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.