Shropshire Community Health NHS Trust

R1D

Community health inpatient services

Quality Report

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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

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.