responsible for maintaining compliance with Ionising Radiation Regulations 99 and IRMER 2000 regulation. This involved supervising the arrangements set out in the local rules which were drawn up by the Radiation Protection Adviser.
- The service maintained records in accordance with national radiological guidelines. We saw necessary documentation pertaining to the maintenance of the X-ray equipment. The records contained the critical examination packs for each X-ray set along with the regular maintenance logs in accordance with a copy of

the local rules. The records were maintained on the trust's intranet. These measures were in accordance with national regulations pertaining to ionising radiation.

- Dental X-rays when prescribed were justified, reported on, and quality assured every time. We saw dental records that confirmed that this was the case. This ensured that the service was acting in accordance with national radiological guidelines and protected staff and patients from receiving unnecessary exposure to radiation.
- Each location had a well maintained control of substances hazardous to health (COSHH) file in accordance with the COSHH regulations.

Quality of records

- The service maintained patient clinical records in electronic and paper based formats.
- Electronic records were password protected and paper clinical records were kept securely so that confidential information was properly protected. Information such as written medical histories and referral letters were collated in individual patient files and archived in locked and secured cabinets not accessible to the general public in accordance with data protection requirements.
- We reviewed six sets of records at Shrewsbury Dental Access Centre and two sets of records at Dawley Dental Clinic. The records were well-maintained by each dentist and provided comprehensive information on the individual needs of patients such as; oral examinations; medical history; consent and agreement for treatment; treatment plans and estimates and treatment records.
- Clinical records viewed were clear, concise and accurate and provided a detailed account of the treatment patients received. Patient safety and safeguarding alerts were recorded by dental staff, for example allergies and reactions to medication such as antibiotics.

Cleanliness, infection control and hygiene

- The service used a system of local decontamination and central hospital decontamination units for the processing of contaminated instruments. The systems in place ensured that the service were exceeding HTM 01 05 (guidelines for decontamination and infection control in primary dental care) Essential Quality Requirements for infection control.
- Staff at the clinics we visited where local decontamination took place showed us and demonstrated the arrangements for infection control and decontamination procedures. They were able to demonstrate and explain in detail the procedures for the cleaning of dental equipment.
- Staff described the process for the transfer and processing of dirty instruments through designated on-site decontamination rooms. We saw safe storage of clean instruments and equipment. Sterilised instruments were used within the timescales stipulated in HTM 01 05, the current time scales are that instruments must be used within the expiry date of one year. The service utilised a stock rotation system to ensure that instruments were not used after their expiry date.
- We observed good infection prevention and control practices. Hand washing facilities and alcohol hand gel were available throughout the clinic areas.
- We observed staff following hand hygiene and 'bare below the elbow' guidance. Staff wore personal protective equipment (PPE), such as gloves and aprons, whilst delivering care and treatment. We observed appropriate disposal of PPE.
- There were suitable arrangements for the handling, storage and disposal of clinical waste, including sharps. Safer sharps use was in accordance with the EU Directive for the safer use of sharps.
- Daily and weekly cleaning schedules were in place and displayed for each individual treatment room. Each schedule was signed off by the responsible dental nurse at each clinic. We saw records going back over several months that demonstrated that cleaning schedules were adhered to.
- We observed that the dental nurses at each clinic maintained the daily, weekly and quarterly test sheets for the equipment used in decontamination of dental

equipment. This included autoclaves, ultrasonic cleaning baths and where applicable washer disinfectors. The dental nurses also kept records of the maintenance schedules for this equipment.

- We saw that the dental nurses carried out infection prevention and control audits at six monthly intervals in 2015 and 2016 as recommended by HTM 01 05. The results of the audits we saw showed high levels of compliance in infection control processes across the whole of the end to end decontamination process. Audits revealed minor deficiencies and these had been addressed by the service in the action plans we saw.

Mandatory training

- Staff across the service told us there was good access to mandatory training study days.
- Mandatory training for staff included infection prevention and control, safeguarding for vulnerable adults and children, information governance and the management of emergencies in the dental chair.
- The central log for mandatory training we saw confirmed that all staff working in the clinics across the service had either attended the required mandatory training or were booked to do so. The service managers were diligent in their management of staff in relation to mandatory training.
- All staff undertook yearly training in CPR appropriate to the clinical grade of the member staff. For example staff involved in providing relative analgesia sedation or general anaesthetic services undertook training in Intermediate Life Support Techniques. This was in accordance with the new guidelines recently published by the Royal College of Surgeons and Royal College of Anaesthetists in April 2015.
- We saw that external dental bank and out of hours staff were required to provide evidence that they had completed update training in the core mandatory areas and the service maintained records showing this training had been carried out.

Assessing and responding to patient risk

- We were told that prior to carrying out domiciliary visits the service assessed the risk to patients and staff adopting the principles of the British Society for Disability and Oral Health guidelines for domiciliary care. This involved assessing the patient's medical and social needs in relation to dental treatment and the condition of the home environment before carrying out invasive dental procedures.
- At the two sites we visited there was a range of equipment to enable staff to respond to a medical emergency. This included an Automated External Defibrillator, emergency medicines and oxygen. The emergency medicines were all in date and stored securely, with emergency oxygen, in a central location known to all staff. This was in line with the Resuscitation UK and British National Formulary (BNF) guidelines.
- In the event of a patient's condition deteriorating during surgery, the patient would be managed by the anaesthetist in theatre. In the dental clinic setting, the dentist would call for assistance from the emergency services if a patient's medical condition deteriorated in line with published guidance from the Resuscitation Council UK and the British National Formulary and the annual update training staff received in life support techniques.
- Dentists carried out important checks before patients received inhalation conscious sedation. We saw records showed that the dentist had checked the medical history, ability to breathe through the nose, time of last meal and the availability of an escort. These checks were carried out by the dentist to determine if the patient was suitable to undergo this type of procedure.
- Throughout our inspection visits we looked at a sample of eight dental treatment records across the service. Dental staff always recorded patient safety and safeguarding alerts. For example medical histories were always taken by dentists and updated when patients attended for dental treatment. These histories included any allergies and reactions to medication such as antibiotics.

Staffing levels and caseload

- There were sufficient staff to meet the needs of the service with 34.57 whole time equivalent staff in post (as at 30 September 2015). The service had a vacancy rate of 5% and a sickness rate of 10.6% (as at 30 September 2015). However on the day of our visit we saw that the sickness rate had fallen to 2.01%.

Good

Are services safe?

- There were 18 dentists across the clinics, who were supported by 23 dental nurses. Some of the dental nurses had further training in conscious sedation and general anaesthesia in relation to dentistry. Staff worked across the dental clinics to ensure clinics had appropriate staff grades at all times.
- Two dentists we spoke with felt that they had adequate time to carry out clinical care of the patient. They had sufficient clinical freedom within the service to adjust time slots to take into account the complexities of the patient's medical, physical, psychological and social needs.
- The appointment diaries at each location showed that appropriate appointment slots were allocated for both patient assessment and treatment sessions.

Managing anticipated risks

- There were systems and processes in place to identify and plan for patient safety issues in advance and these included any potential staffing and clinic capacity issues.

Major incident awareness and training

- We were told that staff were aware of the way in which major incidents would be managed through the normal fire and health and safety mandatory training programme.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We have rated this service as good for effective. This is because:

- Services were evidence based and focused on patients' needs.
- We saw examples of effective collaborative and team working.
- All staff received professional development appropriate to their role and learning needs.
- Staff, registered with the General Dental Council had frequent continuing professional development and met their professional registration requirements.

Evidence based care and treatment

- Clinical dental leads were assigned across the service to ensure that best practice guidelines were implemented and maintained. This included clinical leads in special care dentistry, prison dentistry and children's dentistry. Because these dentists held a special interest in these specialisms they were able to cascade the most recent best practice to other members of the dental team.
- Shropshire Community Dental Service delivered dental general anaesthesia (GA) and conscious sedation services according to the standards set out by the dental faculties of the Royal Colleges of Surgeons and the Royal College of Anaesthetists 'Standards for Conscious Sedation in the Provision of Dental Care 2015'.
- We saw that the service had in place a written protocol for delivering safe and effective conscious inhalation sedation to patients in line with current professional standards. This protocol detailed the services criteria for accepting patients and the clinical governance processes and procedures that underpinned the delivery of safe care.
- The dentists, therapist and dental nurses used national guidelines to ensure patients received the most appropriate care. This included the guidance produced by the British Society for Disability and Oral Health and the Faculty of General Dental Practice. Dentists, the therapist and dental nurses we spoke with were fully conversant with these guidelines and the standards which underpinned them.
- The service used the Department of Health's 'Delivering Better Oral Health Toolkit 2013' when providing preventative advice to patients on how to maintain a healthy mouth. This is an evidence based tool kit used for the prevention of the common dental diseases.

Pain relief

- Dentists assessed patients appropriately for causes of pain and other urgent symptoms.
- For example, very young children in pain received general anaesthesia under the care of a hospital anaesthetist for the removal of multiple decayed teeth. The patient records we saw confirmed that this was the case.
- Patients were appropriately prescribed local anaesthesia by dentists for the relief of pain during dental procedures such as dental fillings and extractions.

Nutrition and hydration

- Children and adults having procedures under general anaesthetic were advised by dentists, doctors and dental nurses tonot eat for six hours before surgery but were able to have sips of water up to two hours before surgery. Patients undergoing conscious sedation also received appropriate advice from dentists and dental nurses.
- We saw examples of patient information leaflets detailing nutrition and hydration advice that had been developed by dental staff.
- We observed dentists providing this advice about healthy diets during consultations.

Patient outcomes

- We saw evidence of a rolling programme of local audits to monitor safety performance including safe site

surgery compliance, infection control, radiographs, and adult patient satisfaction following care received at Shrewsbury Dental Access Centre. There were no areas of concern identified by the audit outcomes. The infection control audits used the Infection Prevention Society audit tool for primary dental care. These audits showed over 90% compliance. The audits for radiography showed the quality of X-ray films were within the national recommended thresholds.

- The six monthly infection control audits we saw using the audit tool of the Infection Prevention Society (a national society) showed that although the locations we visited at Dawley and Castleforgate were not at best practice, they were meeting Essential Quality Requirements set out in HTM 01 05. Although these two locations were not at best practice requirements the standards of cleanliness was high and the processes for decontamination were robust.
- There were no incidents of wrong tooth extraction during the removal of teeth under general anaesthesia.
- The radiographic audits we saw showed that the levels of radiographic quality were good and were within the nationally agreed tolerances described in the Faculty of General Dental Practice Selection Criteria for Dental Radiography guidelines which were published in 2013. This prevented patients from unnecessary exposure to radiation.

Competent staff

- The Clinical Director of the service told us they encouraged dentists within the service to undertake additional professional training to provide services to an ever-increasing complexity of patient. In gaining extra qualifications and experience in special care and paediatric dentistry this enabled patients to receive care and treatment closer to home rather than the service referring patients to the nearest dental hospital which is 50 miles away.
- Several dentists were on the specialist list of the General Dental Council for Special Care Dentistry. These dentists could then provide care and treatment to patients who were at the severe end of the disability spectrum or who had very complex medical needs which could impact on the delivery of dental care. These specialist dentists also provided treatment planning advice to other dentists working in the service who were less experienced in dealing with patients at the more severe end of the disability or medically compromised spectrum.
- All dental nurses employed by the service had passed the National Examining Board for Dental Nurses Certificate in Dental Nursing.
- Other dental nurses had taken post qualification courses in General Anaesthesia and sedation, dental radiography, fluoride varnish applications and oral health education.
- All staff had received regular annual appraisal. The Clinical Director and senior dentists appraised the dentists and the senior dental nurses in turn appraised the basic grade dental nurses. We saw examples of the process that dental nurses go through as part of the appraisal system and found that the end-to-end process was completed in full.
- One dentist we spoke with explained the appraisal process from the dentist's point of view. Each dentist maintained their file with evidence of a current appraisal of clinical competencies and evidence of communication, management and leadership, professionalism and teaching and training commitments. The dentist's appraisal file also contained a professional development plan, details of continuing professional development.

Multi-disciplinary working and coordinated care pathways

- When patients presenting with a spectrum of special needs were referred into the service for continuing care they entered a pathway. This pathway progressed from very intensive one to one compassionate care, often termed tender loving care (TLC), through to a combination of TLC and inhalation sedation for patients who do not respond to TLC and finally treatment under general anaesthesia for those patients whose treatment cannot be provided in the normal way.
- There was effective and collaborative working across disciplines involved in patient's care and treatment. For example, patients would often present with complex medical conditions requiring consultation with the patient's GP and or consultant physician or surgeon.

Good

Are services effective?

- The service maintained close working relationships with health visiting and learning disability teams to ensure that vulnerable groups requiring dental care can secure ready access to treatment and care as the needs arise.

Referral, transfer, discharge and transition

- There were clear referral systems and processes in place to refer patients into the service. The dental service and commissioners of services had developed this approach to ensure efficient use of NHS resources.
- Patients were seen by the dental service for single courses of treatment for sedation services or general anaesthesia. Patients were then discharged by the service to their referring general dental practitioner with a discharge letter detailing the treatment carried out by the service.
- Patients attending for urgent care treatment could be offered continuing care in one of the salaried dental practices to ensure that their oral health needs were met on an ongoing basis, if they met the acceptance criteria of the service.

Access to information

- Staff used paper records for the clinical notes and electronic records for patient generic information that were aligned with the trust's systems.
- Paper records would be used on domiciliary visits and any information that was required in an electronic format would be transferred to the computer system when the dental team returned to their base clinic.
- Although we were told that improvements could be made in the IT system in relation to the ability to share digital X-ray images, the dental computer software system used enabled clinical treatment records to be maintained and could be accessed easily by all members of staff when required.
- All staff had access to best practice and evidence based guidance in relation to information governance through mandatory training and trust policy that was available on the trust intranet.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- There was a system for obtaining consent for patients undergoing general anaesthesia, relative analgesia sedation and routine dental treatment.
- The consent documentation used in each case of general anaesthesia and relative analgesia sedation consisted of the referral letter from the general dental practitioner or other health care professional, the clinical assessment including a complete written medical, drug and social history. NHS consent forms were used by each dentist as appropriate during the consent process for each patient.
- We observed six treatment records that demonstrated that the systems and processes for obtaining consent by dentists were carried out.
- Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 and applied these requirements when delivering care. Data provided by the trust during the inspection showed that 96% of staff had completed training on the Mental Capacity Act 2005.
- Staff we spoke with understood the legal requirements of the Mental Capacity Act 2005 and had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead.
- Where adults or children lacked the capacity to make their own decisions, staff sought consent from their family members or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.
- Staff we spoke with were familiar with the concept of Gillick competence in respect of the dental care and treatment of children under 16. Gillick competence was used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We have rated this service as good for caring. This is because:

- We observed that patients and their carers were supported and involved with their treatment plans.
- Staff displayed compassion, kindness and respect at all times.
- Treatment rooms were situated away from the main waiting areas and we saw that doors were closed at all times when patients were with dentists. Conversations between patients and dentists could not be heard from outside the treatment rooms which protected patients' privacy.

Compassionate care

- NHS Friends and Family Test (FFT) data provided by the trust showed that 97% of respondents were positive about dental services.
- During our inspection observed a patient's treatment session. We saw staff treating patients with dignity and respect. Staff treated patients in a sensitive and supportive manner. We heard and observed staff using language that was appropriate to the patients' age or level of understanding.
- Staff were compassionate and considerate of people's anxieties and provided them with reassurance and were clear about the treatment. They allowed the patient time to respond if they were not happy or in pain.

Understanding and involvement of patients and those close to them

- Patients and their families were appropriately involved in and central to making decisions about their care and the support needed. To facilitate this aim, the dentists were able to determine the most appropriate length of the appointment dependent upon the complexity of the patients disability or medical condition so that extra time could be given to discuss with the patient and their carers the prescribed treatment.
- We observed one treatment session where a patient with special needs who was at the more severe end of the spectrum was being treated. We saw that the dentist and the dental nurse were providing caring and gentle support enabling the patient to get through their dental appointment as comfortably as possible. The dentist also involved the patient's parent during treatment and in the decision making for the follow-up appointments for the completion of the course of treatment. We also saw that the parent made a contribution in helping the dentist to understand what the patient was trying to communicate about the treatment that was being proposed.
- With respect to patient satisfaction we saw survey results detailing the comments of 155 patients who were seen at the Shrewsbury Dental Access Centre. The comments revealed that the patients had received good outcomes in relation to the friendly approach of the staff, the reassurance given when patients were undergoing difficult procedures and the painlessness of the treatment provided.

Emotional support

- Staff were clear on the importance of emotional support needed when delivering care.
- We observed positive interactions between staff and patients, where staff knew the patients very well and had built up a good rapport.
- Through our discussions with staff, it was apparent that they adopted an holistic approach to care.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We have rated this service as good for responsive to people's needs. This is because:

- People could access services in a timely way that suited them.
- The service had met waiting times targets for an initial assessment for general anaesthesia and for special needs adults treatment and children under general anaesthesia.
- Patients from all communities could access treatment if they met the service's criteria.
- The service had a proactive approach to understanding the needs of different groups of people.

Planning and delivering services which meet people's needs

- To assist with the national planning of dental services the service carried out dental epidemiological survey's on children and some adult groups as part of the national epidemiology programme undertaken under the auspices of the national public health observatory.
- Information from these surveys can then be used by the local Consultant in Dental Public Health in conjunction with NHS England and local authority Health and Wellbeing Boards to plan and prioritise local dental services.
- Also involved in the planning of local services are the Local Professional Network for dentistry. These work closely with local authorities and Public Health England to deliver and develop cohesive Oral Health strategies and associated commissioning plans
- One of the senior dentists we spoke and the Clinical Director liaised with the Local Dental Committee and Local Professional Network for dentistry. This enabled them to influence these bodies with respect to the needs of the community dental service and the important role that they play in the delivery of patient care.
- We saw the dental service specification for Shropshire Community Dental Service which reflected the commissioning intentions of the local commissioners of services through the core clinical services that the Community Dental Service provides; special care and children's dental services, urgent services through the dental access centres, community dental practices and the out of hours emergency dental services.
- The facilities we observed at Shrewsbury Dental Access Centre were safe and appropriate for the delivery of urgent and out of hours care and the facilities at Dawley Dental Clinic were appropriate for the delivery of special care and children's dental services.

Equality and diversity

- At each location we visited, the trust had made adjustments to buildings to enable patients with various disabilities to access the service easily.
- This was facilitated for example by ground floor access to services for wheel chair user patients and other patients with mobility difficulties.
- The service had access to telephone interpreter for patients whose first language was not English.
- The training records we looked at indicated that 96% of staff had up to date training in equality, diversity and human rights as part of the rolling programme of mandatory training. This was against a trust target of 85%.

Meeting the needs of people in vulnerable circumstances

- To meet the needs of vulnerable people in society the service provided a number of services, including:
  - Special care and children's dentistry services for patients who needed specialised dental care approaches that were not available in general dental practice
  - Patients suffering from spinal injuries at the Robert Jones and Agnes Hunt Orthopaedic Hospital.
  - Service provision extended to patients with physical, sensory, intellectual, mental, medical, emotional or social impairments or disabilities including those who are housebound.

Good

Are services responsive to people's needs?

- Shropshire Community Dental Service offered inhalation conscious sedation in selected clinics when treatment under local anaesthetic alone was not feasible because of dental anxiety and phobia.
- The service also provided general anaesthesia as necessary for the very young, the extremely nervous, patients with special needs such as severe learning disabilities and patients who need multiple extractions. These services were provided through three hospitals in Shropshire.
- Dental services were provided for patients at HM Stoke Heath Prison and Young Offenders Institute.

