Peninsula Community Health C.I.C

1-247215513

Community health services for adults

Quality Report

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This report describes our judgement of the quality of care provided within this core service by Peninsula Community Health C.I.C. 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 Peninsula Community Health C.I.C and these are brought together to inform our overall judgement of Peninsula Community Health C.I.C

Summary of findings

Ratings

Overall rating for Community health services for adults	Good
Are Community health services for adults safe?	Good
Are Community health services for adults effective?	Good
Are Community health services for adults caring?	Good
Are Community health services for adults responsive?	Good
Are Community health services for adults well-led?	Good

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Overall summary

Overall rating for this core service Good

Peninsula Community Health Community Interest Company (CIC) provides community health care services for a population of around 538,00 people living in Cornwall and the Isles of Scilly. The care and treatment is provided under the regulated activities; diagnostic and screening procedures and treatment of disease, disorder or injury.

During our inspection we visited staff and patients in relation to the provision of community services in the following areas;

- Liskeard
- Launceston
- Bude
- Wadebridge
- St Austell
- Bodmin
- Truro
- Falmouth
- Camborne and Redruth.

We reviewed the following services and spoke with a total of 123 members of staff including;

- District nursing teams
- Musculoskeletal physiotherapists outpatient and community teams
- Speech and language therapists
- Community matrons
- Respiratory rehabilitation therapists
- Specialist nurses, for example, tissue viability
- The Emergency Intervention Service (EIS)
- Acute Care at Home team
- Podiatry
- Falls prevention team

This was in addition to organised focus groups and drop in sessions where staff were invited to come and speak with us regarding their role and the services provided.

We spoke with 54 patients and five of their relatives/ representatives to seek their views of the service provided to them. Patients made very positive comments regarding the care and treatment that staff provided.

During the inspection we looked at patient care documentation and associated records, and observed care in patients' homes and clinics.

We spent three days inspecting the community services provided across Cornwall and found patients were provided with safe, effective, caring, responsive and well led services.

There was an open culture of reporting incidents and learning from them to improve the care provided in the future. Staff were trained and competent in safeguarding patients from abuse. Staff had experienced an increase in workload over the past year and in some areas there were vacancies in the staff team which added further pressures. Staffing levels were being reviewed and monitored by the provider. The Isles of Scilly staff teams were short staffed and concerns had been raised regarding future staffing levels. Recruitment was ongoing and gaps in the staffing rota were filled with agency staff or permanent staff working additional hours.

Staff provided care that was evidence based and in line with national guidance and recommendations. We found staff were innovative when developing their practice. Patients were encouraged to be self caring and independent when possible and to this end tele health was in use and working successfully for a number of patients. Tele health is the remote exchange, by phone lines or wireless technology, of data between a patient living in their own home and health care professionals. It is used to assist with the diagnosis and monitoring of patients with long term conditions. The provider captured feedback from patients and changes had been made following feedback to provide an improved service. Staff worked well as part of a multidisciplinary team, both with colleagues within the organisation and those who worked for external partners across Cornwall.

Patients were provided with a caring service by dedicated and kind staff. They were treated with dignity and respect when receiving care in their own homes and in outpatient clinics. Staff worked hard and were innovative when it came to meeting patients' diverse needs.

Patients told us they felt able to talk to the staff if they were not happy with any aspect of their care and treatment. While patients we spoke with told us they had

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had no reason to make a complaint, it was not evident that written information was provided to them on how to do so. The organisation was open in its approach to investigating issues and complaints raised, responded to people who had complained and was prepared to acknowledge where care delivered could have been better.

The provider had a clear organisational structure and staff spoke positively of their local managers and the support they received. There had been a significant number of management changes in the period leading up to our inspection and the provider was working to address gaps left in senior management as a result of these changes.

Summary of findings

Background to the service

Background to the service

Peninsula Community Health Community Interest Company (CIC) provides a community healthcare service to a population of approximately 538,00 people living in Cornwall and the Isles of Scilly. The organisation employs a total of 2,104 staff, although not all of these work within the community services.

