Shropshire Community Health NHS Trust

R1D

Community health services for adults

Quality Report

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

Date of inspection visit: March 2016
Date of publication: 07/09/2016

Summary of findings

Locations inspected

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

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

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

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

Summary of findings

Ratings

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

Summary of findings

Contents

Summary of findings

Overall summary

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

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

However we also saw that:

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

Summary of findings

Background to the service

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

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

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

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

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Tim Cooper, Care Quality Commission

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

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

Why we carried out this inspection

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

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

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

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

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

Summary of findings

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

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

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

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

How we carried out this inspection

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

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

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

"The care is wonderful".

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

What people who use the provider say

Good practice

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

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

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

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

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

Summary of findings

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

Action the provider SHOULD take to improve

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

Shropshire Community Health NHS Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

Summary

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

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

However we also saw:

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

Safety performance

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

Requires improvement

Are services safe?

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

Incident reporting, learning and improvement

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

Duty of Candour

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

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

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

Safeguarding

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

Requires improvement

Are services safe?

Medicines

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

Environment and equipment

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

Quality of records

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

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

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

Cleanliness, infection control and hygiene

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

Requires improvement

Are services safe?

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

Mandatory training

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

Assessing and responding to patient risk

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

Staffing levels and caseload

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

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

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

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

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

Managing anticipated risks

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

Major incident awareness and training

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

Good

Are services effective?

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

Summary

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

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

However we also saw:

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

Evidence based care and treatment

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

Pain relief

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

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

Nutrition and hydration

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

Technology and telemedicine

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

Patient outcomes

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

Good

Are services effective?

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

Competent staff

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

Good

Are services effective?

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

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

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

Multi-disciplinary working and coordinated care pathways

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

Good

Are services effective?

Referral, transfer, discharge and transition

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

Access to information

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

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

Consent, Mental Capacity act and Deprivation of Liberty Safeguards

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

Good

Are services caring?

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

Summary

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

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

Compassionate care

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

Understanding and involvement of patients and those close to them

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

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

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

Emotional support

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

Good

Are services responsive to people's needs?

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

Summary

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

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

Planning and delivering services which meet people's needs

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

Equality and diversity

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

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

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

Meeting the needs of people in vulnerable circumstances

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

Access to the right care at the right time

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

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

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

Learning from complaints and concerns

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

Good

Are services responsive to people's needs?

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

Requires improvement

Are services well-led?

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

Summary

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

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

However we also saw:

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

Service vision and strategy

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

Governance, risk management and quality measurement

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

Requires improvement

Are services well-led?

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

Leadership of this service

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

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

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

Culture within this service

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

Public engagement

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

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

Staff engagement

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

Innovation, improvement and sustainability

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