Access to the right care at the right time

- Patients who were in need of urgent dental treatment and did not have access to an NHS dentist could access the service Monday to Friday 9.00am to 5.00pm.
- Patients could also access treatment on Saturday, Sunday and Bank holidays between 9.00am and 12 noon.
- Patients requiring advice or treatment outside of these hours could access the out of hours service between 7.00pm and 9.00pm.
- The service had an on call dentist available between 7.00pm and 9.00pm Saturday, Sunday and Bank holidays.
- Access to domiciliary care was determined by assessing the patients ability to access a clinic in the normal way using a domiciliary dental care request form which patients can access from the services web site.
- The service monitored waiting times for patients undergoing treatment under general anaesthesia.
- Service waiting times for an initial assessment for general anaesthesia at each hospital were within two and a half to eight weeks dependant on the hospital. The waiting times for special needs adults' treatment under general anaesthesia were eight weeks or less. This is against a target of 18 weeks. Following their initial assessment, patients were then seen promptly for their active treatment.
- Patients were referred to the community dental service by general dental practitioners and other health professionals for short-term specialised treatment. A set of acceptance and discharge criteria had been developed by the service and commissioners so that only the most appropriate patients were seen by the service.
- On completion of treatment, dentists discharged the patient back to their own dentist so that ongoing treatment could be resumed by the referring dentist. A discharge letter was always sent by the service to the referring practitioner following completion of treatment.
- Internal referral systems were in place, should the dental service decide to refer a patient on to other external services such as the salaried dental practices, local maxillofacial services and the local dental hospital.
- Protocols were in place describing how patients were discharged from the service following general anaesthesia or relative analgesia conscious sedation. Protocols we saw described how patients were discharged in an appropriate, safe and timely manner.
- During the discharge process staff made sure the patient or responsible adult had a set of written post-operative instructions and understand them fully. Patients and their carers were given contact details if they require urgent advice and or treatment. The service had developed bespoke patient information leaflets that detailed these instructions.
- At each location we visited, we observed clinics that ran to time and were not overbooked; this minimised delays for patients. Patients were kept informed of any delays by dental staff and were offered the opportunity to rebook appointments if clinics overran.

Learning from complaints and concerns

- Written information in the form of posters were displayed in every clinic informing people how to raise concerns and complaints.
- We saw minutes from staff meetings that showed both formal and informal complaints were discussed to allow learning and reflection to take place.
- The service had received six complaints between October 2014 and October 2015. Three complaints related to treatment and advice, two related to staff

Good

Are services responsive to people's needs?

attitude and one complaint was about a delay in treatment. We saw that the complaints had been responded to appropriately and action taken where required.

- During the same period the service received nine compliments.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We have rated this service as good for well-led. This is because:

- Governance arrangements were proactively reviewed and reflected best practice.
- There was effective leadership of the service, with an emphasis on driving continuous improvement.
- The local management team were visible and the culture was seen as open and transparent.
- There was strong collaboration and support across all of the service with a strong emphasis on improving the quality of care.
- Staff were aware of the way forward and vision for the organisation and said that they felt well supported and could raise any concerns with their line manager.
- Staff at all levels were actively encouraged to raise concerns.
- There were high levels of staff satisfaction across all staff groups.
- Team meetings and staff surveys demonstrated that the service engaged all staff.
- Staff members told us the service was a good place to work and that they would recommend it to family members or friends.

Service vision and strategy

- The service had in place a service specification which described the service, the expected outcomes and the range of services the service was expected to provide.
- The service had in place a standard NHS Personal Dental Services contract which reflected the aims and objectives of the commissioners in terms of improving access to NHS dental services and the delivery of their contracted UDA activity target. The data we saw for 2014-15 indicated that the service was very efficient in the delivery of services, and were providing more activity than their target required.
- The trust had a clearly articulated vision and set of values which staff within the service were aware of and understood.

Governance, risk management and quality measurement

- The dental service had in place a set of governance procedures that aimed to satisfy all relevant UK and European legislation. Policies and procedures satisfying these criteria were available to all staff on the services'.
- All locations had in place protocols and procedures dealing with the main areas of clinical practice pertinent to the delivery of dental care. This included the provision of general anaesthesia and conscious sedation, radiation, infection prevention control, medicines management and dealing with common medical emergencies during dental treatment and reducing the risk of contracting Legionella during dental care.
- The dental management team were responsible for sharing information upwards to the trust managers and downwards to the clinicians and dental nurses on the front line. The structure in place appeared to be effective which was confirmed when we spoke to various members of staff and the examples of the minutes of staff meeting we observed. They were responsible for the safe implementation of policies and procedures in relation to infection control, dealing with medical emergencies and incident reporting.
- We found that the systems for monitoring the quality of care were always complete and up to date. This included the daily, weekly, quarterly and annual maintenance schedules and checks of equipment, medicines and materials used for the provision of dental care. For example the were shown the systems in place to ensure that the autoclaves used in the decontamination process were working effectively at Shrewsbury Dental Access Centre. It was observed that the data sheets used to record the essential daily and weekly validation checks of the sterilisation cycles were always complete and up to date.

Good

Are services well-led?

- The community health divisional risk register includes six risks that are related to dental services. One risk is rated as "low" risk, this relates to Practices at Market Drayton, Craven Arms, Dawley Bridgnorth, Castle Foregate being non-compliant with decontamination best practice. The other six risks are rated as "medium" risks. These risks related mostly to staffing and IT issues.

Leadership of this service

- The Clinical Director and Dental Service Manager maintained overall responsibility and accountability for the running of the service.
- The Clinical Director told us that to improve accountability and engender a culture of individual responsibility they had devolved responsibility to other members of the team. For example, two of the senior dental officers had been given responsibility for delivering the prison dental services and domiciliary care. This also enabled the work load to be evenly distributed. The relevant staff we spoke to welcomed this approach.
- We spoke to dentists, therapist, dental nurses and administrative staff who said they felt they had a forward thinking and proactive professional lead who was well supported by senior managers within the trust.
- Staff confirmed that they felt valued in their roles within the service and the local management team were approachable, supportive and visible at all times.
- Clinicians stated that there was an open door policy to the Clinical Director for professional support and advice at all times.

Culture within this service

- The culture of the service demonstrated to be that of continuous learning and improvement. This was facilitated by clinical staff being encouraged by the Clinical Director to undertake additional training and taking post graduate clinical qualifications. For example, one of the senior dental officers was undertaking a post graduate diploma in conscious sedation. When this individual has finished their training the service will be in a position again to undertake intravenous conscious sedation for patients.
- Staff were committed to provide the best care possible for every patient. This was demonstrated to us when we observed the patient treatment session at Dawley Dental Clinic and speaking to a senior dentist at Shrewsbury Dental Access Centre.
- We observed staff who were passionate and proud about working within the service and providing good quality care for patients.
- The NHS staff survey for 2015 did not identify results for community dental services. However, the results for children and family services (which includes dental services) were very positive. Scores relating to motivation at work and recommending the trust as a place to work were better than the national average. Scores relating to staff feeling recognition and value were also positive.
- We found staff to be hard working, caring and committed to the care and treatment they provided. Staff spoke with passion about their work and conveyed their dedication to what they did. Staff knew about the organisation's values and beliefs, including the organisation's commitment to patients and their representatives.

Public engagement

- The service undertook regular patient satisfaction surveys. We saw the collated patient experience survey for Dawley, Oswestry and Shrewsbury clinics based on 143 completed forms that patients were satisfied with the cleanliness of the locations, helpfulness of the staff and the involvement in the decisions about treatment.
- The latest Family and Friends Test analysis showed that 97% of patients were extremely likely or likely to recommend the service to family or friends.

Staff engagement

- We saw that team meetings were an opportunity where the staff could come together to discuss the performance of the service.
- The open door policy of the Clinical Director and their 'hands on' approach providing practical clinical advice, help and guidance to clinical colleagues provided a collegiate atmosphere for all members of the dental team and in turn meant good clinical outcomes for patients.

Good

Are services well-led?

- The NHS staff survey for 2015 demonstrated a high engagement score of 3.89 compared to the national average of 3.82 for children and family services (which includes dental services) were very positive.

Innovation, improvement and sustainability

- All staff had the opportunity to take further qualifications to enhance the patient experience dependent on the outcome of their appraisal and subsequent PDP. The nurse manager described how the dental nurses had undergone additional training in dental radiography, fluoride varnish applications and oral health promotion which enabled the service to provide enhanced care for patients.
- A number of the dentists had additional post graduate degrees and diplomas which enabled the service to provide increasingly complex care to an increasingly complex and diverse patient base. Staff were supported in accessing and attending training, ensuring they had the appropriate skills and training to make effective clinical decisions and treat patients in a prompt and timely manner.

Requires improvement

Shropshire Community Health NHS Trust

Child and adolescent mental health wards

Quality Report

Shropshire Community Health NHS Trust
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL
Tel: 01743 277500
Website: www.shropscommunityhealth.nhs.uk

Date of inspection visit: March 2016
Date of publication: This is auto-populated when the report is published

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1DHQ	Shropshire Community Health NHS Trust - HQ	CAMHS Learning disability team	SY1 3GZ
R1DHQ	Shropshire Community Health NHS Trust - HQ	Shropshire CAMHS Team	SY1 3GZ
R1DHQ	Shropshire Community Health NHS Trust - HQ	Telford and Wrekin CAMHS Team	TF4 2EX
R1DHQ	Shropshire Community Health NHS Trust - HQ	Compass Shropshire CAMHS tier 2 staff	SY2 6FG

This report describes our judgement of the quality of care provided within this core service by Shropshire Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Shropshire Community Health NHS Trust and these are brought together to inform our overall judgement of Shropshire Community Health NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

We rated this service as requires improvement. This is because:

- The service did not have sufficient staff to provide effective care. None of the CAMHS teams could provide the full range of psychological therapies recommended by the National Institute for Health and Care Excellence (NICE).
- Average caseloads within the CAMHS learning disability team exceeded national guidance.
- The tier 2 Telford and Wrekin service was not fully staffed and was unable to triage referrals to CAMHS or offer interventions on a Friday.
- Staff did not feel engaged by senior managers. Staff found out about a major CAMHS transformation plan after its public release and did not broadly believe that senior managers understood CAMHS services or listened to their concerns.
- The trust failed to consistently inform staff about lessons learnt from CAMHS incident investigations.
- The service did not effectively manage waiting lists. Teams organised waiting lists around where patients lived rather than the urgency of patients' needs. Staff did not actively monitor for changes to waiting list patient risk levels.
- The service made limited use of outcome measures and did not undertake regular audits of performance and quality. The service did not use key performance indicators other than referral-to-treatment waiting times to measure and monitor the quality of services.
- The environment was not suitable for delivering effective care. Soundproofing was ineffective across all CAMHS sites. Conversations and movement were heard between staff offices, consultation rooms and adjacent rooms, disturbing work and compromising confidentiality.

However we also saw that:

- The service worked around patient, family and carer needs.
- The teams had flexible appointment times, and carers told us they could access support quickly if needed.
- Staff were respectful and supportive and adapted their behaviour to match patients' ages and specific requirements.
- Staff completed detailed and recovery-focused care records. Staff also worked with patients, families and carers to produce written plans that set out how the service would meet the patient's care and support needs.
- The service encouraged and facilitated patient feedback, and made changes based on this feedback where possible.
- When the service received formal complaints, the trust investigated responded and implemented changes when appropriate.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

We rated this service as requires improvement for safe. This was because:

- CAMHS learning disability had a high staff vacancy rate. This stressed existing staff and reduced the range of treatments available to patients.
- Average caseloads within CAMHS learning disability exceeded national guidance. Two staff members' caseloads were double the recommended levels.
- The service did not actively monitor waiting lists for changes to patient risk levels.
- Not all eligible staff were up to date with Safeguarding children training levels 2 and 3.

However, we also saw that:

- All areas we inspected were visibly clean and well maintained.
- Reach-out service staff completed and regularly reviewed patient risk assessments and care management plans.
- Staff prioritised work to respond to patient crises.

Are services effective?

Requires improvement

We rated this service as requires improvement for effective. This was because:

- The service did not have a sufficient staff skill mix to provide a range of psychological therapies as recommended by the National Institute for Health and Care Excellence (NICE).
- The service made limited use of outcome measures. This reduced their ability to monitor patient progress.
- Staff considered patients' capacity to make decisions about their care but did not consistently record these considerations in the patient' notes.

However, we also saw that:

- All staff we met with were skilled in their fields and had experience of working in CAMHS environments.
- Staff shared information and discussed cases to inform patient care. They also documented these interactions in patient care records.
- All teams worked well with other agencies to ensure a joined-up approach to patient care.
- Staff produced recovery-focused patient care plans that also covered patients' physical health needs.

Summary of findings

Are services caring?

Good

We rated this service as good for caring. This was because:

- Staff were respectful, responsive and supportive to patients, families and carers.
- The service involved patients, families and carers in care decisions. Staff adapted their behaviour to match patients' ages and needs.
- Staff had a good understanding of their patient confidentiality obligations.
- The service encouraged patients, families and carers to provide feedback about the service. Staff made changes based on this feedback where possible.

Are services responsive to people's needs?

Requires improvement

We rated this service as requires improvement for responsive. This was because:

- Noise and vibrations from a public gym above the Telford and Wrekin CAMHS team base caused significant and consistent disturbance to staff and patients at this location.
- There were long waiting times for neurodevelopmental assessments and specialist psychological therapy treatments.
- Soundproofing was ineffective in staff offices and consultation rooms at all service locations. This meant conversations could be overhead, causing disturbances and confidentiality issues for staff and patients.

However, we also saw that:

- The trust investigated all formal complaints, gave apologies, and reviewed systems when complaints were upheld.
- The CAMHS learning disability team moved patients up treatment waiting lists in response to reported increases to risk or need.
- Carers told us they could always access support quickly if needed and all teams had flexible appointment times.
- All teams provided patients, families and carers with written, easy-to-read information about their services as well as patient rights, complaints procedures and other important details.

Are services well-led?

Requires improvement

We rated this service as requires improvement for well-led. This was because:

- Staff did not feel involved in the trust's CAMHS development plans. Staff recently found out about a major transformation plan after its public release.

Summary of findings

- Staff could identify senior managers but felt they were not visible, did not understand CAMHS services and did not respond when staff raised concerns or made complaints.
- The teams measured referral-to-treatment waiting times but did not otherwise use key performance indicators to track and improve performance.
- New team leaders did not receive sufficient induction to their roles and lacked key skills and awareness as a result. No staff had access to leadership development opportunities.
- The trust did not keep a centralised database to monitor compliance with level 2 & 3 children's safeguarding training.

However, we also saw that:

- At a local level, staff respected their team leaders and felt supported by them.
- Staff received regular clinical and managerial supervision as well as annual appraisals.
- Staff used risk registers to identify and rate risks. Managers reviewed these registers, created action plans, and review dates for identified risks.
- The service employed administrative staff to allow clinical staff to concentrate on patient needs.

Summary of findings

Information about the service

Child and adolescent mental health services (CAMHS) are delivered in line with a four-tier strategic framework, which is now widely accepted as the basis for planning, commissioning and delivering services. Although there is some variation in the way the framework has been developed and applied across the country, it has created a common language for describing and commissioning services.

Shropshire Community Health NHS Trust provides tier 2 and tier 3 CAMHS services. The tier 2 staff work within multiagency teams that offer single point of access to a range of services and professionals. There were two single points of access services, Compass in Shropshire and Family Connect in Telford and Wrekin. They also provide tier 3 CAMHS within three core teams; CAMHS learning disability team, CAMHS Shropshire and CAMHS Telford and Wrekin.

We visited all three tier 3 teams and met with tier 2 staff from family connect.

CAMHS Shropshire and CAMHS Telford and Wrekin provided assessment and interventions for children and young people up to the age of 18. They shared a group of staff who offered a reach out service for patients with increased risks and needs. They were able to provide more intensive support.

CAMHS learning disability offer a service to all children and young people with a learning disability across the Shropshire, Telford and Wrekin. They share a team base with Shropshire CAMHS just outside of Shrewsbury. Telford and Wrekin CAMHS were based on a school/ leisure centre campus.

Each of the three core teams had a band 7 team leader. The service has recently appointed a band 8 CAMHS clinical services manager, due to start April 2016

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included two CQC inspectors and two CAMHS practitioners, a CQC observer and an Expert by Experience. Experts by Experience are people who have had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Summary of findings

- Is it well-led?

Before the inspection visit, we reviewed information we held about these services, asked a range of other organisations for information and sought feedback focus groups.

During the inspection visit we visited Shropshire child and adolescent mental health services (CAMHS) team base, Telford and Wrekin CAMHS team base, CAMHS learning disability team base and Family Connect. The inspection team spoke with four patients who were using the service, 11 carers, the team leaders for each of the core teams and 27 other staff members including a clinical psychologist, doctors, nurses and a social worker. The inspection team also attended and observed four multidisciplinary team meetings, two home visits and three appointments. During the course of the inspection we looked at 28 patient care records and a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

A carers forum, Parents Opening Doors (POD), participated in a CQC survey prior to inspection. They found parents were concerned about waiting times for assessments and accessing a psychiatrist. All carers we spoke with during the inspection were also concerned about waiting times to access CAMHS services and four specifically highlighted difficulties in booking appointments to meet with the psychiatrists.

The survey also highlighted that most parents and carers were happy with the service they received once in receipt of CAMHS interventions.

Carers had also shared experiences via Healthwatch, a health-monitoring agency. These were long waiting lists, concerns around transition to adult services, no support following a neuro development diagnosis. Positive comments were shared about the reach out service and individual staff being very supportive.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure they have sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the needs of people using the service. In particular, within the CAMHS learning disability team and tier 2 staffing.
- The trust must review caseload capacity for all staff.
- The trust must review the systems for monitoring waiting time for patients requiring a neurodevelopmental assessment and put in place systems to reduce length of wait.

Action the provider SHOULD take to improve

- The trust should ensure systems are in place to monitor staffs compliance with children's safeguarding training and ensure that all eligible staff are up to date with required training levels.
- The trust should review the impact of noise and vibrations within premises upon staff and patients.

Shropshire Community Health NHS Trust

Child and adolescent mental health wards

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
CAMHS Learning Disability team	Shropshire Community Health NHS Trust - HQ
Shropshire CAMHS Team	Shropshire Community Health NHS Trust - HQ
Telford and Wrekin CAMHS Team	Shropshire Community Health NHS Trust - HQ
Compass Shropshire CAMHS tier 2 staff	Shropshire Community Health NHS Trust - HQ

Mental Health Act responsibilities

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act, however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- All areas we inspected were visibly clean and well maintained. Cleaning records were not available as cleaning contractor kept these.
- Staff were aware of the trust-wide infection control policy. Hand gels and wipes were available to staff to use whilst out on community visits. There were laminated posters in bathrooms, demonstrating good hand washing techniques. Eighty one per cent of staff were up to date with the trusts mandatory infection control training. The trusts target for this training was at least 85% of its staff would have completed it.
- Toys and equipment in the waiting rooms and consultation rooms were visibly clean. Records confirmed these were cleaned on a regular basis.
- Telford and Wrekin CAMHS had alarms in rooms to summon assistance if needed. Staff told us they were tested on a regular basis. We did not see documentation to confirm this.
- There were no alarms in consultation rooms at Coral House, but staff had access to personal alarms.
- The team bases did not have clinic rooms and did not store medication. This is standard practice in a community CAMHS environment and did not affect patient care.

Safe staffing

- The service did not use any recognised approach to assess staffing levels. Commissioners had agreed current staffing levels with the trust. There were proposals in place to address identified staffing shortfalls. The trust was negotiating funding for these posts with commissioners.
- Across CAMHS, there were 50.7 whole time equivalent (WTE) clinical substantive staff.
- In the last 12 months (1 October 2014 – 30 September 2015), 6.14 WTE staff had left. CAMHS had a 13% vacancy rate. This was the second highest vacancy rate within the trust. CAMHS had a staff sickness rate of 4.5 %. All staff said the impact of vacancies resulted in large caseloads, high stress levels and less therapeutic interventions offered to the patients.
- Staff did not use any caseload management tools to monitor caseloads. Caseloads were managed through supervision and at referral and allocation meetings.
- Caseloads for clinical staff varied. Within the two generic CAMHS teams, caseloads were between 35 and 45 cases. A Royal College of Psychiatrist's a report dated November 2013, "CAMHS in the UK" advised that 40 is the recommended average caseload across a team, but individual clinicians may have more or less than this according to their role and work. The trust told us that weekly meetings were held with consultants to manage risk.
- The average caseload within the CAMHS learning disability team was 50, however, two nurse prescribers on this team held a caseload of approximately 100 patients.
- There were 3.8 WTE psychiatry posts. Of which, 2.9 were covered by locum psychiatrists. The locums we spoke with had been in place for some time. One locum consultant psychiatrist had been in post for two years.
- Psychiatrists across CAMHS reported having 200 – 250 patients on their caseload. There was one vacant psychiatry post that had no locum cover. The remaining psychiatrists said they covered the urgent cases but it was not clear how the service managed this cover.
- There was a 24-hour CAMHS consultant on call rota. All staff we spoke to reported psychiatrists were accessible.
- Average mandatory training compliance across CAMHS was 85%. This met the trusts target rate.