The services are based in locations covering the whole of Cornwall providing:

- Therapy services, including podiatry, rehabilitation therapy, speech and language therapy, falls prevention and musculoskeletal physiotherapy for patients attending outpatient departments and in their own homes
- District nursing services
- Community matrons
- Acute Care at Home
- Health for the Homeless
- Emergency Intervention Service (EIS)

Community nurses made 301,246 patient visits in 2013-2014 and physiotherapists carried out a total of 91,132 outpatient appointments, plus additional visits to patients in their own homes.

Our inspection team

Our inspection team was led by:

Chair: Dorian Williams, Assistant Director of Governance, Bridgewater Community Healthcare NHS Foundation Trust

Team Leader: Mary Cridge, Care Quality Commission

The team included CQC inspectors and a variety of specialists: district nurses, a community occupational therapist, a community physiotherapist, a community children's nurse, palliative care nurses, a director of nursing, a governance lead, registered nurses, a community matron and two experts by experience who had used services.

Why we carried out this inspection

We inspected Peninsula Community Health CIC as part of our comprehensive community health services inspection programme.

Peninsula Community Health CIC is an independent organisation providing NHS services and therefore we used our NHS methodology to undertake the inspection.

How we carried out this inspection

During our inspection we reviewed services provided by Peninsula Community Health CIC across Cornwall and the Isles of Scilly. We visited community hospital wards, minor injuries units and outpatient clinics. We accompanied district nursing teams on visits to people in their homes where they were receiving treatment.

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 core services and asked other organisations to share what they knew, this included Healthwatch. We carried out an announced visit on 21, 22 and 23 January 2015. During the visit we held focus

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groups with a range of staff who worked within the service, such as nurses, doctors and therapists. We talked with patients. We observed how people were being cared for and talked with carers and/or family members and reviewed patients' care or treatment records. We carried out an unannounced visit on 29 January 2015.

What people who use the provider say

The friends and family test had recently been implemented to obtain the views of patients who were in receipt of a community based health care service. No results were available at the time of our inspection. Individual services requested feedback from patients in different ways. Managers of teams audited feedback received. We were shown evidence from audits which identified patients had expressed positive comments regarding the services provided to them.

During our inspection we spoke with 54 patients and five of their relatives/representatives. Patients made positive comments to us regarding the care they received and the staff who provided it. We heard that staff were kind, helpful and caring. Patients were positive regarding their involvement in their care and the planning of any treatment. We were consistently told that staff informed them in detail of the plan of care and treatment and their consent was sought both verbally at each intervention and in writing in the planning stage.

Patients were clear that they were able to speak with their staff at any time and could telephone them regarding any worries or anxieties.

Concerns were expressed by a number of patients regarding the district nursing service. They voiced worries that the service was short staffed and on occasions nurses were late visiting them. We were told that nurses often rang the patient if they were going to be late to reassure them. Patients also added that the community staff were flexible regarding visit times to accommodate other commitments they may have.

Good practice

During our inspection we saw many elements of good practice across the community services.

The district nursing team had a high number of Queen's Nurses. The Queens Nurse is an award presented by the Queen's Nursing Institute to nurses who are deemed committed to delivering high standards of practice and patient centre care. This is a nationally recognised award.

We saw examples of where district nursing teams and the community rehabilitation therapy teams had provided individualised and holistic care to patients living in challenging environments which were potentially damaging to their health. The teams respected the patients' decisions and supported them to access services and health care as necessary.

The organisation had been part of a joint initiative that had been awarded a health publication - Managing Long Term Conditions award. This project enabled the staff to work with voluntary and council workers to offer a combination of medical and non-medical support to develop a care plan which suited the person's life and helped them to maintain their health and wellbeing. This project had initially been developed in the Newquay and Penzance areas. Staff were positive about the outcomes they had witnessed and been part of.