Assessing and managing risk to patients and staff

- Staff reported they completed initial risk screening on all patients. Staff used an in-depth risk assessment and management following screening if indicated. Staff said

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

they used an adapted version of the Sainsbury Risk Assessment Tool. It had recently been amended to include specific risks identified for patients with a learning disability.

- Out of the 28 care records we reviewed, 24 had full risk assessment and management plans. Three care records had an initial risk screen and one care record had no risk assessment or screening. The 24 risk assessments were up to date and signed by staff. Where there was no risk assessment present, we found reference to risk and management plans in letters and ongoing contacts.
- Four of the risk assessments and management plans we reviewed were for patients under the Reach Out service. Staff reviewed and updated them weekly. They also included detailed and personalised safety plans. Staff and the patients had signed them all. They included reminders of what coping strategies worked or did not work for that patient in a crisis and supportive telephone contacts.
- We could see when reviewing contact entries in notes that risk monitoring was taking place where appropriate.
- Both generic CAMHS teams were able to respond to deterioration in a patient's mental health via the duty system. There was no duty system within the CAMHS learning disability team. However, they reported they would respond quickly to patients, carers or other agencies concerns. We observed this during inspection, when staff prioritised work to respond to a crisis.
- The services did not actively monitor the waiting lists to detect increases in level of risk. Patients, families and or carers were encouraged to contact the service if risks increased. Shropshire schools for the children and young people with learning disabilities could also contact services if they felt risks were increasing.
- The trust had a named safeguarding nurse and doctor. Staff told us that they knew who they were and how to contact them.
- Staff had a clear understanding of safeguarding and their responsibilities in relation to identifying and reporting allegations of abuse.
- The safeguarding lead in Telford and Wrekin CAMHS attended child exploitation meetings with the local authority.
- Ninety eight percent of staff had completed level one adult safeguarding training. This was provided within the trusts mandatory training.
- National guidance from an intercollegiate document published by the Royal College of Paediatrics and Child Health set out minimum safeguarding children training requirements for NHS staff. All staff within a CAMHS service should be trained to level 2 minimum and all clinical staff who work directly with children and young people should be trained to minimum level 3. It was not clear from data provided by the trust if all CAMHS staff met these requirements. Data given by the trust showed that 41 % of eligible staff within CAMHS had were up to date with safeguarding children level 3 training and 32 % of eligible staff were up to date with level 2 training. The trust said that it was likely that more staff had completed levels 2 and 3; however, they did not record completed training on centralised records for this service.
- However, the trust did not keep centralised data and were unable to tell us accurately how many staff had completed level two and level three children's safeguarding training.
- One clinician had completed additional level four safeguarding training with the NSPCC.

Track record on safety

- There were no serious incidents reported by the service between 1 December 2014 and 1 December 2015.
- The trust shared with the CQC actions and learning from a local serious case review and a multi-agency public protection arrangement discretionary review.

Reporting incidents and learning from when things go wrong

- Staff reported incidents in the electronic reporting system called Datix.
- The service had reported 85 incidents on Datix between March 2015 and March 2016. All incidents reported had been reviewed by the trust and had an outcome and local action plan. There was evidence that some changes had been made to practices to ensure incidents were not repeated. For example,

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

implementing changes to administration systems. We saw that staff had reported some incidents repeatedly but they had not yet been resolved. For example, noise within consultation rooms and increase in workloads.

- All staff we spoke with were aware of duty of candour principles and the importance of being open and transparent in their work.
- Nine of the staff we spoke to were concerned they did not receive feedback from investigation incidents. They felt the trust did not share lessons learnt. The teams discussed incidents from a local perspective. Staff said the trust did not feedback lessons learnt from incidents. Senior managers had recently invited team leaders to this meeting and on that occasion, team leaders had fed back information to the teams. Senior management had not previously included team leaders at this meeting and it was unclear if this as to be a regular feature. Team leaders felt that it would be beneficial to attend to improve communication between management levels.
- Staff said they could debrief following incidents in various settings. For example, team handover, meetings and peer supervision.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We looked at 28 care records, all of which had care plans. We found the majority were personalised, holistic and recovery focused. Recovery based means focused on helping patients to be in control of their lives and build their resilience so they can stay in the community and avoid admission to hospital wherever possible. All records reviewed were up to date and signed.
- Staff had completed comprehensive and timely initial assessments with patients, and where appropriate family and or carers.
- Assessments included physical health care issues.
- Following assessment, staff agreed a plan of care with patient and parent/carer.
- All care records were paper based and were stored securely. Staff had access to a locked case to transport notes within the community.
- Staff were able to access care records easily and a tracker system was in place to identify the whereabouts of notes if they were removed from cabinets. The tracker system reduced the likelihood of care records going missing. We observed staff using this system throughout the inspection.
- Tier 2 staff had some difficulty accessing records as they used the local authority electronic records system. Staff told us that after 3pm Monday to Thursday and all day on Fridays, they did not have access to administrative support. This meant to ensure any urgent referrals for tier 3 staff were hand delivered. This impacted upon their time to carry out direct patient work.

Best practice in treatment and care

- Tier 2 staff had easily accessible National Institute for Health and Clinical Excellence (NICE) guidelines available to support their triage of referrals.
- Nurse prescribers followed NICE guidelines when prescribing medication. For example, staff monitored physical observations of patients prescribed anti-psychotic, i.e. electrocardiograms, height, weight and other physical observations taken.
- The service could not offer sufficient psychological therapies to match NICE recommendations. This was due to limited skill mix and availability of suitable trained staff. Four staff commented they feel they were more likely to prescribe medication in the first instance because of this.
- The use of patient and clinician rated outcome measures was limited. There was evidence of Health of the Nation Outcome Scales for Children and Adolescents (HONOSCA), goal-based outcomes, strengths and difficulties questionnaire and the Sheffield learning disability scale. However, these were not in all notes we reviewed and appeared to be used inconsistently. We found that outcome measures were not personalised and there was no corresponding evidence of individual goals.
- One psychiatrist reported they had completed one audit in the last year. They felt this was insufficient but felt pressured to prioritise clinical work. Another psychiatrist confirmed that there was little time to complete audit.
- CAMHS learning disability completed a case note audit last August 2015. They found care records had no clear evidence of a care plan or risk assessment. Following this, they implemented the use of an easily accessible and distinct care plan document. They also amended the risk assessment to include specific sections relating to risks specific to patients with a learning disability. The team plan to complete further case note audits this during 2016.

Skilled staff to deliver care

- Staff we met were skilled and experienced in working within CAMHS.
- The teams did not have a full range of mental health disciplines. They did not have occupational therapists, social workers, psychologists, family therapists or play therapists. They consisted mainly of nursing and medical staff. The CAMHS learning disability team had two psychologists and two behaviour support workers. The CAMHS team had access to a speech and language therapist and an occupational therapist.
- A family therapist had been recruited within the Telford and Wrekin CAMHS and was due to start in May 2016.
- There was one nurse trained in cognitive behaviour therapy (CBT) and they trained and supervised other

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

staff to use CBT within their work. Another nurse was qualified in eye movement desensitization reprocessing therapy (EMDR). They held a small caseload providing specific EMDR interventions.

- CAMHS learning disability staff had training in intensive applied behaviour analysis (ABA). ABA is the techniques and principles used to bring about meaningful and positive change in behaviour.One member of staff had also completed skills-based training on risk management (STORM). STORM is an evidenced based training package developed by the University of Manchester to equip staff in assessing and managing risk of suicide and deliberate self-harm.
- An agency worker said she had been given two weeks to shadow the CAMHS learning disability team before working with their caseload. They felt this was supportive and gave them time to become accustomed to processes used within the team.
- Records showed individual clinical and managerial supervision regularly took place. Staff reported they had access to peer supervision as well as one to one supervision. Staff told us if supervision had been cancelled, it was always rebooked.
- Across CAMHS, there were three nurse prescribers. Supervision for these staff had been intermittent; this had left them feeling unsupported. However, since December 2015 regular supervision had been in place and were feeling increasingly supported.

Multi-disciplinary and inter-agency team work

- We observed multidisciplinary team working across all teams. We observed staff sharing information and discussing cases to inform practice and treatment.
- All teams had a weekly multidisciplinary team meeting, which included discussion of referrals, allocation of cases and business agendas. Some meetings were longer than necessary and were repetitive, which we felt was an ineffective use of staff time. For example, one meeting focussed on discussing and allocating referrals leaving little time for case discussion.
- We observed good joint working with schools. The CAMHS learning disability service held joint nurse prescribing and psychology clinics. This meant advice regarding management and strategies of behaviours could be given to a parent, carer, school or young person. Staff acknowledged this was in the absence of being able to provide specialist-talking therapies.
- Psychiatrists told us they had limited opportunity to provide any consultation work with other agencies due to capacity issues.
- We noted documented evidence of staff liaising with other agencies in the care records we reviewed.
- Staff sought information and participation from schools and other agencies involved with the young person and their family. This was included in the planning of their treatment and care.
- CAMHS had staff who worked alongside youth offending services (YOS). This meant they were able to offer mental health interventions to young people within the YOS.

Adherence to the MHA and the MHA Code of Practice

- Consultants were section 12 approved. This meant they were approved to carry out particular duties under the Mental Health Act (MHA).
- CAMHS consultants were part of an on call rota so could be requested to attend out of hours MHA assessments for patients under the age of 18. This follows good practice guidance within the MHA code of practice.
- All clinical staff had access to MHA training. Staff we spoke to had adequate knowledge of the MHA and code of practice. All staff knew how to initiate a MHA assessment if needed.
- Staff could contact the local mental health trust MHA administrative and legal team if they needed guidance. Not all staff we spoke to were aware of this.

Good practice in applying the MCA

- The Mental Capacity Act (MCA) act does not apply to young people aged under 16 years of age. For children under the age of 16, the young persons' decision-making ability is governed by Gillick competence. The concept of Gillick competence recognises that some children may have sufficient maturity to make some decisions for themselves.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

- Staff we spoke with demonstrated knowledge of Gillick competence. This showed that staff understood the importance of judging and assessing a child's capacity to consent.
- Staff did not routinely document Gillick competence.
- The Mental Capacity Act does apply to young people aged 16 and 17 and mental capacity assessments should be carried out if it is established that a person lacks capacity to make a decision.
- The trust provided Mental Capacity Act (MCA) training. Eighty one percent of staff were up to date with MCA training. This was just below the trusts target of 85%.
- Patients over the age of 16 were supported to make decisions where appropriate and when they lacked capacity, staff said decisions were made in their best interests, consulting with parents and or carers and taking into account the young person's wishes, feelings, culture and history. We discussed examples with staff and saw that capacity issues were considered. However, we did not see evidence of this recorded consistently within notes. One psychiatrist felt staff needed reminding that capacity issues were decision specific and not generalised.
- The Deprivation of Liberty Safeguards (DoLS) do not apply to people under the age of 18 years. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. These would include the existing powers of the court, particularly those under section 25 of the Children Act, or use of the Mental Health Act.
- There were no arrangements in place to monitor adherence to the MCA.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- Staff attitudes and behaviours were respectful, responsive and provided appropriate practical and emotional support.
- Staff were sensitive to the needs of different age groups. We observed staff adjusting their language to explain treatment options to younger children.
- It was clear from interactions we observed between staff and patients that staff had a good understanding of individual patient needs.
- Staff sought consent to share and permissions to gather information with others from patients and parents/ carers. These permissions were documented within the care records we reviewed. Staff understood the criteria for breaching confidentiality to protect children and young people and staff explained this to patients and parents/carers. One parent told us initially they were not sure if the CAMHS worker told her what she needed to know – but now had complete confidence they respected their child's confidentiality but would alert parents to any risks if needed.

The involvement of people in the care they receive

- Within CAMHS learning disability, it was clear from records we reviewed that staff involved parents/carers in care planning. Carers we spoke with confirmed that staff involved them with care planning.
- It was not clear how much patients with a learning disability were involved in their care planning. Staff said involving some patients in their care could be challenging due to the patients cognitive levels. However, staff said they worked with relatives and carers where applicable to develop care plans and attempted to care plan with the patients where appropriate.
- Records showed within the CAMHS teams children, young people and their carers usually received a clinic letter rather than a care plan. This detailed the support they would receive, how and why.
- Observations of CAMHS home visits showed staff involving patients and family. This was through discussion of treatment choices, individualised care plans and development of safety plans.
- Staff said some patients had participated in staff recruitment interviews. The team planned to start meetings with local advocacy groups.
- Staff said changes to the décor of the waiting rooms followed feedback from young people that it was too childish. Staff collected feedback from suggestion boxes placed in waiting rooms.
- Staff were aware of various local and national advocacy groups for patients and said they shared this information with patients and families/carers as needed.
- Friends and family surveys were available for patients and families/ carers to complete and provide feedback to the trust.
- The reach out staff had completed a survey with patients and families they had previously worked with. The survey from October 2014 to March 2015 focused on the patient and family experience of the reach out service. From this survey the team set action plans to address findings. For example, they addressed the amount of staff involved in each patients care.

Are services responsive to people's needs?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The CAMHS learning disability team had clear referral criteria and processes. The generic CAMHS teams referral criteria were unclear. Two staff told us they were not sure whether they accepted referrals for children under five years of age.
- The service took referrals from tier 2 colleagues based within the multi-agency single point of access services.
- Telford and Wrekin CAMHS had 2.8 whole time equivalent (WTE) staff working within the multi-agency single point of access. These staff triaged referrals to CAMHS and provided tier 2 interventions and consultancy work. However, due to long-term sickness only 1.4 WTE staff were working within the service. This meant there had been no cover when staff were absent on leave. This meant referrals were not being processed in a timely manner. The team leader said referrals could be made direct to the tier 3 team in this situation. However, we were concerned this would increase the workload of already pressured tier 3 staff and it had the potential for referrals to be delayed.
- Shropshire CAMHS had tier 2 staff working within a different multi-agency single point of access service. This meant processes to access Shropshire CAMHS were slightly different. The tier 2 staff were concerned the local authority did not always tell them about changes in processes. For example, the multi-agency single point of access changed to allow direct referrals from patients/ families and carers. However, CAMHS did not accept direct referrals. This caused confusion and extra work for the tier 2 staff. They have to redirect patients and parents/ carers back to a professional to re refer.
- Tier 2 staff prioritised referrals using a three-level system. All patients triaged as priority level one were seen within 24 hours by tier 3 duty staff. Following initial assessment, all other priority patients were placed on a waiting list for treatment.
- CAMHS had target times of 18 weeks to see a priority level 2- 3 patients for assessment following referral. The average waiting time for CAMHS learning disability team was six weeks, CAMHS Shropshire was eight weeks and CAMHS Telford and Wrekin was seven weeks.
- Waiting times across CAMHS for treatments varied. Cognitive behavioural and eye movement desensitisation reprocessing therapies had waiting times of approximately five months.This meant that patients went unsupported for a lengthy period.
- The CAMHS learning disability team waiting time for treatment varied between 12 and 16 weeks. Records showed patients were moved up the waiting list if there had been a reported increase in need or risk.
- The waiting list for neuro developmental assessment was up to 12 months. Carers we spoke to and feedback from a survey expressed concern for the length of wait. Post neuro development diagnosis support was not available to patients unless they had an additional mental health problem. Staff would refer these patients on to voluntary agencies that support children and young people with Autism.
- Teams offered flexible appointment times before 9 am and after 5 p.m. Two carers we spoke with confirmed this happened and said the services were very flexible.
- Staff told us they followed up with patients who did not attend by phone call or letter, dependent on level of risk. If levels of risk were high, staff would visit the patients home and if necessary make a referral to safeguarding if concerns remained.
- CAMHS monitored their did not attend (DNA) rates. Data shared by the trust showed that between September 2015 and February 2016 approximately 9 % of planned contacts were DNA. They had displayed posters in waiting rooms to remind people the impact of DNA'S onthe service.
- Services did not monitor if appointments ran to time or were cancelled.
- Four carers we spoke with said phone calls were always returned quickly and they could access support quickly if needed.

The facilities promote recovery, comfort, dignity and confidentiality

- Waiting areas across all services were child friendly. Toys and reading materials were available in the waiting areas. CAMHS services responded to feedback from children, young people and parents/carers by updating

Are services responsive to people's needs?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs.

aspects of the waiting area environment. For example, they put up artwork targeted towards the older age group following comments that some teenagers found the artwork childish.

- Consultation rooms were available across all sites. However, a common theme staff reported was there could be difficulties booking rooms. This could make booking regular slots with patients difficult. Staff managed this by booking in advance and seeing patients at school and home. Some staff said home and school visits meant they would see fewer patients due to lengthy travel times.
- All staff offices and consultation rooms had inadequate soundproofing. Staff reported that conversations could be over heard and our observations confirmed this during inspection. This made dealing with sensitive issues difficult for team leaders. It was also distracting for staff trying to carry out work. It could potentially breach confidentiality if other people can hear conversations.
- The Telford and Wrekin team base was situated underneath a public gym. Staff told us that this was problematic as noise from gym equipment could be heard throughout the day. Our observations during the inspection confirmed this, we heard loud noises and felt vibrations from the gym equipment. Whilst observing one care session, we had to change rooms as the noise above one consultation room had become too much for the patient to tolerate and it was interfering with their therapy session.
- Staff said environmental health had assessed noise levels following complaints by staff. However, it was deemed that the noise level did not meet environmental health thresholds for action to be taken. We raised our concerns about the level of noise to senior management and pointed out the interference from the gym and the impact this could have on children and young people on the autistic spectrum as they may find these disturbances particularly distressing. Senior managers told us they could not do anything about it, as they did not own the building.
- There were information leaflets available in the main receptions and numerous notice boards around the buildings to share information with patients, parents and carers. Information included details about patients' rights, how to complain and support services available.
- The reach out service had a leaflet explaining who they were and what they did. The leaflet had useful links and contact details (i.e. young minds) for the patient to access. This was given to all patients working with reach out staff.
- The CAMHS learning disability team had its own leaflet that explained its role and what interventions they offered. Patients, parents and carers were given this leaflet on initial assessment.

Meeting the needs of all people who use the service

- All sites were fully accessible to people with physical disabilities.
- Information leaflets in waiting rooms were in an easy to read format. Staff told us they could access leaflets printed in different languages if needed.
- Staff told us it was easy to access interpreters when needed.

Listening to and learning from concerns and complaints

- We saw patient and liaison service (PALS) leaflets in patient waiting rooms. This meant patients, families and carers had details of the complaints and compliments procedures. CAMHS learning disability staff gave all families a form at the initial assessment but the other teams did not.
- Between October 2014 – October 2015 CAMHS received 16 complaints. Following investigation by the trust, 11 were upheld and five partially upheld. No complaints were forwarded to the ombudsman. A common theme from the complaints was poor communication and waiting times. Where complaints were upheld, records showed the trust had given apologies and systems had been reviewed to reduce further issues. For example, an apology was given for breach of confidentiality and staff were advised to leave minimal information on answerphone messages.

Are services responsive to people's needs?

Requires improvement

By responsive, we mean that services are organised so that they meet people's needs.

- Two carers we spoke with said they wanted to make complaint but did not feel it would be answered. They were worried it would impact negatively on the care they received.
- Team leaders said they dealt with informal complaints at a local level. However, due to a lack of communication and induction, they had only recently found out they needed to log these with PALS.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- The trust had visions and values of 'Strive to make a difference'. All staff we spoke to within CAMHS wanted to work within the field to make a difference in children and young people's lives.
- In line with government policy, a transformation plan for children and young people's mental health and wellbeing 2015 -2020 had been prepared by local clinical commissioning groups and the local authorities. However, all staff we spoke to said they had not been consulted about this document. Staff reported they had first seen the document when it was publicly accessible on the internet.
- Staff reported they did not feel part of the development of CAMHS services and had concerns about the future tendering of services. Several staff said they did not feel the trust understood what CAMHS services did and did not feel part of the trusts overall development plan.

Good governance

- All staff had regular supervision and yearly appraisals. There were systems in place to monitor these events.
- There were administrative staff in place who allowed staff to focus on direct care activities.
- Teams had one key performance indicator. They measured referral to treatment waiting times and were aware they were in breach of this if a patient wait was more than 18 weeks.
- There was a CAMHS risk register. The CAMHS learning disability team reviewed their section of the risk register every two weeks in a team business meeting.
- The risk registers were accessible by team leaders. This meant they could review and input information on the registers.
- We reviewed the risk registers. Staff had identified and rated risks. They had additional action plans and review dates. Concerns we had identified on inspection were on the risk register. Examples of risk identified were length of waiting lists, noise at team bases and issues with commissioning.
- We met with admin staff across the teams.They were concerned they had no regular business meetings. When business meetings happened, they were conducted in the main staff office. This meant there was no privacy and they were interrupted. They felt this caused a lack of communication between themselves and clinical staff.
- Each team had a business meeting. We reviewed minutes of these meetings. We could see from the minutes that they were attended by staff and local team issues were discussed. It was not evident that there was clear communication between teams and the board. Team leaders told us that they had only been invited to one governance meeting with the operational managers. This was in February and they were unsure if they were going to be invited again.
- The service did not keep centralised records to monitor which staff were up to date with level 2 and level 3 children's safeguarding training. This meant the service was unable to monitor if staff were trained to the required standard.

Leadership, morale and staff engagement

- Most staff we spoke with felt senior leaders within the trust and managers above band seven were not visible, did not communicate with CAMHS teams, did not know and understand CAMHS services and its needs.They did not feel listened to when they raised concerns and complaints. They did not feel involved in CAMHS service planning.The CAMHS staff group had written a letter to managers sharing their concerns prior to the inspection. However, they had not been responded to and felt disappointed by the lack of response. All staff said changes in the management of CAMHS over last few years has meant messages do not get conveyed, processes were not implemented and staff were constantly 'firefighting'. Comments made by staff in the CQC staff survey also reiterated these concerns.
- CAMHS staff reported they did not feel part of the development of CAMHS services and had concerns about the future tendering of services. Several staff said they did not feel that the trust understood what CAMHS services did and did not feel part of the trusts.
- Team members felt supported by each other but several staff indicated they were stressed and overstretched due to workloads.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

- Staff told us they felt there were limited opportunities for them to access leadership development courses.
- There was no local induction for team leaders. They had not been given guidance to their full range of duties in a timely manner. A team leader shared they had not had full training on the datix and were not aware of their roles as team leaders in the datix process.
- One member of staff had reported harassment and bullying to their line manager. They felt able to report this and that It was dealt with effectively.. They had received support through supervision and team leaders.
- A comment in the CQC staff survey stated staff would not feel safe whistle blowing due to pending tendering process , in that they were concerned they would not get job if they whistle blew.

Commitment to quality improvement and innovation

- The CAMHS team were helping with recruitment to a national research project being organised by the Anna Freud centre, a national children's mental health training and research organisation.

Shropshire Community Health NHS Trust

R1D

Community health services for children, young people and families

Quality Report

Shropshire Community Health NHS Trust
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SY3 8XL
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Website: www.shropscommunityhealth.nhs.uk

Date of inspection visit: March 2016
Date of publication: This is auto-populated when the report is published

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1DHQ	Shropshire Community Health NHS Trust - HQ	**Community health services for children, young people and families**	SY3 8XL

This report describes our judgement of the quality of care provided within this core service by Shropshire Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Shropshire Community Health NHS Trust and these are brought together to inform our overall judgement of Shropshire Community Health NHS Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

We have rated this service as good. This is because:

- The service had effective safeguarding procedures in place and staff had received safeguarding children training appropriate to the role they performed.
- Staff across the service knew how to report incidents and were encouraged to do so. Learning from incidents was shared amongst staff and between teams in a number of formats.
- Staff provided individualised and patient centred care. Children, parents and carers were positive about the care that staff provided and the way that staff treated them. People told us and we saw that staff always did more than was needed when they provided care.
- Staff felt committed to empowering young people through providing them with appropriate information and support to enable them to make decisions around the care they received.
- Children, young people and their carers told us that staff treated them with compassion, dignity and respect. They were involved in discussions about treatment and care options and able to make decisions.
- Information was provided in a number of formats to enable young people to understand the care available to them and help them to make decisions about the care they wanted to receive
- Evidence based practice was delivered across all services and national programmes of care were followed. Staff assessed patient needs thoroughly before care and treatment started and staff took part in competency based training programmes.
- We saw strong local leadership with the majority of staff we spoke to telling us that they felt supported by their direct line manager.

Summary of findings

Background to the service

Shropshire Community Health NHS Trust provided a range of services for children and young people between the ages of 0 and 19 years, across Shropshire, Telford and Wrekin. This included community children nursing, school nursing, health visiting, therapies, psychology services and the Family Nurse Partnership. School Nursing was also provided and to the adjacent locality of Dudley. There are two Child Development Centres, which provide assessment of children with additional needs who are under five years old.

Children and young people under the age of 20 years make up 21.7% of the population of Shropshire and 25.9% of the population of Telford and Wrekin.

During the inspection, we spoke with 73 members of staff, 20 parents and 5 children. We reviewed 75 individual care plans for children, risk assessments and a variety of team specific and service based documents and plans.

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including: Community matrons; physiotherapists; occupational therapists; senior community nurses; community children's nurses; school nurses; health visitors; consultant clinical psychologist; palliative care consultant; nurse practitioner; head of quality; deputy director of nursing; palliative care nurse; substance misuse consultant, substance misuse nurse, CAMHS practitioner.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 7 to 11 March 2016.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a very defined period of time, however we

Summary of findings

did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held six focus groups with a range of staff across Shropshire who worked within the service. Around 20 staff attended those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

Children, young people and their carers told us that they were treated with compassion, dignity and respect

Feedback from a parent using the Health Visiting service and Paediatric physiotherapy when talking about the service said, “my daughter was referred to paediatric physiotherapy by my lovely and dedicated health visitor and I was seen a day later in a drop in session, I am grateful to my health visitor who is amazing”.

Good practice

The trust’s asthma guidance won the Nursing Standard School Nurse Team of The Year Award in 2014.

We saw good outstanding practice in child protection and children’s safeguarding arrangements.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve

- Record keeping and risk assessment should be regularly updated and filed in all child records within the Children Community Nursing team
- All toys should be cleaned in between all clinic session and cleaning rotas must be in all clinical areas and be completed and checked daily.

Shropshire Community Health NHS Trust

Community health services for children, young people and families

Detailed findings from this inspection

Good

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as good for safe. This is because:

- Staff across the service knew how to report incidents and were encouraged to do so. Learning from incidents was shared amongst staff and between teams in a number of formats.
- Staff were aware of their Duty of Candour responsibilities and were able to share examples of where it had been applied.
- Staffing levels and skill mix were planned and implemented to meet the needs of children, young people and families.
- The service had effective safeguarding procedures in place and staff had received safeguarding children training appropriate to the role they performed.
- We saw staff were washing their hands between clinics, and where washing hands facilities were not available staff were using alcohol gel.

However, we also found that:

- Risk assessments were not present in some paper-based patient records we looked at and care plans were out of date.
- There were no cleaning logs for furnishings and toys in one clinic and we saw no cleaning of toys between clinics.

Incident reporting, learning and improvement

- Staff were aware of how to report incidents. They told us that they were aware of trust wide incidents in various forms, for example, through weekly team meetings, monthly governance meetings and emails from line managers to share lessons learned. We saw evidence in the form of meeting minutes of incidents and actions discussed at the monthly Children, Young People and Families Quality and Safety Group.
- From March 2015 to February 2016, 180 incidents were reported within CYP services. There were no serious incidents reported by the trust, against this core service.

Good

Are services safe?

Eighteen incidents were reported by the paediatric community nursing team. Issues included a faulty suction unit, information governance and infection control.

- Of the incidents reported within the Health Visiting team, 74% were identified as communication concerns with maternity and social care; leaders were in the process of arranging regular meetings to establish a plan of action to improve the lack of communication.
- We spoke with staff across CYP services who told us that they were encouraged to report incidents and were aware of the need to do so. We saw examples of incidents which had been investigated and minutes from a root cause analysis meeting. Staff said they received feedback from investigations.
- Never events are serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented. . At the time of inspection there had been no Never Events registered across community CYP services.

Duty of Candour

- During interviews, staff demonstrated awareness of the Duty of Candour regulations 2014. Staff told us that they had received information on 'lessons learned' on Duty of Candour within their team meetings with examples of when the regulations should be applied. Staff were able to describe when Duty of Candour had been applied, where a child's father had a needle stick injury from the nurse who was administrating an injection to their child. First aid was administered and infection control and occupational health informed and advice given. The father was given an immediate apology and a full explanation. We saw this reported in the trust incident reporting system.
- The trust had a Complaints Procedure in place with explanation of Duty of Candour. In addition, we saw that the trust's electronic incident reporting system included a dedicated section for recording whether an incident was subject to Duty of Candour.

Safeguarding

- Staff demonstrated a good knowledge of the trust safeguarding policy and the processes involved for raising an alert. We saw safeguarding posters on display in the clinical bases, which meant that staff had access to the relevant information and phone numbers to raise safeguarding concerns.
- The trust had an 85% target for staff completion of safeguarding children training for eligible staff. We saw safeguarding children training figures for level 1, which is basic awareness training, was 100% for all CYP services except in paediatric physiotherapy (94%) and school nursing (96%).
- Safeguarding children level 2 training had an average completion rate of 93% across CYP services, however, we saw that the community children's nursing team had achieved 100% compliance. Safeguarding level 3 training is advanced training to include child protection and identification of children at risk. Data provided by the trust showed that 94% of eligible staff had completed this training.
- Safeguarding adults training is included in the mandatory training for community CYP staff. At the time of inspection, we saw from data provided by the trust that 100% of CYP services staff had completed adult safeguarding level 1 training, except for physiotherapists (93%) and school nurses (86%).
- There was evidence of robust safeguarding procedures in place to protect vulnerable children; safeguarding alerts investigation with multi-disciplinary, multi-agency approach with trust wide governance support and review. Local and serious case reviews were held in a timely manner and we saw action plans supporting these reviews. Staff had access to the Multi Agency Safeguarding Hub (MASH) if they had safeguarding concerns.
- We saw good peer review between health visitors to prevent safeguarding events from occurring through identifying areas of safeguarding risk. We saw implementation of early interventional strategies to reduce risk, particularly for patients on the antenatal pathway.
- Staff within the Family Nurse Partnership (FNP) service told us that they were fully aware of the safeguarding aspects of their role and knew who the main point of contact was for raising safeguarding concerns. Staff also told us that they felt fully supported by management should they need to raise a safeguarding concern. They had a named person who they could approach when faced with a safeguarding issue and when they required advice when referring.

Good

Are services safe?

- The school nursing teams and health visiting teams received training in childhood sexual exploitation and female genital mutilation.
- Staff from the FNP, school nursing and health visitor services involved with safeguarding cases had received regular safeguarding supervision sessions. This ranged between weekly to three monthly depending on the complexity of the cases. Staff told us they were supported with extra sessions if required.
- The trust was involved in two serious case reviews. We saw that the trust learned from the reviews to improve practice and safeguarding procedures.

Medicines

- The trust had a medicines management policy in place. We saw awareness amongst staff about the policy and how to access it, through the trust's intranet site. The policy supported practices within CYP services.
- For vaccination and immunisation, CYP had a specific team who offered school based immunisation programmes, advice, support and training to colleagues and the public for both childhood and adult immunisations. They saw children and young people of all ages across Shropshire and Telford and Wrekin. All childhood immunisations offered as per national guidance as detailed in The Green Book 2006 and Public Health England.
- The community pharmacist ensured children's medication was available and supported the children's community nurses with advice and support when required. The pharmacists were independent contractors and not employed by the trust.
- Nurses were encouraged to complete their nurse prescribing training; those who were nurse prescribers had a prescribing pad, carried with them at all times and was held securely for transporting.

Environment and equipment

- We looked at the storage, maintenance and availability of equipment used in clinics, schools and in children's own homes. There were systems in place to ensure that equipment was regularly serviced and maintained. However, we saw one weighing scales within health visiting team was out of date.
- We saw that children's clinics were generally provided in appropriate clinical settings. For example, we saw that the children's speech and language therapy clinic in Telford provided in a suitably equipped and child friendly room with appropriate décor. We also saw a baby clinic at the Shropshire Children's Centre was provided in child specific premises.

Quality of records

- Medical records we observed were all in paper format. We reviewed paper records in the FNP and health visitor services and found that records well written with legible entries signed and dated. The records we reviewed within health visitor and FNP services had completed home visit risk assessments, assessment tools, and care plans completed. However, we found that the records reviewed within the community children's nursing team were missing risk assessments; We looked at 24 records within the community children nursing service. Seven records had no care plans and four of the care plans were out of date, one care plan was over 12months out of date and others varied from weeks to months out of date.
- There was evidence of written consent and family involvement in records. We also saw records that demonstrated care continuity and multidisciplinary approach to the care delivered. We saw service specific record keeping audits in which good practice was highlighted, for example, they would use a 'buddy up' process where each team would audit their peers, such as Telford health visiting team would audit Shropshire health visiting team and vice versa. This system of records keeping audits was also within the FNP services.
- The records audits had associated action plans for individual teams across the CYP service. Staff confirmed the results were discussed in team meetings.
- The service kept medical records securely in line with the data protection policy and were all in a key locked cabinet.

Cleanliness, infection control and hygiene

- Across all CYP services, infection control training compliance was 93%, against the trust-wide target of 85%.

Good

Are services safe?

- We saw staff washing their hands or using hand gel in between each intervention. Staff had access to personal protective equipment (PPE) if required, we saw staff followed the trust infection prevention policy of 'bare below the elbows'.
- Hand hygiene signs were displayed throughout the clinics and offices we visited to remind staff and visitors of the importance of handwashing to protect patients from the risk of cross infection.
- We observed inconsistency in infection prevention control. We saw areas in paediatric physiotherapy drop in centres had no cleaning logs for furnishings and toys and we saw no cleaning of toys between clinics, including play mats between patients.

Mandatory training

- The Trust had a list of mandatory training for CYP services that staff must complete and adhere to, this included safeguarding children and adults, moving and handling, paediatric basic life support.
- The average training compliance rate was 88%, against the target compliance rate for the trust of 85%.
- Staff told us they were supported to attend mandatory training. We saw that staff had access to their online training performance and were updated online for what training they required to complete and when. They were reminded via email if they had not completed training within the timescale.
- Staff told us they were alerted to mandatory courses which were out of date by their online training record and managers also e-mailed them reminders.

Assessing and responding to patient risk

- There was a range of risk assessments locally implemented in the services, for example in Health Visiting and FNP services. Detailed risk assessments and care plans were shared with parents to guide them on what to do in the event of an emergency or their child's condition deteriorating. If urgent medical treatment was required then families would call emergency services on 999.
- A wide range of risk assessments were used across children's services to assess and manage individual risks to children. For example, the FNP service used a child sexual exploitation risk assessment and children's nurses assessed for pressure ulcer risk. When staff identified risks, they had access to support, guidance and equipment to help manage risks.
- We saw examples of newsletters staff received via emails on risks, incidents within their core services, staff also informed us that they have face to face discussions with their manager.

Staffing levels and caseload

- Overall, we saw and staff told us that there were adequate staffing levels across the CYP services to meet the needs of children and families. The sickness rate across the service was 3.6%, which is below the trust average of 5%. Long-term absence was 2.8% and 0.8% for short term absence.
- In Shropshire, there were three health visiting teams in the North, Central and South Shropshire and one FNP team. Telford also had three health visiting teams across North, Central and South with one FNP team.
- In September 2015, there were 16.7 vacancies for qualified nurses, which equates to 9% of the funded establishment. The highest number of vacancies for qualified nurses were for Dudley school nurses (8.4 WTE). For nursing assistants, staffing was above establishment levels, giving a negative number of vacancies (-11).
- All health visiting and FNP teams had a 0% vacancy position and were fully staffed to agreed establishment levels. The headcount for health visiting within Shropshire and Telford was 167, which equated to 107 Full Time Equivalent (FTE) ranging from Band 8a to band 2.
- FNP were at full capacity of 100 clients as per FNP license objectives. We saw that the expected caseload were in line with the FNP Advisory Board recommendation.
- Staff told us that individual caseloads were reviewed within regular supervisions with their managers. Health visiting teams arranged their own appointments; this enabled them to manage their own caseloads.

Managing anticipated risks

- We saw that risk assessments in relation to lone working were completed. Measures had been put in place such

Good

Are services safe?

as the use of mobile phones to inform their colleagues of their location. If they were unsure of certain areas they were visiting, they would meet their patients' in a public area or take their colleague with them for safety.

- We saw lone working arrangements for health visitors were in place and implemented well at a local level. For example, we saw the use of a tracking application on health visitors' mobile phones in order that their location would be known.

Major incident awareness and training

- We saw that major incident and business continuity training was discussed at trust board level and that the Trust had identified the training needs for all staff that had a role in the business continuity plan.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We have rated this service as good for effective. This is because:

- Evidence based practice was delivered across all community CYP services and national programmes of care were followed.
- We saw competency based training programmes within each community CYP service.
- There were many examples of multiagency and multidisciplinary working to make sure that patients' were able to access all of the services they needed.
- Consent was obtained prior to treatment and was recorded in patients' notes.

However we also saw that:

- We saw that IT systems were not fully integrated across community CYP services.
- There was no transition policy, although this was recognised and the trust was developing a policy.

Evidence Based Care and Treatment

- The organisation followed the Department of Health national initiative called the Healthy Child Programme. The programme requires the early intervention of health visitor contacts with babies and children. It offers regular contact with every family and includes a programme of screening tests, immunisations and vaccination, developmental reviews and information, guidance and support for parents. The trust told us this also underpins school nursing.
- Family Nurse Partnership (FNP) services provided evidence based, preventative support for vulnerable first time mothers, from pregnancy until the child is two years old of age. This was a voluntary programme for young mothers who could "opt out" and "opt back in" if they needed to. Family nurses delivered the programme, within a defined and structured service model. We saw that the service adhered to NICE guidelines of antenatal care and postnatal care.
- All community CYP services delivered evidence-based practice and followed recognised and approved national guidance in accordance with governing bodies. This included the NMC (Nursing and Midwifery Council), RCPCH (Royal College of Paediatrics and Child Heath) and NICE.
- We saw evidence of completed local audits being held within the community CYP teams and saw evidence that learning was being discussed at team meetings.
- School nurses completed a school asthma audit, and won an award for this audit, which resulted in a positive effect on children living with asthma. Children were managed effectively during school hours, resulting in good record keeping of asthmatic children in schools and an asthma policy placed in all schools. Schools now have access to emergency treatment medication. Since the audit, there has been improved progress of asthma management within Shropshire schools.
- Health visitors followed the NICE postnatal depression pathway and approval had been gained to undertake cognitive behavioural therapy (CBT) training.

Pain Relief

- There were clear guidelines for staff to follow in regards to pain relief that reflected national guidance.
- Care and treatment was planned and delivered to meet the needs of patients', children's parents completed training to administer medications at home with guidance and support from the children's community nurses.

Nutrition and hydration

- We saw staff planning care to treat and deliver nutrition and hydration support for children. Where appropriate, children had a nutritional and hydration plan in place that reflected national guidance and demonstrated a multidisciplinary approach to meeting children's dietary needs.
- During our inspection, we saw staff giving advice to parents on relevant information about their children's

nutrition and hydration requirements. In the speech and language therapy service, we saw demonstration of this in a session for child development. We observed therapists undertake detailed questioning in a calm and reassuring manner.

Patient outcomes

- We saw that community CYP services completed audits to measure quality of patient outcomes.
- Overall referrals made to children's services from January 2015 to February 2016 was 3,404.
- Health Visitors had key performance indicators (KPI's) aligned to the contact stages in the healthy child programme. Exception reporting took place against the health visiting KPI's. It was seen that the majority of reasons for an uncompleted visit was recorded as a "did not attend" (DNA) appointment.
- Community Children's nursing service audit activity 2015/16 included; observational audit of aseptic technique, clinical record keeping, phlebotomy clinic parent survey; constipation clinic survey, contribution of the Paediatric Psychology Service (PPS), use of referral pathways to the PPS in paediatric diabetes; NICE enuresis; declined immunisations survey; SLT community clinics and school nurses special educational setting.
- These audits commenced in 2015 and we were unable to review the results from these audits as they are ongoing and not yet been collected.