The Health for the Homeless demonstrated holistic and individualised care for patients who required additional support to attend appointments to monitor their health and diagnose and treat medical conditions. The service had been working with the liver department at the acute trust to arrange a clinic to be held in local communities. This was to target homeless patients who were known to be non-attenders at the clinic at the acute hospital.

The tissue viability team were working on a project to make sure patients were provided with the correct pressure relieving equipment. This innovative project was also looking at the education of patients, staff and carers

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in how to manage pressure area care rather than relying on equipment. The tissue viability lead told us that since this has started in December 2014 they had found 50 pressure relieving mattresses which were not required.

The Emergency Intervention Service had received an award for outstanding team contribution from the Cornwall Council Adult Care, Health and Wellbeing Department in 2014.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider SHOULD take to improve:

- Ensure robust arrangements are in place at all time to ensure the district nursing and community based services are adequately staffed.
- Ensure patients in the community have access to replacement tele health equipment in the event of a failure of their device to ensure continuity of monitoring their health whilst at home.
- Ensure access for people with disabilities at Bodmin Hospital is adequate to enable people to be independent.

Peninsula Community Health C.I.C

Community health services for adults

Detailed findings from this inspection

The five questions we ask about core services and what we found

Good

Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

Summary

We found this service protected patients from avoidable harm. Staff were trained and competent in safeguarding patients from abuse. Staff were encouraged to report incidents and received feedback following such reports. We identified changes had been made to improve the service following some incidents.

Equipment required for the provision of safe care and treatment for example, for pressure relief and mobility aids, was available and a system of servicing and maintenance was in place.

Staff had experienced an increase in workload over the past year and in some areas staff vacancies had added further pressures. Teams managed their staffing requirements and supported other teams to meet the care needs of patients safely. Staffing levels were being reviewed and monitored by the provider.

Detailed findings

Incident reporting, learning and improvement

- Staff were encouraged to report incidents using the provider's electronic recording system. All incident reports were seen by the appropriate team manager and locality manager. Feedback was provided to the staff member, or the team manager, following the reporting of an incident. We were told by team leaders in the district nursing teams and therapy services that the reports submitted, were reviewed monthly to identify any trends and to share learning within teams. Staff told us there was a 'no blame' culture and incidents were viewed as an opportunity for learning by the provider.
- We saw that learning was shared between teams at county-wide forums, for example at the district nursing team leader monthly meeting and the community matron monthly meetings. This information was cascaded to their team members during team meetings, as demonstrated by minutes of meetings.

- We reviewed a number of incident reports that had been completed by one district nursing team and staff advised us on how the process worked including feedback given and action taken for specific incidents.
- Changes had been made to the recording templates used by the musculoskeletal physiotherapists when delivering acupuncture. The changes had taken place following a reported incident through the electronic system.
- A number of incidents had been reported concerning patients experiencing poor discharge arrangements from external organisations. Learning from these incidents had resulted in staff development on information gathering prior to admitting patients to the organisation's community services. This showed learning and improvements took place following incident reports.
- The provider had reported one Never Event in August 2014 which had occurred within the podiatry community services provided to adults and was regarding wrong site surgery. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. This incident had been reported to CQC and thoroughly investigated by the provider. A full report of the investigation had been provided to CQC prior to this inspection. We spoke with the manager for the area where the Never Event had occurred. During our inspection we found systems had been reviewed following the investigation and were told changes had been made to the way staff prepared patients for minor surgery. These changes included the use of the World Health Organisation (WHO) safety checklist during minor surgery. No podiatry surgery was taking place during our inspection so we were unable to evidence this in use. This showed the organisation had taken learning from the reported Never Event and had taken action to reduce the risk of a repeat of the incident.
- The community nursing teams monitored the safety thermometer indicators relevant to their area of work, for example, pressure ulcers. Results were reported monthly. As a result of safety thermometer reporting we saw that changes to the way in which pressure damage prevention and reporting had been put in place which had provided more detailed information for the provider as all grade 2 pressure damage was now reported.

Duty of Candour

- A new statutory duty of candour regulation applicable to the provider will come into force in April 2015 (Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The duty of candour explains what providers should do to make sure they are open and honest with patients when something goes wrong with their care and treatment.
- We spoke with staff throughout our inspection, about their understanding and knowledge of the new statutory duty of candour in preparation for the new Regulation coming into effect. We received a mixed response, with some staff being fully aware of the implications for them following information received from the provider in emails and discussions in team meetings. Some staff, whilst not aware of the term Duty of Candour were aware of some of the principles, whilst others had not heard of this at all.

Safeguarding

- The provider submitted appropriate notification reports to CQC regarding any suspected safeguarding concerns and subsequent investigation. These reports detailed the involvement of external professional organisations, for example, the local authority and the police. This demonstrated the provider was aware of its responsibilities under the Health and Social Care Act 2008 to make suitable arrangements to ensure that service users are safeguarded against the risk of abuse.
- The provider had a named nurse for safeguarding for both adults and children. Staff were aware of these members of staff and their role when suspected safeguarding issues had been identified.
- Community staff, including district nursing teams, therapists and the health for the homeless service had all raised alerts for vulnerable adults who lived in their own homes, care homes and hostels. This demonstrated staff were able to identify abuse or neglect and acted appropriately by raising alerts.
- Safeguarding was incorporated into all staff induction training programmes. Staff we spoke with told us and records showed they had completed adult safeguarding training at a level appropriate for their role. The level of training depended on their grade with all registered nurses and healthcare assistants undertaking level 2 and level 3 being completed by band seven and above staff. This included team managers, community matrons

and specialist nurses and some therapists. Safeguarding training for children was also undertaken by all staff, as demonstrated by training records. The requirement for this training was dependent on the staff member's role in providing care to children.

- The provider used an electronic system to monitor staff training. This system identified when staff were required to attend their three yearly safeguarding update. We noted in ten staff records that all staff had attended their safeguarding and Mental Capacity Act 2005 training.
- The provider had policies and procedures in place on the intranet to ensure staff recognised and were aware of their responsibilities to report abuse and 'whistle blow' if necessary. Information, in the form of a poster providing detail on how and when to report, was clearly displayed in a number of team bases across the geographical area.

Medicines management

- Medication policies and procedures were in place for staff to refer to. The staff we spoke with were all aware of the guidance available to them.
- The musculoskeletal therapy service had Patient Group Directives (PGDs). These are written and approved instructions for the supply or administration of medicines to groups of patients by staff other than doctors who have undertaken additional training. There were PGDs in place for the administration of anti-inflammatory injections. . All medicines were stored in a locked cupboard which was secured to the wall. We saw discrepancies within different outpatient clinics regarding the documentary evidence of the medicines used in individual departments. In one area one type of injection was not logged when new stock arrived or when an injection was used, which did not fully comply with the operational policy for storage and management of the injection therapy. The team leader assured us action would be taken to address this issue which had occurred as a result of staff changes.
- Emergency medicines were available in all outpatient departments and staff were trained in the administration of adrenaline. This is a medicine used for the treatment of anaphylactic shock which can occur in some patients following treatment.
- The Health for Homeless service held an emergency medication box in each of the clinic rooms across the area. Medications were stored securely in the same place in each room so that staff would be able to locate them immediately.
- Medicines which required cool storage were securely stored in medicine fridges, the temperatures of which were checked and recorded daily.
- We found most district nurses were trained to give intravenous medication (usually antibiotics). Staff were also trained and competent to use syringe drivers for the management of people's pain. We saw evidence in ten staff files of the specialist training the nurses were required to complete prior to undertaking this aspect of nursing care. Where staff had not completed this training, support was given by colleagues to ensure the patients were not disadvantaged.
- We were told by all district nurse team leaders that the initial loading of medication for a patient's syringe driver was always checked by two registered nurses. We saw evidence of the protocol and the register that was used to record that this check had taken place and had been clearly documented.
- We were told by district nurses that they did not carry medications other than adrenaline for emergencies.
- Staff from different teams told us their only area of concern around medications was the unreliability of dressings for use by patients in their homes. All dressings were ordered by GPs or nurse prescribers. We saw examples across all of the district nursing teams where dressing supplies were either limited or a different product had been supplied from the dispensing pharmacy. All district nurses carried a first dressing pack with them to ensure they could provide initial treatment if a patient's dressings had not been supplied to their home. One staff member told us they had been unable to change a patient's the week before as no dressings had been supplied to the patient's home. This had since been addressed. We were told the delivery of supplies of dressings had been a long-standing problem in some areas and that team leaders and locality managers in those areas were working with external professionals to resolve the issue.