Competent staff

- Staff across community CYP services demonstrated they possessed sufficient knowledge, and were competent to deliver care and treatment to children and their families.
- Staff told us that they were able to raise additional training requests at their appraisals meetings.
- We saw that services across the trust had competency based training in place. Competencies for training was carried out between services, however was seen to appropriate for each staff role and grade.
- We saw evidence that the health visiting team in Shropshire had been granted funding for a three-day course at a university to develop skills to support patients with perinatal mental health problems.
- Staff were supported with the revalidation process and staff have attended NMC guidance meeting.
- The overall appraisal rate for the trust in November 2015 was 67%, based on 1202 non-medical staff. At the time of the inspection, the appraisal rate was 94%. Most of the staff we spoke with said they had received their annual appraisal. They spoke positively about the process, stating that progress with personal objectives reviewed and linked to training opportunities. Staff received regular (six weekly) clinical supervision. The child health, community paediatrics, FNP, immunisations & vaccinations and newborn hearing screening teams all had appraisal rates of 90% or higher.

Multidisciplinary working and coordinated care pathways

- There were many examples of multiagency and multidisciplinary working to make sure that patients' were able to access all of the services they needed.
- Speech and language therapy undertook joint clinic sessions with the child's key worker from school to help understanding of goals and aid the child's progress.
- We saw that the children's speech and language therapy service worked as part of an effective multi-disciplinary team. For example, we saw that there were strong links with specialists in other disciplines including cleft palate and dysphagia. We attended a regional team meeting and saw the team also worked with a Makaton tutor to provide training for parents. Physiotherapists and occupational therapists sometimes performed joint assessments, for example for supported seating for individual children.
- We saw that there were communication pathways between the service and the local authority for joint cases.

Referral, transfer, and transition

- The health visiting teams in Shropshire and Telford provided us with their Q3 figures for universal contacts being delivered. The highest against target was 95% with new birth visit. The lowest in Shropshire was the two-year review at 72%, with Telford's lowest figures being for antenatal at 60%.
- We saw an example of a referral within speech and language therapy report for inclusion in final transition

Good

Are services effective?

from child to adult services. We also saw an example of a thorough letter with details of individual needs such as required objects used to communicate effectively and what the school and home require to develop this individual service user.

- We asked the Trust about the transition policy. The head of nursing and quality said that they did not have a policy but they were aware that there was a need for one. The Queens Nursing Institute have been funded to undertake this piece of work to which CYP are contributing. However, we saw evidence from letters and reports in patient's notes that transition to adult services was planned effectively and parents and guardians were involved in the process.
- We saw within records that GPs were informed of progress and when children were discharged from services.

Access to information

- Staff told us and we saw that there were numerous IT systems in use across the trust. Access to the IT systems and the effectiveness of their use varied in consistency between school nursing in Dudley but management were aware and told us they were working towards effective IT access for the staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Across CYP services we saw that staff gained consent before each intervention and this was documented in the notes. Parents confirmed they were asked for verbal consent and sometimes written consent, depending on what the treatment of care was.
- We saw evidence of written consent and family involvement in records.
- Staff told us that Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training was included within the safeguarding training.
- We looked at ten care pathways and documentation, we saw this included consent from a service user in each record and was correctly documented.
- To assess whether a child was mature enough to make their own decisions and give consent staff assessed Gillick competence appropriately. When questioning staff, they demonstrated good understanding.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We have rated this service as good for caring. This is because:

- The feedback we received for the CYP community teams was good, children, parents and carers were continually positive about their care.
- Children and young people told us they were treated with compassion, dignity and respect, they were involved in discussions about their treatment and care options and able to make decisions.
- Support was provided to help parents cope emotionally with the care and treatment provided.

Compassionate care

- All of the interactions we observed across CYP services were undertaken in a compassionate and dignified manner.
- Patients and families we spoke to told us they felt that the staff who had provided services were friendly and that they were given ongoing support.

Understanding and involvement of patients and those close to them

- We saw practice across CYP Services to be child-centred and to involve children and their families as partners in their care.
- We saw an occupational therapist involving the child in the discussion of their care by directing questions to them and explaining each stage of the assessment. Activities tailored by the occupational therapist to meet the needs of the child and conversations relating to their support were specific to the patient and their needs.
- We observed an audiologist conducting a hearing test who interacted very well with the child and who discussed the outcome of the test in a way tailored to the child.
- We observed a paediatric psychology appointment where the psychologist used a story to gain information about family history in which involved the family and child effectively. The psychologist paused several times to interact with the child. The family had the opportunity to discuss issues they had experienced with care and the psychologist provided treatment and appropriate information.
- Mothers were given opportunities to ask health visitors questions and advice was given appropriately. We saw a health visitor providing the mother with information for another service to help with an issue. One patient said she found the health visitor “really supportive, to not just me but my family”.
- We saw staff demonstrating activities on a one to one basis with the child whilst providing clear instructions throughout to both the child and parents.

Emotional support

- We heard examples from staff of families who had experienced the loss of a child being given time with staff to discuss their emotions and be supported at the time of the death and over a period of time afterwards.
- We saw examples of emotional support given during the inspection. A health visitor gave a new mother the time to talk through her experience of having delivered a baby prematurely and reassured her with going through notes for how well the baby was progressing.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We have rated this service as good for responsive. This is because:

- Services were tailored to the needs of the local population, care was provided from a number of settings to increase the accessibility of the service being provided
- There was access to interpreters and language forum groups for families whose first language was not English within the community CYP staff.
- Patients were able to access the right care at the right time. Services offered flexible appointments to meet people's needs.
- Information regarding complaints was widely available and teams sharing learning from complaints.

Planning and delivering services which meet people's needs

- Community CYP services planned and delivered care to meet the needs of the child/young person and their parents. We saw during home visits and clinics that care was well organised and managed keeping the child at the centre of the treatment and care.
- Health visitor teams provided care from various settings, for example, Children's centres, baby clinics and children's own homes in order that parents had a choice of options available for accessing the service.
- Senior managers told us they met monthly with commissioners to discuss service provision.
- The Family Nurse Partnership (FNP) service tailored support and care to young expectant mothers, taking into consideration their individual circumstances.
- Therapists planned and delivered care to children in schools, clinics and children's own homes based on the child's individual needs. The school nursing and immunisation teams delivered care within schools and clinics.

Equality and Diversity

- Staff told us and we saw that all community CYP staff had access to interpreters and that they were widely used to ensure that effective communication took place between staff, patients', families and carers.
- CYP staff booked interpreters in advance so that there were no delays in communication during home visits and clinics.
- Equality and diversity training was included within the trust's mandatory training programme as well as within the trust's induction programme, within CYP services, 94% of staff members had completed this training.

Meeting the needs of people in vulnerable circumstances

- Health visitors had local forums for parents and families who were with the armed forces and parents who required support for their children living with Downs Syndrome.
- Therapists and health visitors tried to reduce difficulties with access to services by people with vulnerable circumstances by providing care in a range of venues such as at local children's centres, nurseries, baby clinics as well as home visits.
- Within the Health Visiting service staff were allocated fairly to cover the deprived area this allowed flexibility within their caseloads.
- School nurses had 'text your school nurse', a confidential text messaging service to improve access to health information and empowering young person to take more control of their own health.

Access to the right care at the Right time

- Within the Trust, CYP services had local and national waiting time targets. Children's occupational therapy waiting time targets were that 95% of patients should wait no more than 18 weeks from referral through to treatment. Data provided by the trust showed they had met this target.
- One service failed to meet the 42-day local target this was a consultant led paediatrics outpatient service

Good

Are services responsive to people's needs?

based in the community hospitals. Physiotherapy, Speech and Language therapy services had the same target times. Data provided showed these services met the target.

- Assessments for children and young people took place at appropriate times across the community CYP services. Key stages within the Healthy Child Programme were included within the community CYP services key performances indicators.
- We saw that children's and young people's assessments and treatments across CYP services carried out at appropriate stages of their development and significant times of their lives within each service and between services. For example, the Family Nurse Partnership (FNP) service invited young expectant mothers at the age of 19 years onto the programme and supported them and their families for two and half years through the antenatal period to the child's 2nd birthday.
- We saw health visitors made robust links with FNP services to share care, provide development checks, immunisation programmes, and support parents with children until school age.
- Children and young adults accessed nursing and therapy services at settings to suit them. For example, home, clinic and schools. We observed staff offering parents flexibility and a choice of appointments to suit their individual needs.
- We saw during drop in sessions within physiotherapy, SALT and Occupational Therapy that there was parental involvement in the sessions and that the staff interacted appropriately with both the parent and child.
- The paediatric physiotherapy also had a drop in sessions in children centres, this helped to increase the level of engagement with parents whose children were using the service.
- The SALT team had drop in sessions for parents and their children to attendthe child development centre for support.
- Paediatric psychology had appointments accessible for both parents, this enables both parents to be involved within their child's well being.

Learning from complaints and concerns

- Staff we spoke with were aware of and knew how to access the trusts complaints policy. We saw during our inspection that during a patient's first visit, staff were handing out information leaflets including information on how to make a complaint.
- We saw PALS (patient advice and liaison service) posters and leaflets were displayed in clinics, children centres and schools.
- Staff were aware of how to resolve complaints locally and when to escalate to senior management. The Trust had a complaints policy that staff adhered to.
- Staff told us and we saw that complaints and concerns were discussed at team meetings and that learning was shared locally at the team meetings. We saw that complaints across CYP services and lessons learnt these were discussed this resulted in supporting staff with future training and to improve their practice.
- Between October 2014 to October 2015 CYP had a total of 15 complaints with one being referred to the ombudsmen but not upheld.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We have rated this service as good for well-led. This is because:

- There was a clear vision and strategy within the CYP service.
- We saw strong leadership with the majority of staff we spoke with telling us that they felt supported by their direct line manager. There was effective communication between the senior management team and staff within community CYP Services.
- Governance and risk management systems were in place and the service had systems to mitigate risks.
- There was a culture of support and caring amongst staff and managers and they were committed to providing good quality care to children, young people and their families.

Service vision and strategy

- There was a clear vision and strategy within the CYP service. We spoke with the head of children's services and the professional lead for health visiting regarding their vision for the service. They were able to articulate what the vision was and how it linked to the trust strategy.
- We asked staff and team leaders if they were aware of the trust's strategy for community CYP services. Staff informed us that they were aware there was a local strategy in place.

Governance, risk management and quality measurement

- Community CYP services had Key Performance Indicators in place that were used to measure the performance of the service teams. The quality of care was monitored and performance was discussed at monthly team and governance meetings. We saw minutes were taken and shared among staff to encourage improvements in practice, this enabled staff to be aware of what improvements need to be made and what changes have been made to improve the service.
- Each individual community CYP service held its own risk register, staff told us they felt able to record risks on the register and discuss their issues with their line manager. We saw that the risk register reflected this.
- At the time of the inspection, there were total of 11 open risks recorded on the register for CYP services. The risks were from children's dentistry and child and adolescent mental health, three were regarding the child development centre. All risks were categorised as moderate to low level risk.
- The service had a monthly review of trends, they shared information with Local Authorities to ensure mitigation re links with special education placements, working closely with the commissioner and develop options for the Trust.

Leadership of the service

- Staff told us they felt there was strong local leadership across all CYP services. One staff member within the health visiting team said 'changes had been made for the best, I am happy to work in the team, I feel supported'.
- We saw that services were well-organised and effective team working was encouraged. Staff across all CYP services was enthusiastic, motivated and felt supported by their local team leaders. We saw that team managers were very dedicated to their teams and worked very hard to lead by example.

Culture within this service

- Staff from all disciplines described themselves as happy to work within their respective teams and were proud of the care they provided to children young people and families. This was displayed by all staff we talked to individually and in staff focus groups.
- We found staff across community CYP services were dedicated and compassionate. Staff who told us felt valued and supported by their colleagues and managers.

Good

Are services well-led?

- Staff from all disciplines spoke with passion about their work; Staff told us there was an open culture where they were encouraged to report incidents.

Public engagement

- Services gathered verbal and written feedback in the form of thank you letters and cards to evidence satisfaction across community CYP services.
- The trust took part in the Friends and Family Test. An NHS initiative to assess the quality of services by asking people who used them whether they would recommend the service. Trust Wide the period to January 2016, 340 responses to the Friends and Family Test, 240 (70%) of these responses were extremely likely to recommend the service.

Staff Engagement

- Staff told us that they felt engaged at a local level and we saw that there was frequent communication with them via team meetings and emails within their direct team.
- Staff told us they were encouraged to contribute their ideas for improvements to practice at their team meetings; staff regularly discussed patient feedback from questionnaires in their monthly team meetings.

Innovation, improvement and sustainability

- We saw local strategic leadership in relation to services for vulnerable children including robust procedures and pathways for those children at risk of child sexual exploitation and female genital mutilation.
- Feedback from the Friends and Family Test questionnaires on what was good and suggestions for improvement were shared in monthly meetings across the CYP group.
- Methodology of improving the services was shared locally between trust services and with external organisations to help drive wider health improvements an example being asthma audits within the school nurses this improved children safety in schools who had asthma.

Shropshire Community Health NHS Trust

R1D

Urgent care services

Quality Report

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Date of inspection visit: March 2016
Date of publication: This is auto-populated when the report is published

Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1D22	Bridgnorth Community Hospital	**minor injury services**	WV16 4EU
R1D21	Ludlow Community Hospital	**minor injury services**	SY8 1QX
R1D34	Whitchurch Community Hospital	**minor injury services**	SY13 1NT
R1DX5	Oswestry Health Centre	**minor injury services**	SY11 1GA

This report describes our judgement of the quality of care provided within this core service by Shropshire Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Shropshire Community Health NHS Trust and these are brought together to inform our overall judgement of Shropshire Community Health NHS Trust

Summary of findings

Ratings

Overall rating for the service	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Summary of findings

Overall summary

We have rated this service as requires improvement. This is because:

- There were not always staff on duty with all the appropriate skills and no formal arrangements for clinical supervision of lead nurses or supervision from paediatric doctors although each MIU saw children and babies.
- Arrangements for feeding back to staff and for learning from incidents were variable.
- There were inconsistencies in safe staffing levels and high numbers of staff absence from work
- Care and treatment was mostly based on evidence based guidance but staff were not trained in dealing with sepsis.
- The service had not compared its performance against other similar services or undertaken any local checks of how well it does.
- The trust's scheme to support patients with dementia through their treatment pathways was not understood by MIU staff
- X-ray services were not always available at the same times an MIU was open which meant patients had to be referred elsewhere.

However, we also saw that:

- The MIU's all consistently met national targets for response times.
- Services were planned and delivered to meet the needs of the local population and there was evidence of the service working with local commissioners to improve access for patients.
- Staff were kind and professional in their approach and attentive to patients' needs.
- Patients felt informed and involved in their care and decisions about their care.

Summary of findings

Background to the service

The trust provided four minor injuries units (a type of walk-in clinic service) in rural locations spread across the county. Three were located within community hospitals at Whitchurch, Ludlow and Bridgnorth and the fourth in a community health centre at Oswestry. Each unit is nurse led, staffed by emergency nurse practitioners (ENPs) who can work autonomously to treat minor injuries such as lacerations and fractures.

The minor injuries units saw in total 27,688 patients between January 2015 and February 2016. This included 7,088 children and babies. Oswestry saw the greatest proportion of patients (40%), followed closely by Bridgnorth (31%). Ludlow saw 5200 (19%), Whitchurch is the smallest unit seeing around 2,900 patients each year.

We visited each unit including one out of hours and spoke with twenty two patients including children and with thirteen staff.

The trust also provided a diagnostics, assessment and access to rehabilitation and treatment (DAART) service. It offers patients an assessment and diagnostic service including assessment by a GP with special interest in older people. Assessment is completed by multidisciplinary teams. The aim of the service is to keep poorly patient out of hospital where appropriate, allowing care to be given closer to their home or in a community setting.

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included CQC inspectors and a variety of specialists, including: Community matrons; physiotherapists; occupational therapists; senior community nurses; community children's nurses; school nurses; health visitors; consultant clinical psychologist; palliative care consultant; nurse practitioner; head of quality; deputy director of nursing; palliative care nurse; substance misuse consultant, substance misuse nurse, CAMHS practitioner.

The team also included other experts called Experts by Experience as members of the inspection team. These were people who had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?

Summary of findings

- Is it well-led?

Before visiting, we reviewed a range of information we hold about the service provider and asked other organisations to share what they knew. We carried out an announced visit from 7 to 11 March 2016.

We did not hold a public listening event prior to this inspection as we were looking to assess changes and progress over a very defined period of time, however we did contact Shropshire Healthwatch and Telford Healthwatch to seek the views that they had recently formed on the trust. Additionally, number of people contacted CQC directly to share their views and opinions of services.

We met with the trust executive team both collectively and on an individual basis, we also met with service managers and leaders and clinical staff of all grades.

Prior to the visit we held six focus groups with a range of staff across Shropshire who worked within the service. Around 20 staff attended those meetings and shared their views.

We visited many clinical areas and observed direct patient care and treatment. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

We carried out an unannounced visit of the minor injury services on Thursday 24 March 2016.

What people who use the provider say

We spoke with people using the services in all four MIU's. Patients were very positive about the services and commented on the convenient location and told us services hold a good reputation amongst the local communities and are highly valued. People who had used the service told us staff were very caring and sensitive, answered all their questions and explained things well. They also commented on the short waiting times and quick service. One patient who used a walking aid commented that there was no ramp access to the MIU at Ludlow.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must review the staff sight line and visibility of waiting patients to aid quick identification of a deteriorating patient especially children and that triage and assessment arrangements are consistently in place across all four MIUs.
- The trust must review the inconsistent approach to identifying and managing risk across the MIU's.
- The trust must review the formal arrangements for clinical supervision of emergency nurse practitioners and medical supervision from paediatric doctors.
- The trust must review staffing levels to ensure sufficiently skills number of staff are on duty at all times in order to meet the needs of the service.

Action the provider SHOULD take to improve

- The trust should ensure that lone working arrangements reflect trust policy at all times and protect staff from the risk of harm
- The trust should ensure that incident reporting across all four of the MIU's is consistent and reflects good practice
- The trust should review its participation in national clinical audits and local audit of its services, and improve staff understanding of the benefit of audit including of the outcomes for children
- The trust should ensure that staff are familiar with the significant morbidity and mortality associated with sepsis and possess the knowledge and skills to recognise it early and initiate resuscitation and treatment.

Summary of findings

- The trust should review systems for documenting consent to treatment on record for patients.
- The trust should ensure that staff receive training in awareness for patients with dementia, learning disability and mental ill health.

Shropshire Community Health NHS Trust

Urgent care services

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

We have rated this service as 'requires improvement' for safe. This is because:

- Criteria for incident reporting varied across the four MIU's and there was no consistent arrangement in place for feeding back to staff and for learning from incidents;
- Waiting areas did not always provide a clear view for staff to quickly identify a deteriorating patient including children;
- Lone working arrangements for staff were not robust in one MIU;
- Triage and assessment arrangements were not consistently in place in each MIU;
- Staffing rosters showed that safe staffing levels were achieved inconsistently, staff absence levels were high;
- The approach to identifying and managing risk at each MIU varied.

However we also found:

- Staff knew how to report incidents;
- Staff understood their role in relation to safeguarding children and there were good systems in place;
- Medicines were safely managed;
- The MIU's were well equipped and maintained;
- The MIU's were clean and uncluttered and cleaning schedules and checks were in place;
- There were good infection control measures in operation consistently.

Incident reporting, learning and improvement

- Staff we spoke with in each of the four minor injuries units (MIU) told us they used the trust's electronic system to report incidents and gave us examples of this.
- Not all health care assistants were confident about completing reports without assistance however; they said they passed information to nurses verbally.
- What was reported through the incident reporting system varied across the four MIU's. For example at the Oswestry MIU local leaders told us they routinely made staffing incident reports (of insufficient/skilled staffing to safely meet the planned safe staffing numbers). At Bridgnorth local leaders told us they did not report staffing incidents "unless it was something that had given us alarm." This meant the trust may not get a robust picture of issues across the service.