Safety of equipment

- We saw appropriate equipment was used to support safe patient care and treatment. Staff understood their responsibilities to ensure equipment was safe to use and serviced and maintained.
- Some equipment was on loan to patients and other equipment had been purchased by the League of Friends who supported individual hospitals. Equipment which had been purchased had been logged and servicing and maintenance requirements were met by the provider.
- Emergency resuscitation equipment was available in each outpatients department. The therapy staff were aware of this equipment and had access to single-use masks in each cubicle in which they treated patients. The emergency trolleys were checked and records maintained to identify the checks, on the days the department was open to evidence they were safe to use.
- Where clinics required sterilised equipment, a contract had been set up with the Royal Cornwall Hospitals Trust. Staff told us this worked well. If they required any additional equipment they telephoned to request this.
- The Tissue Viability Service had implemented the provision of pressure relieving equipment to mitigate the risks to patients from tissue damage. Each district nurse had a supply of pressure relieving equipment.

Records and management

- We reviewed fifteen patients' records across the team bases and noted they were completed to a high standard and were accurate and complete. Records were stored in filing cabinets which were lockable. Offices which we visited were also locked when staff left them unattended.
- Electronic records we reviewed showed an accurate and detailed account of care and treatment provided to individual patients.

Cleanliness, infection control and hygiene

- Policies and procedures regarding the promotion of infection prevention and control were available to staff on the provider's intranet. We reviewed these documents and saw that information related to staff working in patients' own homes, registered care homes and hospital clinics. Team leaders told us the policies were currently being reviewed by the infection control team.
- We observed district nurses and therapists working in patients' own homes, and saw they followed the policies and procedures relating to hand washing and use of personal protective equipment, for example, the use of antibacterial hand gel, gloves and aprons.
- Records and discussions with staff demonstrated that infection control training was provided during staff induction training and updated every three years.
- Hand hygiene audits were carried out on a monthly basis and results were reported back to staff. Records showed that the standard of hand hygiene within district nursing and therapy teams was high. Hand inspection audits were carried out by inpatients, outpatients and community teams. This looked at the length of nails, absence of nail varnish / extensions and the permissible one ring only and ensured that any cuts and abrasions were covered appropriately.
- Infection prevention and control link nurses were in post and attended quarterly meetings to discuss infection control issues and update on practice. Information from these meetings was cascaded to community teams, as demonstrated by minutes of team meetings.
- Outpatient areas were clean and bright. We observed a general services assistant thoroughly cleaning the area prior to a clinic opening. Equipment was clearly labelled once cleaned and ready to use. We saw that bins were emptied throughout the day in the outpatients departments and were clearly labelled as to their use, for example, general or clinical waste.
- We observed district nurses disposed of clinical waste, such as used dressings and dressing packs, in the correct bags.
- We observed two patients being treated in a podiatry clinic. The member of staff was seen removing dry skin from the feet of these patients. The removed skin hit the podiatrist in the face which carried a possible risk of infection to them. Staff were not wearing a face mask which was in accordance with the provider's policy, which informed staff to wear face protection when at risk of being splashed by body fluids or blood. However the risk of cross infection from skin scales should be considered when undertaking such procedures to ensure staff are protected.