Requires improvement

Are services safe?

- We heard mixed accounts as to whether staff received feedback on incidents they had reported. For example Oswestry staff told us they received no feedback from divisional leaders on these reports. At Ludlow we noted a print off of incidents reported by that team on the staff notice board with the follow up action included so staff could see the outcome of the reports they submitted.
- At Bridgnorth staff told us they escalated concerns by reporting staffing incidents to local leaders 'but not filling out a report each time'.
- Local leaders told us were not aware how lessons learned from reported incidents in the minor injury units or from complaints were shared across the units. Staff at one MIU did tell us they were aware incidents were discussed at divisional managers meetings.
- One senior nurse was not familiar with 'root cause analysis' (RCA) and told us hearing about incidents from other parts of the service was considered 'gossiping'. Others did not refer to RCA but understood that learning lessons from incidents was beneficial.
- We asked at each MIU for examples of any improvement action plans as a result of learning from incidents or near misses but we were told there were none.
- Nursing staff we spoke with in most MIU's told us they understood the Duty of Candour and had some experience of exercising it within their role, for example immediately telling a patient if a mistake had been made in their care or treatment and putting it right. However some, although clear about their professional duty to be open and honest about mistakes, were not sure about the Duty of Candour requirement.

Safeguarding

- Nursing staff on duty we spoke with gave us examples of paediatric safeguarding concerns and referrals they had made recently this demonstrated they were aware of and understood their responsibilities. They confirmed a safeguarding tool was part of paediatric assessment and this provided a good platform to initiate questioning. We observed this during our visits.
- High attendance rates by children were flagged on the electronic system and four visits across the MIU's would trigger a review and if considered appropriate, a safeguarding referral.
- We saw staff noted and senior nurses checked and signed off re attendances within a 12 month period of patients under 16.
- Local leaders confirmed a report was generated on the electronic records system for every patient under five years who attended and a copy of the report was sent to the child's health visitor. A similar report for children under 16 year olds was generated and sent to the relevant school nurse.
- We heard of a recent example at Whitchurch MIU of staff referring a query non-accidental child injury to the local acute trust emergency department and contacting the department in advance to expect the patient. This was then followed up by a safeguarding alert to the local safeguarding children authority.
- The trust set a target of 85% for mandatory training including safeguarding. Data provided by the trust showed minor injury unit compliance rates were well above this with 95% for level 1 adults and 92% for level 1 children's safeguarding.
- The Head of Nursing and Quality told us any aged child was seen in the MIU's, all nursing staff had level 2 child protection training, but we were not provided with any data to demonstrate this.
- The trust had put in place a pathway to paediatrics advice for MIU staff. There was 24 hour telephone access to Shrewsbury and Telford Acute Hospitals and then discussion with the safeguarding lead.

Medicines

- Nurses had access to trust pharmacists for advice.
- We saw medicines were safely managed across all four MIU's for example, monitoring information being held in at the nurse's station in a file.
- We specifically focused on practice in one MIU. Records showed fridge temperatures were being monitored against the minimum and maximum safe range and single temperatures recorded for March 2016 were all within range. Staff were able to tell us the procedure in the event of a break in the cold chain.
- The room temperature where medicines were stored was monitored and we noted records for March 2016 as all below 25 degrees as it should be.

Requires improvement

Are services safe?

- Oxygen was checked as part of the medicines check.
- Staff carried out monthly check of expiry dates of all stock medication held in the locked clinic room and stock checks to ensure they had the correct amount and right stock for patients.
- A monthly check was made of expiry dates of all stock medication held in the locked clinic room.
- We spoke with one member of the nursing staff team who demonstrated a clear understanding of safe management of medicines

Environment and equipment

- All four MIU's were situated in appropriately set out environments and well equipped. Three MIU were part of community hospitals and the MIU at Oswestry was in a newly refurbished community health centre.
- Each had an equipped and decorated children's cubicle/treatment room and most necessary assessment equipment was available in child sizes.
- We saw equipment trolleys were clean, well-organised and well stocked.
- We saw from records that resuscitation trolleys were regularly checked on a weekly basis and this included the medicines contents and expiry dates.
- Arrangements were in place to secure premises that opened out of hours. For example at Ludlow MIU the access door to minor injury services was switched out of hours to a side door and waiting area with CCTV monitoring and this was clearly signed from the front door of the hospital.

Quality of records

- An electronic system held patient records across all four sites and this facilitated 'flags' for significant triggers. The MIU's used a paper based attendance system. We observed the card for each patient was generated and printed off from the electronic system when the patient booked in. At the end of the episode of care, information carrying codes was transferred from this card back onto the electronic system and a discharge letter was generated.
- We looked at a sample of these records, the last six under two year old patients seen before our visit, at one MIU. They were clearly and fully completed and included details of assessment, treatment and transfer arrangements or discharge.

Cleanliness, infection control and hygiene

- The trust had a policy and set of procedures for hygiene and control of infection.
- Data provided by the trust showed that 93% of MIU staff were up to date with infection control training.
- We observed that each area of each MIU was clean and uncluttered and we noted cleaning schedules and checks in place.
- We saw dispensers with alcohol hand gel on walls around each MIU and wall mounted dispensers of protective clothing such as gloves and aprons in treatment rooms, which staff used.
- We noted there were wash basins at the point of care in each treatment room in each MIU and saw staff cleanse their hands before and after treating patients and were bare below elbows in clinical areas.
- We saw some information to patients and visitors about the importance of hand hygiene but this did not have a high visual impact and we saw no patients using hand dispensers in any of the MIU's during the three days of our visit. Nor did we see staff prompt them to do it.

Mandatory training

- Data sent to us by the trust showed the average training compliance for the MIUs overall was 81%, which was below the target compliance rate for the trust (85%).
- Of note, fire safety had a compliance rate of 39% with a 0% rate recorded for Whitchurch MIU. The only other compliance rate under 80% was conflict resolution (78%).
- Basic adult life support and basic paediatric life support training update compliance was at 82% respectively.
- We noted from records at Ludlow MIU that all staff were up to date with mandatory training and safeguarding training updates were in progress at the time of our visit.

Requires improvement

Are services safe?

- Local leaders assured us all staff at Bridgnorth MIU were up to date and this includedextra mandatory competency of blood transfusion and falls prevention as this team also provided the DAART) service.

Assessing and responding to patient risk

- We noted that none of the units we visited had dedicated reception staff. Health care assistants or temporary (bank or agency) staff rostered as part of the nursing teams, acted as receptionists. The trust told us that Oswestry MIU has a dedicated receptionist on weekdays when activity is greater.
- We saw that staff had a list of conditions including shortness of breath or head injury that they were expected to draw to the attention of nursing staff quickly if a patient presented at reception with them.
- We noted that although during our visits there were few patients for minor injury services, the staff acting as receptionists were constantly diverted away from the patient arriving and booking in to deal with outpatients' clinics running in the same area and receiving blood samples. Where the reception was also the front door of the community hospital such as at Bridgnorth, they also dealt with therapists and visiting professional queries. This meant that patients may not be observed whilst waiting for treatment and if a patient's condition deteriorated whilst they were waiting it may be missed.
- Nursing staff in each MIU told us they were satisfied that they had a clear visual field of waiting patients through the small glazed hatches from their nurse's office. However we noted these offices were not always occupied as nurses were treating patients in cubicles or supporting outpatients, phlebotomy clinics or at Whitchurch MIU, minor operations. At Whitchurch MIU, where there were no reception arrangements we noted the glass partition was opaque and closed over on occasions.
- We noted there was CCTV surveillance of any out of hours waiting areas that were away from the treatment areas when the main doors were locked for security.
- All nursing staff we spoke with were aware of the risk of a deteriorating patient particularly children and babies.
- All MIU's treated minor injuries in children and babies but none were commissioned to treat minor illness. Nursing staff told us they were always made aware by 'reception' staff when a child or baby had been booked in. The approach to minor illness in presenting children varied between the MIU's.
- The receptionist check list for presenting conditions to immediately refer to nursing staff we saw at Bridgnorth MIU did not include babies or children under two years. This could increase the risk of rapid deterioration in an infant's condition.We raised this with the nurse in charge who agreed that it should be included.
- In one MIU we observed practice where the assessing nurse handed over to the emergency nurse practitioner (ENP) and the ENP then referred the child to the local on-site GP and conducted the handover of the patient.
- In another MIU a nurse gave us an example of assessing a toddler's condition as a minor illness and sending the patient and parent home with verbal advice to obtain an over the counter remedy. This nurse told us they felt confident that was a safe discharge because they were themselves, a parent.
- We noted public information leaflets about children that pointed out 'their healthcare can be best provided by a facility with well-trained hospital staff whose only interests and concerns are met with the total health and well-being of children and adolescents'.
- We asked the trust for data on recent emergency transfers to acute ED's but we noted this data did not include data such asresponse times so the trust could establish a full picture of its service.

Staffing levels and caseload

- The trust told us they had experienced staffing difficulties in the minor injury units at the time of our inspection. Staff we spoke with at each of the MIU's told us the unit was short staffed and they felt levels were unsafe.
- The trust said there were high levels of sickness leave and many staff were reluctant to travel the distances between units to cover vacant shifts and agency staff were used to cover some shifts.
- We noted the numbers of WTE vacancies for qualified nurses supplied by the trust were very low with 0.30 for Bridgnorth MIU; 0.47 for Ludlow MIU; 0.04 for Whitchurch MIU and 1.00 above establishment rate at Oswestry MIU.

Requires improvement

Are services safe?

- The trust used paper rostering forms for three MIU's and an electronic format for Oswestry MIU. The trust identified the staffing levels for each shift and told us they used the West Midlands Quality Standards (WMQRS) to ensure appropriate staffing levels. The quality standards state that at least one registered health practitioner should be available and have competencies in a range of skills including intermediate life support (ILS) and paediatric life support (PILS).
- We reviewed staffing rosters for the four months December 2015 to March 2016. The rosters showed us that shifts were frequently unfilled or the WMQRS standards were not being met. For example, we noted for February 2016, the staffing roster for Oswestry MIU showed nine triage nurse shifts were not filled and 14 Band 6 (leadership) shifts had been filled by agency staff.
- While Bridgnorth MIU recorded no use of agency or bank staff during that period, rosters and supporting records demonstrated the trusts staffing levels were not met on 50 shifts as worked in January and February 2016.
- Thirteen separate days for January 2016 showed staffing without the full quota of competencies for all or part of the shift. Six of these days fell at a weekend (3 per weekend day) and four fell on a Monday. This pattern continued through February and March 2016.
- For Ludlow MIU, rosters showed one day in February 2016 where there were three hours with no cover for ILS and PILS. For two days in March 2016 there was one full shift (8am -8pm) with no cover for ILS or PILS and 1.5 shifts with no cover for the same (2pm-8pm).
- Staff at Bridgnorth, Whitchurch and Ludlow also supported outpatients and minor operations or phlebotomy services on site. This took them from their role in the MIU's to a greater or lesser extent. For example when we visited Bridgnorth unannounced on Thursday 24 March 2016 we found the unit staffed by one nurse, who was covering minor injuries, phlebotomy appointments and the DAART service because of staff sickness absences.
- When there were staffing shortages patients did not always get the full attention of clinical staff. For example we observed one nurse working on duty single handed for a number of hours before an agency nurse arrived to fill one of two sickness vacancies. The telephone was constantly ringing in the treatment room where the nurse was seeing patients and then the agency nurse interrupted consultations with enquiries because they were not familiar with the service.
- Patients could not be guaranteed the same standard of care and access depending on which day they attended including within the same unit.
- Staff shortages and lone working had been identified as red risks on the risk register for Ludlow MIU in September 2015. There was no date to indicate that these risks had been formally reviewed since that time.

Managing anticipated risks

- We were concerned about the vulnerability of lone working staff at the Bridgnorth MIU out of hours. Measures were in place but appeared less than adequate. We raised this with the trust during our visit and it agreed to review these arrangements.
- The Bridgnorth MIU risk register had a number of clinical risks relating to serious presenting conditions addressed on its risk register.
- The Ludlow MIU had no clinical risks relating to serious presenting conditions addressed on its risk register.
- The Oswestry risk register had no clinical risks relating to serious presenting conditions addressed on its risk register except ligature points.

Major incident awareness and training

- We asked staff at one MIU about major incidents awareness and they showed us the trust 'incident response plan dated November 2015 on the intranet. We noted however that it did not include any specific role for any of the MIU's. We raised this with local leaders and they had no information about the specific role their MIU would be expected to perform or contribute to in the event of a major incident. The trust confirmed there is no defined role for MIUs in the event of a major incident, but decisions would be made on what their contribution might be as part of the wider process.

Requires improvement

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary

We have rated this service as 'requires improvement' for effective. This is because:

- The service had not participated in national clinical audits or undertaken any local audit of its services for two years, staff had little understanding of the benefit of audit including of the outcomes for children;
- There were not always staff on duty with the appropriate competencies that had been identified by the trust as necessary;
- Nurses had no specific training in awareness or pathways for patients with dementia, learning disability or mental ill health;
- There were no formal arrangements for clinical supervision of emergency nurse practitioners or medical supervision from paediatric doctors although each MIU saw children and babies;
- There was no sepsis pathway and staff were not trained in dealing with sepsis;
- Consent to treatment was not recorded for patients.

However we also found:

- Extensive evidence based clinical guidelines and pathways were in place in each MIU;
- The trust set out staffing competencies for each MIU based on regionally agreed standards;
- Nurses had developed good working relationships with GP's, local acute hospital emergency departments and paramedics.

Evidence based care and treatment

- We specifically focussed on the care and treatment of eight patients including children through their experience across three of the four MIU's. We observed assessments to be appropriate, thorough and in line with evidence based guidelines.
- Where staff required advice with treatment plans we heard them seek it from colleagues.
- We noted the "Red Dot" system for interpretation of X ray images was in place in some MIU's but not others. The aim of the red dot system is to reduce the number of missed fracture diagnoses by emergency medicine staff when specialist radiologists are not immediately reporting on the image. It is good practice to have a system in place consistently across the trust to allow for audit of its effectiveness. The trust told us that all radiographs are reported on by a specialist radiographer.
- There was no sepsis pathway at any MIU. Staff who provide emergency care have a key role in identifying patients with sepsis. They should be familiar with the significant morbidity and mortality associated with sepsis and possess the knowledge and skills to recognise it early and initiate resuscitation and treatment.
- The Royal College of Emergency Medicine and the UK Sepsis Trust have developed a clinical toolkit for emergency medicine. Sepsis Without quick treatment, sepsis can lead to multiple organ failure and death. Appropriate and skilled response within the first hour (the golden hour) can be crucial to saving the life of an infant or child

Patient outcomes

- The trust told us it had taken part in no minor injury service audits activity during 2015.
- In keeping with the Urgent and Emergency Care draft Quality Standards of the West Midland Quality Review Service (WMQRS) the trust had undertaken a record keeping audit in 2012.
- No local audit of its minor injury services had been undertaken for two years and we noted from the trust audit plan that minor injury services were not included for 2016. One local leader told us the Minor Injuries Unit Forum was the basis for agreeing and planning audit activity and four audits had been 'pencilled in' for 2016. These were NICE management of fracture, head injury,

emergency care transfer to the acute ED and bench marking against other MIU's. No dates had been agreed for these at the time of the inspection. There seemed to be no focus on children's outcomes.

- Staff we spoke with in all MIU's and a divisional clinical manager confirmed no governance system was applied to monitoring outcomes for patients transferred to local acute emergency departments (ED) for example.
- We asked the trust for data relating to recent transfers to acute ED from each MIU and noted that the information collected was minimal. This meant there was no structured opportunity to assess clinical practice and check the quality of 'safety net' arrangements in place for, for example a deteriorating child as recommended by the RCPCH standards 2012.
- The trust had a protocol for the referral for x-ray examination of patients, including children attending the MIU's by registered nursing staff and we noted this had been last amended in 2014. The trust had not audited this process to evaluate the outcomes.

Competent staff

- We noted the trust set out safe staffing competencies for each MIU and these reflected the Urgent and Emergency Care Quality draft Standards of the WMQRS
- The trust told us MIU staff were encouraged to undertake the university specialist emergency medicine modules and this was confirmed by staff we spoke with. On the day of our unannounced visit to Bridgnorth MIU we were told both Band 6 sisters were absent because it was their graduation day at Wolverhampton University.
- We noted the skills and experience level varied among nurse leaders of the units. Many were highly skilled and qualified and some carried ENP status, all were very experienced. The Head of Nursing and Quality told us the trust had prioritised MIU training with a view to uplift all nursing staff to ENP competence.
- At the time of our inspection three senior nurses in Oswestry MIU were nurse prescriber trained, two at Ludlow, one at Whitchurch was in training and none at Bridgnorth.
- Nurses in Oswestry MIU were all IRMA trained and so could order and interpret x ray images.
- One bank nurse who told us they worked across two MIU's said they had no minor injuries training. This meant they were carrying out work they were not qualified for or experienced in.
- Some nurses held emergency medicine of the child qualifications. Two nurses, one at Whitchurch and one at Oswestry held paediatric nursing qualifications.
- Local leaders told us there were no formal arrangements in place for their clinical supervision and no protected time for team meetings meant they had to be conducted before or after a shift when the service was not open.
- Nurses in all MIU's told us they had no specific training in awareness or pathways for patients with dementia, learning disability or mental ill health.
- Nurses in all MIU's told us they had no training in sepsis.
- The overall staff appraisal rate for the trust was 67%, based on 1,202 non-medical staff. Trust data sent to us before our visit showed the appraisal rate for minor injury services was 78% as the end of September 2015. We were not aware of a trust-wide target for appraisals. Nurses we spoke with confirmed they had their annual appraisal for 2015/16.

Multi-disciplinary working and coordinated care pathways

- At three of the four MIUs, the duty GP for the day could be contacted for advice on patients attending each MIU that could not be managed by the nursing staff. Oswestry had arrangements via an service level agreement to link directly with a local emergency department for advice.
- Also nursing staff could contact the on call doctor for telephone advice, further assessment, and interpretation of x-rays during normal contracted hours.
- We saw this process in practice in Oswestry MIU when we focussed on the care and treatment of a child.
- We noted at Ludlow MIU the out of hours GP service was on site.
- Out of normal contracted hours when the MIU was open there was an arrangement for the out of hours GP service to respond to MIU staff requests for support and advice.

Requires improvement

Are services effective?

- Local leaders told us they had good working relationships with acute ED staff that they could contact either through a service level agreement or informally and with the NHS ambulance trust.
- GP's supporting the MIU staff could speak with appropriate on call consultants within the local acute trust, for example paediatricians.
- There were no formal arrangements for medical supervision from paediatric doctors although each MIU saw children and babies.

Referral, transfer, discharge and transition

- We asked the trust for data about the six transfers to acute ED's for each MIU immediately before our visits.
- Divisional leaders told us the trust collected no data on transfers to local acute trust ED's and could not therefore audit the appropriateness and effectiveness of decisions to transfer.
- We observed an example of good practice at the Oswestry MIU when the nurse assessed the condition of a child and made an effective handover referral to the on-site GP.
- There had been six transfers to acute emergency departments in the period prior to our inspection. We reviewed the records of these patients and found there were arrangements in place to safely follow through referral and transfer to local acute ED services where appropriate and GP's and health visitors.

Access to information

- We noted extensive evidence based clinical guidelines easily accessible to staff in folders and on wall charts within each MIU.
- The Head of Nursing Quality told us very little information could be currently downloaded quickly from the system and the trust was investing in a new one. This would link into other services like the school nurse and health visitor records.

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

- We heard staff ask for parental consent to physical examinations of children.
- To assess whether a child was mature enough to make their own decisions and give consent staff used 'Gillick competencies'.
- However local leaders confirmed, although it was the trust policy and good practice to seek patients consent verbally, it was not established practice to record consent for any patient.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary

We have rated caring as good because:

- Staff were consistently kind, friendly and supportive to patients and their families;
- Staff spoke with patients about what they were doing, what assessment they had made and discussed treatment plans with them;
- Parents of young children and babies were reassured and supported to understand the treatment options and follow up requirements;
- Patients', including children, privacy and dignity were maintained.

Compassionate care

- Every patient and relative/friend we spoke with commented on how caring staff were.
- We observed the care and treatment of eight patients across all four MIU's and found staff were consistently kind, friendly and supportive.
- We observed that patients, including children's, privacy and dignity was maintained and patients commented on this when we spoke with them.
- Two of these patients were children, and we noted that one nurse referred to the young patient in the third person and used terms the child was unlikely to recognise, the other child was spoken to in an age appropriate way.

Understanding and involvement of patients and those close to them

- We observed that staff spoke with patients about what they were doing, what assessment they had made and discussed treatment plans with them.
- Parents of young children and babies were reassured and supported to understand the treatment options and follow up requirements.

Emotional support

- A worried parent of a young teenager with a suspected fracture commented to us on the relaxed atmosphere of the MIU compared with a busy ED in a large hospital.
- Patients attending the MIU's could access all support services available within the hospital.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We have rated responsiveness as good and this is because:

- The minor injury services had generally good relationships with local primary health care providers;
- The MIU's all consistently met national targets for response times;
- Patients were well informed about how to raise concerns and complaints and the trust responded to and learned from complaints.

However we also found:

- The trust's scheme to support patients with dementia through their treatment pathways was not understood by MIU staff;
- X-ray imaging services were not coordinated with MIU operating times which meant patients had to be referred elsewhere.

Planning and delivering services which meet people's needs

- According to trust figures between January 2015 and February 2016 the MIU at Oswestry Community Health Centre saw the most number of patients at 11,042 including 2,871 under 16 year olds. The Whitchurch MIU at Whitchurch Community Hospital saw the least in that period at 2,921 patients, including 750 under 16 year olds. However this was the highest percentage of under 16 year olds seen by any of the MIU's. Patients under 16 years represented by far the largest age group to attend each of the MIU's during that period. The MIU's saw 810 under two year old patients between April 2015 and the beginning of March 2016.Bridgnorth MIU at Bridgnorth Community Hospital saw almost as many patients in the age range 61 to 75 years as it did under 16's. Ludlow MIU at Ludlow Community Hospital saw the highest percentage of over 75 year old patients at around 10% of its total. The other three MIU's had seen approximately eight to nine percent of their total patients aged over 75 years.
- The premises and facilities of the MIU's were adapted to support the needs of children patients and 24 hour telephone access to paediatricians in local acute trusts was in place to support MIU staff.
- However we saw no strategic recognition of the high number of child patients that used the MIU's. For example there had been no recent audit activity of how responsive the services were to children and none was in the 2016 plan.
- The trust told us urgent care services was a 'big issue' with local partners as it was a very pressured system and the trust spent a lot of time supporting it. It had set up the diagnostics, assessment and access to rehabilitation and treatment (DAART) to support the needs of elderly patients and divert them from unnecessary visits to the local acute ED's. However we did not see heavy uptake of this service during our visits.
- We found during our visits the MIU's were under used by the public. Perhaps with the exception of Oswestry where local leaders told us they saw on average 50 patients each day (opening hours 8.30 to 6pm Monday to Friday and 8.30am to 1pm at weekends). For example Bridgnorth opening hours were 8am to 9.30pm seven days a week but when we visited on a Wednesday evening there were no MIU patients. When we visited on a Thursday morning there had been 15 MIU patients before 10.30 and no further patients between 10.30 and 13.15.
- We observed that all MIU's were assessing minor illness in babies, children and adults as well as injury. Local leaders confirmed the service was not commissioned to treat minor illness and no staff were nurse prescribers.
- Trust leaders told us the trust was in the process of 'developing what offer it could make' to local commissioners of services to meet community needs beyond just providing rural urgent care centres.
- We observed and staff confirmed they had generally good relationships with local primary health care providers.

Good

Are services responsive to people's needs?

Equality and diversity

- Each MIU was situated on the ground floor of premises with good access including automatic doors and car parking close to the entrance.
- Staff at Whitchurch MIU told us a significant national minority in the local population was Polish. However, although there were a comprehensive range of information leaflets about common conditions and injuries available, there was no notice in Polish to identify this information and inform patients how it could be obtained in Polish or other languages.

Meeting the needs of people in vulnerable circumstances

- Each MIU had one child friendly treatment cubicle and two had a play space for children in the waiting area.
- We asked staff in all MIU's about dementia friendly pathways. They told us there was a 'butterfly' scheme in place. None could describe to us exactly what this meant however. They struggled to demonstrate a clear understanding of providing proactive support to improve the experience of minor injury services for patients with complex needs.

Access to the right care at the right time

- Staff we spoke with confirmed the trust website information and a leaflet we saw at Ludlow MIU that each MIU 'is open to anyone of any age'.
- Each MIU operated different opening hours. Bridgnorth opened between 8am to 9.30pm seven days each week; Ludlow opened between 8am and 8pm seven days a week; Whitchurch opened between 9am and 5pm on Monday to Friday and Oswestry opened between 8.30 am to 6pm on Monday to Friday and 8.30 to 1pm at weekends. These were clearly and prominently shown on the trust's website.
- Each MIU had met the national response targets for urgent and emergency care during 2015/16. These included treatment times (arrival to seen time); assessment times (arrival to triage time) for arrivals by ambulance; percentage of people who leave MIU without being seen; total time in department (arrival to discharge) and unplanned re-attendances (within 7 days of discharge).
- With the exception of one patient, all the patients we spoke with and specifically focussed on during our visits in March 2016 were seen within a few minutes of arrival. However the services were not very busy at those times.
- Notices were prominently displayed in each MIU external area about the opening hours and included advice and details for patients to access other services such as the nearest acute hospital ED out of these hours.
- X-ray imaging services were not coordinated with MIU operating times. For example at Whitchurch MIU the x ray service was available only between 9am and 1pm weekdays and not available at all on the day we visited. When we asked why this was staff told us 'because it's Thursday'. This seemed to a local long-standing commissioning arrangement that everyone just continued to accept. The Easter two bank holiday weekend was serviced by X ray imaging being made available on only one of the bank holidays. This meant patients had to be referred elsewhere out of those times or return the following day.

Learning from complaints and concerns

- We saw notices and leaflets about how to raise concerns and how to access the PALs service in each MIU.
- Data provided by the trust showed between October 2014 and October 2015 minor injury services had received one complaint. This was about detection of a hair line fracture through x ray imaging.
- Minor injury services received a total of eight compliments for that period.
- Staff we spoke with across all four MIU's were able to give us examples of how the local team had made changes or improvements in response to comments made by patients.
- We saw 'you said, we did' displays on the notice boards at two MIU's. For example the waiting area seating was reconfigured at Whitchurch MIU as part of a trust 'improvement day' project.

Requires improvement

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We have rated this service as 'requires improvement' for well-led. This is because:

- There was not a clear, shared vision for the minor injury services at the trust.
- Systems in place to identify and monitor risk were not robust and significant clinical risks were overlooked.
- Some leaders beyond the MIU did not have the necessary experience to lead effectively.
- Governance systems did not support robust review and assessment of key clinical processes and service performance. This meant that leaders working in MIU were not always sighted on governance issues.
- There was limited evidence of public engagement.
- Staff did not feel fully engaged with the trust.

However, we also saw that:

- There was strong local nurse leadership within each MIU.
- There was an open, positive culture and staff were committed to providing good quality care.

Service vision and strategy

- Currently there is not a clear, shared vision for the urgent care services at the trust. The trust is working on this with other key stakeholders within the health and social care economy on a strategy called Future Fit and also Community Fit which the trust is developing.
- The trust told us a strategic initiative for 2016/17 was a 'solution for sustainable local enhanced community services focussing on [including] urgent care.' For example the Head of Nursing and Quality told us that the trust's strategy for the MIU's was to review the ENP status and bring them all up to a common competency level that included prescribing. In this way the trust was 'wanting to make nurses more confident in a move away from reliance on GP support and towards acute ED support'.
- However staff we spoke with across all four MIU's told us they did not know of any local plan for the service they worked in.

Governance, risk management and quality measurement

- The community health service division maintained risk registers. We noted although minor injury services were treating children, including under two years old, the specific risks associated with children and babies attending for care in a setting with no quick physical access to paediatric clinicians was not identified on a risk register. It is nationally recognised that parents are inclined to take very sick children to the closest NHS facility even if this is not an ED.
- There was one risk entered on the divisional risk register for minor injury services and this was rated as 'high amber' at November 2015 and continued to be rated at the same level in February 2016, 'reception at Oswestry MIU hours have changed. In the absence of a receptionist - qualified nursing staff have to be taken away from direct patient care to undertake an administration role at the reception desk. Patient assessment, flow and care are compromised in the absence of receptionist'. We observed this was an issue at each MIU we visited, not just at Oswestry. We noted each MIU had a risk register and we saw copies of each. However these registers did not appear to be actively managed working tools. For example, Whitchurch MIU risk register last entry was dated March 2015, other entries were risks 'opened' in November 2012 and none had any indication of review. The Bridgnorth MIU risk register had a number of clinical risks relating to serious presenting conditions addressed on its risk register but there was not one date anywhere on the document. The Oswestry MIU risk register had no clinical risks relating to serious presenting conditions addressed on its risk register except ligature points. This risk was opened in November 2012 and there was no date to indicate any review.

Requires improvement

Are services well-led?

- The Ludlow MIU had no clinical risks relating to serious presenting conditions addressed on its risk register. 50% of the risks had been opened in September 2012 including the three identified 'red' risks and the others in February 2016. None had any date indicating a review.
- We asked local leaders how risks were monitored and escalated to the Board and they told us they did not know. However staff told us about a trust wide MIU forum. This was chaired by the head of nursing quality, met bi-monthly and was open to all MIU staff. We saw some minutes of meetings and these were displayed on staff notice boards.
- Local leaders told us they attended the forum when they could 'get away' and while they valued it they were clear that it had no operational influence.
- The system for identifying, capturing and managing issues and risks at a team and directorate level was not effectively embedded for the minor injury service.
- We raised this with a clinical services manager. They told us they responded when an incident or national waiting time outlier flagged on the electronic system by producing a report. This was a reactive not proactive approach to risk in four dispersed services that were operating different styles of minor injury service provision.
- The role of clinical manager did not seem to clearly set out their responsibility for quality assessment and improvement. Each of two posts had been recently appointed to by staff inexperienced in the role.
- This meant staff were unable to describe the process of governance influence exercised by this forum and we remained unsure of its status and impact on assuring the Board.
- We noted there were some service level agreements in place for quality control, such as for interpretation of X ray imaging and acute ED consultant opinion.

Leadership of this service

- The MIU were geographically disparate within the county. Three were situated within community hospitals and the head of nursing quality acknowledged they had various models of working.
- Local leadership in the MIU's were Band 6 nurses or Band 5 nurses acting up. We noted their leadership was strong at unit level. They told us they experienced a lack of senior clinical leadership and support. We observed a lack of audit activity of the services. We raised this with a divisional leader. They confirmed that a post for clinical lead of the MIU's trust wide had been vacant for 6 months and the trust was having difficulty filling it.

Culture within this service

- From conversations we had with staff across all four MIU's we found the culture was an open one. Staff told us they could raise concerns with local leaders.
- On the whole staff were interested in learning and developing services and all staff were very committed to providing a good quality service for their patients.
- The MIU forum was recognised as a means for bringing staff across the county together and discussing good practice with a view to achieving consistency.
- However we noted that MIU's were geographically isolated and staff did not really see beyond their place of work and their team. There was minimal movement of staff between MIU's or placements at local acute ED's to gain insight and experience a share skills and knowledge.
- Staff told us they felt frustrated and over worked. While the uptake of the service was unpredictable from one day to the next and some units were open and therefore needed to be staffed 12 hours a day seven days a week, we noted little demand for most of the MIU's during our visits.
- The trust's NHS staff survey results data were not specific to minor injury services.

Public engagement

- During the inspection we saw limited evidence of the services offered by the MIU's being promoted locally. However, the trust told us that they had carried out campaigns to promote the MIUs in the past, using traditional and social media.
- Staff expressed pride that patients that did use the services told them they valued having them locally. One parent accompanying a child patient remarked to us how pleased they were to be informed by a neighbour that a local service existed when they were leaving home to go to the local acute trust ED.

Requires improvement

Are services well-led?

Staff engagement

- The trust told us a culture working group had been established to support change and transformation and this was 'starting to pay off' and staff felt engaged.
- We found across the MIU's staff did not feel engaged. Many for example were working above their salaried grade, Band 5 nurses told us they were acting up to a Band 6 position without the enhanced remuneration.
- Trust data showed between October 2014 and September 2015, minor injury services experienced the second highest staff turnover within the trust at 17.27%. The staff sickness rate for that period was 3.6% and this was the second lowest within the trust.
- Although staff commented positively about university training opportunities being encouraged by the trust, staff absence and vacancies were high within the minor injury services and nursing staff told us they felt their skills were under used.

Innovation, improvement and sustainability

- There were no improvement action plans in place for minor injury services at the time of our inspection.
- The trust told us it was discussing within the wider healthcare economy possible plans for the development of urgent care centres.

Requires improvement

Shropshire Community Health NHS Trust

Substance misuse services

Quality Report

Shropshire Community Health NHS Trust
William Farr House
Mytton Oak Road
Shrewsbury
Shropshire
SY3 8XL
Tel: 01743 277500
Website: www.shropscommunityhealth.nhs.uk

Date of inspection visit: March 2016
Date of publication: This is auto-populated when the report is published

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
R1DHQ	Shropshire Community Health NHS Trust - HQ	Specialist community substance misuse service, 1st Floor Crown House, Saint Mary's Street, Shrewsbury	SY1 1DS

This report describes our judgement of the quality of care provided within this core service by Shropshire Community Health NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Shropshire Community Health NHS Trust and these are brought together to inform our overall judgement of Shropshire Community Health NHS Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Requires improvement**

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

Contents

Summary of findings

Overall summary

We rated this service as requires improvement. This is because:

- The recording of information about safety within Care planning and Risk Assessment documents was often partial or incomplete. In the paper and clinical notes we reviewed, we found staff had not documented the identified risk and management plans sufficiently well.
- There were no serious incidents recorded in the previous twelve months. Incidents could be reported on Datix.
- Trust substance misuse team staff did not use trust systems or processes to learn from safeguarding incidents, instead relying on the local authority to manage and feedback on all safeguarding incidents.
- The Community Substance Misuse Team (CSMT) had not responded to public health guidance on opiate overdose, shown by the fact it had no programme for delivering Naloxone hydrochloride. Opiates are medicines with effects similar to opium. This includes illicit heroin which is a drug associated with a high risk of overdose. Naloxone is a medication used to block the effects of opiates, especially in overdose. Public health guidance states it is good clinical practice to give this drug to substance misusers and their carers.
- Multidisciplinary teamwork was inadequate and there was no evidence of case discussion in clinical notes.
- There had been no clinical supervision of prescribing medics since June 2015.
- However, we also found the following areas of good practice:
- Patients reported positive experiences of approachable and caring staff at the CSMT.
- There were short waiting times for community detoxification although these had recently increased.
- Community detoxification was carried out in accordance with NICE clinical guidelines.
- Referral to partnership agencies was high as recorded in the clinical notes.
- We saw that the service consulted local community pharmacists about patients it referred to them.
- Electronic prescribing systems and administration were well organised and systems were in place for the timely and accurate production of prescriptions for controlled drugs.
- Mandatory training records for safeguarding were observed by the inspection team to be up-to-date and meeting trust targets.
- We saw that supervision and appraisal records were up-to-date.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires improvement

We rated this service as requires improvement for safe. This was because:

- NHS staff were not following infection control policy in two cases. They did not have up to date cleaning logs for medical equipment and they did not have a clinical waste bag or bin in the toilet used to take urine samples.
- Care records demonstrated comprehensive patient assessments before treatment started but we also saw that risk assessments and risk management plans were not complete or accurate.
- All safeguarding alerts, including those made by NHS staff, were through Shropshire Council systems. Shropshire Community NHS Trust did not therefore formally record CSMT safeguarding alerts through NHS systems. There was also no evidence of joint learning between partnership agencies.

However, we also saw that:

- Caseloads matched staffing levels.
- Staff were up-to-date with safeguarding training.

Are services effective?

Requires improvement

We rated this service as requires improvement for effective. This was because:

- Clinical supervision of prescribing staff was not carried out in accordance with national guidelines.
- Care records and care assessments reviewed at the CSMT base were incomplete with very few multidisciplinary team-meeting outcomes recorded in clinical notes.
- The service could not demonstrate that prescribing services completely complied with the Drug misuse and Dependence, UK guidelines on Clinical Management.
- Care assessments were incomplete and the multidisciplinary team did not meet formally to discuss patient's clinical care.

However, we also saw that:

- Community detoxification was provided to a good standard, meeting NICE guidance CG100 for the diagnosis and management of physical complications in alcohol withdrawal.
- Liaison with community pharmacists was well organised and the administration of the electronic prescribing system was administrated efficiently by both prescribing officers.

Summary of findings

- Nursing staff had a comprehensive understanding of assessing the capacity of patients to understand their treatment and care plans.

Are services caring?

Good

We rated this service as good for caring. This was because:

- Patients and carers were positive about staff and described them as approachable, caring and always willing to help and support them.
- Staff and managers listened to patients' suggestions.

Are services responsive to people's needs?

Good

We rated this service as good for responsive. This was because:

- The service was flexible in accepting self and 'drop in' referrals and patients could usually be assessed within two weeks.
- Patients could drop in to access information and needle exchange services.
- Patients knew how to complain.

However, we also saw that:

- There was no evidence of a prevention of overdose programme.

Are services well-led?

Requires improvement

We rated this service as requires improvement for well-led. This was because:

- There were no detailed plans available regarding the imminent transfer of clinical services to the newly commissioned provider.
- There had been no clinical director overseeing trust substance misuse services since June 2015, leaving the prescribing service without senior medical oversight since that date.
- Staff were not supported in developing the recovery agenda and public health directives due to no clinical director being in place since June 2015.
- The trust's policy on placing sole responsibility for safeguarding with Shropshire Council meant that safeguarding alerts and incidents were not tracked through trust processes. There was also no evidence of a formal process by which trust staff were part of safeguarding reviews or learning opportunities.

However, we also saw that:

- Staff spoke positively about their job roles and one member of staff was given the opportunity to pilot an innovative project on steroid abuse.

Summary of findings

- Staff had confidence in the Clinical Nurse Manager and felt supported by them.

Summary of findings

Information about the service

Shropshire Community Substance Misuse Team (CSMT) was a county-wide service jointly provided by Shropshire Community Health NHS Trust and Shropshire Council in association with Aquarius and the National Association for the Care and Resettlement of Offenders (NACRO). This structured drug and alcohol treatment was provided in a community setting for residents of the area. It included treatment at the main centre at Crown House in Shrewsbury and locality satellite services at Castle View, Oswestry, the Parish Rooms, Bridgnorth and the Hawthorns in Ludlow.

The core services provided were the prescribing to and clinical management of those dependent on illicit drugs and the community detoxification (assisted withdrawal) of those dependent on opiates and alcohol.

At the time of inspection, the team had a caseload of 730 active patients.

The service provided community detoxification for alcohol and illicit drug users. The total number of patients completing alcohol detoxification for the year April 2015 to March 2016 was 73.

Following a retendering process towards the end of last year, substance misuse services will be transferred to an independent provider except for the two alcohol liaison nurses that were based at Princess Royal Hospital in Telford. These staff will remain employed by Shropshire Community Health NHS Trust.

Our inspection team

Our inspection team was led by:

Chair: Dr Timothy Ho, Medical Director, Frimley Health NHS Foundation Trust

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

The team included two CQC inspectors and two CAMHS practitioners, a CQC observer and an Expert by Experience. Experts by Experience are people who have had experience as patients or users of some of the types of services provided by the trust.

Why we carried out this inspection

We inspected this core service as part of our comprehensive community health services inspection programme.

How we carried out this inspection

We inspected this service in March 2016 as part of the comprehensive inspection programme.

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information we held about these services, asked a range of other organisations for information and sought feedback focus groups.