Mandatory training

- The provider had recently changed the mandatory training arrangements to enable staff to access their annual training update in a single day. Staff reported

that it was easier to be released and they were away from clinical roles for less time. They also said it was easier for them to ensure all of their mandatory training was up to date.
- Staff were aware of their responsibilities to complete mandatory training and those we spoke to were positive regarding the format, content and availability of the training.
- We reviewed the electronic training records for three district nursing teams and noted that compliance for mandatory training was between 75% and 80% from October to December 2014. We saw records of training attended in the 10 staff records we reviewed. This showed some staff had attended over 90% of their mandatory training which was higher than the figure provided by the electronic training register.
- The provider monitored compliance with mandatory training and was aware where there were shortfalls. Line managers were responsible for following up training needs with each individual member of staff.

Assessing and responding to patient risk

- Risk assessments were carried out for patients and plans were developed to manage identified risks. For example, if a patient being visited at home had a pet which was considered to pose a risk, the patient or family was required to sign to say that they had removed the pet from the vicinity for the duration of the district nurse visit. Known patient risks were discussed at team handovers to ensure all staff were made aware of the action they must take to reduce the risk.
- The therapy rehabilitation teams had a system of triage to ensure that where necessary, patients were prioritised for treatment if a risk was detected at the stage of referral. The therapy team gave examples of where patients were enabled to make informed choices regarding their rehabilitation and discharge home. We saw an outstanding example of risk management by the community rehabilitation team which demonstrated the support offered to one patient at an appropriate time and way to enable the patient to determine where they lived and ensure their safety whilst respecting the patient's informed decision making. The team had concerns regarding the patient's decision to return home with no care/support package in place. They visited the patient two days after their discharge, at which point the patient realised they would benefit from assistance and this was then promptly arranged.
- The Acute Care at Home team were able to assess new referrals to their service on the same day. This meant if a patient who they had been requested to review in their own home deteriorated they could then be admitted to hospital promptly.
- During our visits to the Falmouth district nurse team, the team received an urgent referral. One of the nurses visited the patient within a couple of hours and provided treatment. They then referred the patient to the GP and the Early Intervention Service to ensure the patient was safe to remain in their own home.
- The Braiden assessment score (based on the Braiden assessment tool to determine the risk to patients from pressure damage) was in use to identify patients at risk from pressure damage, with appropriate action taken depending on the score.
- The district nursing and therapy services did not provide emergency care and treatment services. People and their families and carers were advised that if they became acutely unwell or their condition deteriorated they were to contact their GP, attend the nearest emergency department or call an ambulance depending on their need.
- We observed a district nurse visiting a vulnerable person in their own home. The person was deemed vulnerable as they had become unable to care for themselves and was at risk from falls. On our arrival the patient had experienced a fall and had been lying on the floor for a number of hours. The nurse dealt with the situation in a calm, reassuring and professional manner, providing support to the family and social care worker who had both arrived after the district nurse. The nurse then went on to arrange respite care for later that day with the consent of the patient. Arrangements were made for a home assessment to be completed by the occupational therapist prior to the person returning home.

Staffing levels and caseload

- We reviewed the staffing and caseloads teams of district nurses and therapy staff. Each team leader had a good understanding of their staffing levels and were monitoring their service provision together with their locality leads. The interim director of operations was aware of staffing vacancies, sickness and turnover throughout the services. Ongoing recruitment was taking place but the provider had found it difficult to recruit registered nurses staff across all the teams. We were provided with a number of reasons for this but

primarily it appeared fewer staff were re-locating to Cornwall. Concerns had been raised, by senior staff working on the Isles of Scilly, with the provider regarding current and projected staffing levels on the Isles of Scilly.