Summary of findings

During the visit, the inspection team focused its enquiries on those services provide by NHS staff; specifically, community prescribing and community detoxification. We visited the community substance misuse team premises, looked at the quality of the environment, and observed how staff were caring for patients. We spoke with six patients who were using the service, senior managers and four other staff members, including the prescribing doctor, two nurses and a prescribing officer. We also received feedback about the service through a patient satisfaction survey. We reviewed 18 care and treatment records of patients and looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- Patients had high levels of satisfaction with the services they received.
- All those interviewed said that staff were helpful, treated them with respect and said they 'went the extra mile' to help them.
- Patients stated that they had not been formally asked to provide feedback on the services they received.
- They said they were signposted to other support groups and services.
- All said they felt the service was a 'lifeline' and had some anxiety about the imminent transfer of services to the new provider and its implications for continuity of care.
- A patient satisfaction survey carried out in November and December 2015 reported a high satisfaction rate with the alcohol liaison nurses at the Princess Royal Hospital.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure a clear and robust plan for the transfer of patients to the new provider is in place.
- The trust should ensure that infection control policies are followed at all times and that this is monitored to ensure the risk of infection for staff and patients is minimised.
- The trust should ensure that risk assessments are complete and comprehensive to ensure patient risks can be anticipated and minimised.
- The trust should ensure review the arrangements for reporting safeguarding concerns to ensure that patients are protected from the risk of abuse and that staff are able to learn from any incidents to minimise the likelihood of them reoccurring.
- The trust should ensure review the arrangements for the clinical supervision of all prescribing GPs to ensure compliance with national guidance.
- The trust should ensure patient records are complete and comprehensive to ensure patients care is delivered in a timely and responsive way.
- The trust should review arrangements for the overdose programme to ensure it reflects current best practice guidance.

Shropshire Community Health NHS Trust

Substance misuse services

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Specialist community substance misuse service, 1st Floor Crown House, Saint Mary's Street, Shrewsbury	Shropshire Community Health NHS Trust - HQ

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- The main service premises of the Shropshire Community Substance Misuse Team (CSMT) were clean, tidy and well organised.
- Despite 100% of trust staff having received Infection control training, we saw that the policy was not followed in the only male patient toilet where urine samples were taken, as there was no clinical waste bag or bin.
- There was no infection control-cleaning log for the cleaning of medical equipment meaning that it was unknown if equipment was regularly decontaminated.
- There was an emergency alarm system in working order although on the day of inspection it had not been reset from a previous alarm call and therefore could not have alerted staff to an emergency the day the inspection team visited.

Safe staffing

- Data provided by the trust for September 2015 showed there were 7.8 whole time equivalent (wte) qualified nurses and 1.94 wte vacancies. This level of staffing was considered appropriate, as caseloads held were temporary with patients handed over to local authority colleagues after initial assessment.
- Substantive staff for the health part of the CSMT included a lead practitioner (vacancy), a nursing sister, who covered the central Shropshire area, one detox nurse each for north and south Shropshire, a needle exchange worker (vacancy), three alcohol liaison nurses, two prescribing officers and a prescribing GP with a specialist interest (GPwSI) in substance misuse.
- Detoxification services were safely staffed and carried out by two detoxification nurses and a nursing sister, who held caseloads of approximately 15 and eight patients each respectively. Risk was managed within the home by regular visiting and where possible through good communication with carers to report risk.

Assessing and managing risk to patients and staff

- The Drug Misuse and Dependence, UK Guidelines requires that clinical supervision and multidisciplinary (MDT) meetings take place to ensure the appropriate clinical management of patients in line with the clinical guidelines. The service could not demonstrate these guidelines were being complied with as we saw no evidence of supervision or MDT meetings, this was confirmed by staff we spoke to.
- We reviewed 14 sets of clinical notes both paper and electronic. We saw that records demonstrated comprehensive assessments of patient's drug or alcohol dependency levels, healthcare and other needs had been made before treatment started and that the prescribing doctor had conducted a face-to-face assessment of the patient. However, we also saw that risk assessments and risk management plans were not complete or accurate. Patient care plans did not always address the potential risks to people of relapse into unsafe drug use in the event of early exit from the programme.
- Assessment of need was evidenced to be of high quality as demonstrated at interview with staff and in the four clinical notes of the detox service. Validated tools were used to assess levels of alcohol use and physical health and all had comprehensive care plans, risk assessments all personalised to the patient.
- Physical examinations at the prescribing clinic were not carried out in a systematic way meaning that not all patients physical well-being was considered at assessment.
- All (100%) of NHS staff in the service had completed safeguarding training for vulnerable adults and 88% of staff had completed safeguarding training for children.
- There were no specific handover documents confirming that all prescribing met the standards set out in the NICE UK guidelines on clinical management. This meant that the new provider would have to make an immediate reassessment of all patients to ensure all prescribing was safe at the point of transfer.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Track record on safety

- There were no serious incidents reported by the service between 1 December 2014 and 1 December 2015.

Reporting incidents and learning from when things go wrong

- Incident reporting and learning between partner agencies was not coordinated as there were separate systems for logging and managing them. Shared learning between partnership agencies relied on discussion at team meetings. However team meetings did not have a standing agenda for discussing and learning from incidents.
- Safeguarding was formally managed by Shropshire Council meaning that all safeguarding incidents were reported through local authority systems. It was unclear how NHS staff learnt lessons formally within the Shropshire Council system or within the joint staff team. There was no formal process for NHS staff to deal with safeguarding issues and the NHS did not prioritise CSMT safeguarding within its own systems. The use of Shropshire Council alert systems also meant that there had been no safeguarding notifications to CQC as they were not the registered provider of services.
- Safety concerns from the NHS team to Shropshire Council staff were escalated from NHS staff to partnership staff through the shared electronic patient record (EPR) system and at team meetings although staff could not provide assurance that there was documentation or escalation of all cases of risk. However good interpersonal relationships between partnership staff meant risk was discussed regularly although this did not guarantee that risk was identified or addressed quickly enough.
- There had been no reported serious incidents in the detox service. If incidents had been reported this would have been through the DATIX incident reporting system. DATIX is the system the trust uses to report incident/ concerns, medical and drug alerts and stores and administers policies.
- The trust was not providing methadone storage boxes for those on prescription and living with or in contact with children meaning that children living or in contact with users of illicit or controlled drugs might have been at risk of ingesting drugs that could kill them. Nice guidance on the clinical management of drug misuse and dependence states that 'risks to dependent children should be assessed as soon as possible after contact with services. This would normally include all patients being asked about their children, their ages (some service protocols may require date of birth), and the level of contact they have with them, as a minimum at initial assessment.' It is widely accepted that this should include assessing whether drug-misusing adults have contact with children and that risks including those posed by the unsafe storage should be reduced by the issuing of methadone storage boxes.
- Voided prescriptions were recorded on the care path document before the prescription was destroyed. An incident form would then be completed and sent to the chief pharmacist. This means that there was no opportunity for controlled dug prescriptions to find their way on to the illicit market. Staff had not reported or recorded any medication errors.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- Community detoxification was carried out in accordance with NICE clinical guidelines CG 115 and CG100.
- The Diagnostic Outcomes Monitoring Executive Summary (DOMES report) is a Public Health England report measuring the outcomes for patients' receiving services. The DOMES report for the Shropshire Community Substance Misuse Team (CSMT) showed that from October to December 2015 the service achieved good outcomes for its patients.
- The number of opiate users who left drug treatment free of drugs of dependence, who did not return for treatment within six months, was 8.2% of the total number of those in treatment. This figure was above the national average of 7%.
- Abstinence rates for opiate users was 33.3%, for crack cocaine it was18.8%, Cocaine 40% and Alcohol 29.8%. National comparative data was not available.
- Improvement rates for those no longer injecting drugs were 55.9% meaning more than half of all would be at risk of transmitting blood borne virus such as Human Immune (HIV) Deficiency virus and Hepatitis C between each other and the wider community. National comparative data was not available.
- 100% patients showed improvement in housing and employment by reporting no housing issues when they left the service against a national average of 95.8% This means that nearly all patients using the service had the stability of accommodation when leaving treatment and were therefore at lesser risk of relapse into substance misuse.
- The number of patients working more than 10 days in the 28 after leaving the service was 44.8% against a national average of 24.3%. This means that more than the average number of patients discharged from the CSMT had the stability of work and were therefore at lesser risk of relapse into substance misuse.
- The number of patients who completed treatment or stayed in the service for more than 12 weeks was 97.5% against a national average of 95.2%. For non-opiate users this was 90.1% against a national average of 86.7%.
- The proportion of opiate and/or crack users in treatment for the area was 79.6% against a national average of 52%.

Best practice in treatment and care

- Care plans were lacking in detail, notwithstanding the CIWA, and care plan templates differed and were therefore not standard for patients going through alcohol detoxification. This meant that information regarding a patient's progress through detoxification was not readily available for all clinical staff.
- The detoxification nurses we spoke with understood NICE and other national guidance that describe best practice in detoxification or withdrawal and used the Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar) to monitor and manage withdrawal symptoms.
- Prescribing records showed that the prescribing doctor used medicines recommended by NICE as the first line of treatment.
- Liaison with community pharmacists was well organised. We saw the prescribing officer check that patients could be accommodated at particular venues, and referred to the community pharmacist who could check that medication was in stock and that patients were collecting their prescriptions correctly. A list of pharmacies was accessible and updated quarterly.
- We looked at an audit focusing on whether prescribing at the CSMT followed the Drug misuse and Dependence, UK guidelines on Clinical Management. It found that it did and made a number of recommendations such as key workers to attend medical review appointments to improve multidisciplinary working.
- There is no legal requirement for drug treatment services to supply naloxone hydrochloride (a drug that can reverse the effects of opiate overdose) although it was recommended, by the Advisory Council on the Misuse of Drugs (ACMD) to reduce rates of drug-related deaths. The trust did not provide the drug. We noted that the manager of Shropshire CSMT had made efforts

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

in July 2015 to roll out a programme of supply under Public Health England guidelines for promoting wider availability. However despite several patients expressing an interest in being trained to administer Naloxone no program was developed due to uncertainties relating to whether the new provider would continue the program. In the meantime, staff were able to give Naloxone in the clinic setting.

Skilled staff to deliver care

- The prescribing GP had had no formal clinical supervision from the trust's medical director since June 2015 (nine months). The UK Guidelines on Clinical Management states; that all NHS staff have an obligation to update their knowledge and skills base and to be appraised regularly. No alternative arrangements were in place to make sure the clinical guidelines had been followed during that time.
- Care and treatment was delivered by a team of multidisciplinary professionals. The team included NHS nurses, doctors, and partnership staff made up of addiction professionals that the local authority deemed appropriately qualified in counselling and social work.
- All 10 non-medical staff had received an appraisal in the previous twelve months.
- All detoxification staff were nurse qualified and further trained by the trust to deliver competent and safe care. All staff were supervised regularly and had annual appraisals.

Multi-disciplinary and inter-agency team work

- Multidisciplinary team meetings did not include all the necessary staff, most notably the GP prescriber. This is important for the comprehensive and safe planning of care. Patients had comprehensive assessments, which included consideration of social and health needs. However, physical health screening was inconsistent because it was not always available to all patients.Recording of need in care plans was also not up-to-date or reviewed regularly. This meant that essential information on common physical health problems associated with addiction such as thrombosis, weight loss and respiratory problems were not identified at first assessment for some patients.
- Multidisciplinary teamwork took place within weekly team meetings at the main agency base and in the satellite localities, although patient records showed minimal evidence of multidisciplinary team input. This was except for the Alcohol Liaison Service at the Princess Royal Hospital where there was high-quality multidisciplinary team work reported by staff between Shrewsbury and Telford Hospital NHS Trust (SaTH) staff on wards at the hospital, the accident and emergency department (A&E) and community voluntary organisations.
- We looked at 18 sets of care records and found care assessments did not consider the full range of patients' needs. There was inadequate staff recording of multidisciplinary team (MDT) discussion and clinical decision-making. Care plans reviewed by the inspection teamin these 18 cases, was recorded as not recorded, not done, poorly done, present and done but less than good.
- Communication with other agencies and organisations was good and took advantage of cordial and productive working relationships with Social Care and Health, NACRO and Aquarius staff. However all staff involved in assessing, planning and delivering people's care and treatment were not informed through formal minutes of an MDT of changes in patient care, need and risk. Staff did work together to assess and plan ongoing care and treatment in a timely way through their close working relationships on an informal level. All the information needed to deliver effective care and treatment was not always available to relevant staff in a timely and accessible way through care and risk assessments, care plans and case notes.
- The use of the shared electronic care pathway, case management and reporting system helped joint working between the trust staff and Social Care and Health staff.
- Staff said local meetings addressed clinical issues. However, there were no formal minutes available to check this.

Good practice in applying the Mental Capacity Act

- While the Mental Capacity Act 2005 (MCA) was not applicable at the CSMT, we were informed by clinical staff that capacity for their patients to understand the implications of treatment and the choices available to them was always carefully judged at assessment by making sure patients were able to clearly express the

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

benefits of treatment in discussion. However, 88% nursing staff members had completed statutory and mandatory training in MCA. This compared to a trust target of 85%.

Management of transition arrangements, referral and discharge

- Referral of patients between the partnership agencies were clear and effective in helping patients access recovery oriented group work and ongoing one to one key work and therapeutic sessions.
- There was no evidence in the 14 sets of clinical notes of NHS staff writing discharge-planning notes. Although discharge was primarily the responsibility of partnership agencies the trust had a responsibility to ensure with its partners that discharge was comprehensive and planned with the patient. Beyond this, the inspection team were unable to check the quality of discharge planning with partner agencies not regulated by CQC.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We spoke with six patients who used the CSMT. Patients had high levels of satisfaction with the service they received. All said that staff were helpful, treated them with respect, and 'went the extra mile'.
- Patients said they were signposted to other support groups for additional help including Self-Management and Recovery Training (SMART), Alcoholics Anonymous (AA), and Narcotics Anonymous (NA), as well as educational courses.
- Patients stated that there was always someone 'on the end of the phone' and that they could also walk into the service at any time and speak with the duty worker.
- Some patients expressed anxiety about the transition to the new provider of substance misuse services and wondered if they would receive the same high-quality care. They were also concerned about possible reductions in service as a result of the transfer.
- A patient satisfaction survey was carried out for the alcohol liaison work based at the local acute hospital. The audit was supported by the trusts audit department. Sixty-four questionnaires were given out:
  - 100% of patients said they were treated with respect, dignity and compassion by staff.
  - 100% were satisfied with the overall service.
  - 97% said they had as much say as they wanted in decisions about their care.
  - 93.7% said they had their treatment explained to them in a way they could understand.
  - 93.7% were offered referral to a community-based service.

The involvement of people in the care that they receive

- Of the patients we spoke with, all said they had never formally been asked for their feedback on services from the CSMT.
- Four of the patients said they had been involved in their care and recovery plan and one patient talked in depth about the seven recovery targets that they and their key worker had set.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- Waiting times for prescribing and detoxification services were good, with patients being seen within two weeks. This is within the National Drug Treatment Monitoring System (NTDMS) tolerance level of three weeks. Patients reported that the service was flexible, patients could drop in to access information and needle exchange services.
- We reviewed three sets of clinical notes for the alcohol liaison service based at the local acute trust. We found that all three had discharge and care plans completed and signed by the patient.
- Detoxification services were easily accessible and there was a two-week waiting time for assessment. This was an average wait nationally and within acceptable limits.
- An audit of patients not attending clinics (DNA) was made available to the inspection team. The audit measured the attendance rates of patients to the service and made recommendations in targeting services more effectively such as patient non-attendance of appointments should be managed by temporarily adjusting the issuing of prescriptions and that there should be a an attendance policy implemented on the basis of assessed individual patient need.

The facilities promote recovery, comfort, dignity and confidentiality

- The office suite included doctor prescribing, counselling and needle exchange rooms. All were clean and tidy. The needle and syringe exchange service room was particularly well organised and well stocked with a variety of equipment including safe disposal 'sharps' bins for used injecting equipment.
- There were stairs and a lift to the CSMT main internal building entrance making the premises accessible to wheelchair users.
- At the time of the inspection, the owner of the building was refurbishing the facilities at the main CSMT base. At times the noise from drills and other building tools was uncomfortable and prolonged. This made it difficult for patients and staff to have conversations.

Meeting the needs of all people who use the service

- The CSMT had protocols in place to raise awareness of risks from blood-borne viruses such as hepatitis B, C and the human immunodeficiency (HIV) virus. It offered testing for these, and appropriate pathways into treatment. From April 2015 to March 2016, it dealt with 745 such cases, although one member of staff stated that recent vacancies in SCH staff meant numbers had since fallen.

Listening to and learning from concerns and complaints

- We saw that information was provided in the clinic informing patients how to complain.
- There were two complaints made about the service between October 2014 and 16 October 2015. Neither of these were upheld as they were about clinical decisions that were deemed correct when reviewed. The trust responded by explaining the clinical reasons for the decisions made and support the complainant to understand why they were made.

Are services well-led?

Requires improvement

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- During interview, staff demonstrated knowledge of the trusts vision and values and an awareness of the close working relationships with health and social care partners helped to improve patient's lives.
- Staff talked about their commitment to quality, care, respect and dignity for their patients. They stressed the importance of these values within the recovery agenda and described how patients were supported to gain greater control in their lives with their support.
- During the inspection we were not made aware of any strategy in place to develop services further in line with national guidance beyond the routine sharing of information. Progress against delivering strategic objectives could therefore not be monitored or reviewed. However, we recognise that the service was due to transfer to a new provider at the end of March 2016.
- Following a retendering process towards the end of last year, substance misuse services will be transferred to an independent provider. We asked the trust to provide details on the plans in place to make sure all care plans and risk assessments were up-to-date and complete. We also sought assurances on the readiness of prescriptions for transfer. There were no detailed plans available regarding the imminent transfer of clinical services to the newly commissioned provider.

Good governance

- There were no local substance misuse governance meetings as part of the trust governance framework to support the delivery of a substance misuse strategy and good quality care.
- Weekly team meetings were used to convey to staff a variety of business, governance, risk and clinical matters. The minutes we reviewed did not demonstrate a consistent or structured approach to any of these issues.
- Arrangements for identifying, recording and managing risks, issues and mitigating actions relied on the local authority partners to record and manage through their formal processes and systems. There was also no evidence of a formal process by which trust staff were part of safeguarding reviews or learning opportunities. However staff demonstrated at interview that they understood the value of raising and discussing concerns with partnership staff and felt able to do so because of the good working relationships with them.
- The trust's policy on placing sole responsibility for safeguarding with Shropshire Council meant that safeguarding alerts and incidents were not tracked through trust processes. There was also no evidence of a formal process by which trust staff were part of safeguarding reviews or learning opportunities.
- The measure of quality for the substance misuse service was confined to meeting the expected outcomes within the service level agreement. These outcomes being related to the National Drug Treatment Monitoring System (NDTMS). The public health Diagnostic Outcomes Monitoring Executive Summary (DOMES) reported in quarter 3 – 2015-16 that the CSMT was above the national average in successful treatment completions for users of opiates and alcohol. These completions are as a percentage of the overall number of patients in treatment. There were good arrangements in place to ensure that the information used to monitor and manage quality and performance was accurate. For example the collection of Treatment Outcome Profile (TOP) information collected was completed on time and in full.
- The trust did not provide naloxone hydrochloride which is recommended by the Advisory Council on the Misuse of Drugs (ACMD) to reduce rates of drug-related deaths. We saw that the service manager had made efforts in July 2015 to roll out a programme but this not developed due to uncertainties relating to whether the new provider would continue the program. In the meantime, staff were able to give Naloxone in the clinic setting.
- There was not a clear medical line of supervision between the prescribing GPs in the service and the Medical Director. Doctors informally discussed issues with the clinical manager and the service manager as well as each other. While there was regular communication with keyworkers for specific patients and information available on the electronic patient

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records there was no formal multidisciplinary team meeting to discuss and record clinical decisions. Nursing staff within the service had a formal clinical supervision process in place.

Leadership, morale and staff engagement

- Staff were not supported in developing the recovery agenda and public health directives due to no clinical director being in place since June 2015.
- Staff spoke positively about their job roles and one member of staff was given the opportunity to pilot an innovative project on steroid abuse.
- Staff had confidence in the Clinical Nurse Manager and felt supported by them. Staff felt able to raise concerns and described their manager as visible and approachable. They also knew there was a whistle-blowing process.