- The issues around staff recruitment had been identified on the providers risk register and the actions being taken by the provider, including additional recruitment, to address the situation were recorded. Until additional staff were recruited the provider was mitigating any shortfalls in the ways set out below.
- One team of district nurses had identified a potential risk to patients regarding low staffing levels. The team leader had taken responsibility to prioritise patient care and visits when allocating staff and the issue was discussed at handover.
- District nursing teams were commissioned in localities to provide a service from 8.30am to 5.30pm each day, with a rota for one registered nurse per team to be on call from home from 5pm to 10pm. We found inconsistencies amongst teams in how this on call system operated. Some teams had a second staff member on call to ensure where two members of staff were required, a second person was readily available. For example this might be the case for the initial setting up of a syringe driver or a visit a new patient. Other teams rang colleagues who were off duty, until they found someone willing to support them and others had arrangements with neighbouring teams. Arrangements had not always been sufficiently robust to ensure the service was adequately staffed. In response to this, two teams of district nurses were trialling a late shift system, with a view to have staff on duty an available over a longer period, in order for the caseload to be more manageable.
- A workload assessment tool had been developed for district nursing in response to the Francis Report to ensure there were sufficient district nurses to meet the care and support needs of patients in their own homes across the geographical area. The tool was developed in partnership with the organisation's clinical audit team in early 2014 and underwent an initial pilot. It was piloted again in October 2014 across mid Cornwall and enabled the district nurses to monitor their own workload which was then matched to national data. The early findings indicated that the district nurses were working slightly above the national average of eight visits a day.
- The Isles of Scilly locality manager reviewed the staffing required to meet the needs of patients living in their own homes and in the Island's care home each week during the weekly multidisciplinary team meeting. This enabled sufficient resources to be allocated to the district nursing service.
- The Acute Care at Home team were able to care for a maximum number of 18 patients. They had a team of 26 registered nurses and each day's workload varied depending on the needs of the patients and new referrals. They were not able to use bank or agency staff due to the specialist nature of their service and if staff were sick, other staff would cover.
- A staff member in one team told us they had been short staffed but following recent recruitment they would have their full quota of staff in the two weeks after our inspection.
- Each community team had daily handover meetings. We observed two during our visits. At these meetings the caseloads were discussed, together with information regarding future visits required by patients. Staff told us that if staffing levels were inadequate then staff would be moved from another team in the geographical area. All staff we spoke with were keen to support each other and we saw examples during our inspection of how teams provided cover to another team. This was particularly apparent with the provision of on call arrangements across district nursing teams.

Managing anticipated risks

- All team leaders we spoke to told us it was a priority for them to ensure the safety of staff undertaking their roles in community settings. Staff told us they had attended safety awareness training and were able to risk assess to help maintain staff safety when caring for people in their own homes. Staff were able to tell us about the lone worker policy and were provided with mobile phones and safety alarms.
- The district nurses held a daily handover which included reviewing risk issues within the caseload and discussion of patients' care and treatment requirements. The daily handover was also part of the lone working protection as staff rang the office if they were unable to return for the handover. If they did not make the telephone call, staff would take action to ensure they were safe.
- When working alone out of hours, staff were supported by the organisation's switchboard. The switchboard staff took referrals and calls for the district nurses, who then contacted the switchboard when the visit was concluded. Staff told us they were reassured knowing

the switchboard were aware of their whereabouts. Concerns were raised by staff as the switchboard staff did not have access to the provider's electronic recording system so may not have been aware of identified risk issues to pass onto the member of staff.

- The Braiden assessment score was in use to identify patients at risk from pressure damage, with appropriate action taken depending on the score.
- The Health for Homeless service had access to the county-wide abusive, violent patient register on the local GP recording system. This ensured staff were aware that certain patients were required to attend a different GP surgery and not to be seen by lone workers. Clinics were held in day centres during their opening hours when day centre staff were at work. Alarm systems were installed in all of the day centre buildings and staff expressed confidence in colleagues responding to the alarms
- District nurses told us they would be supported by the provider if they decided not to accept a patient due to concerns regarding safety and wellbeing of staff. They clarified this only happened on rare occasions.
- Community staff were aware of guidance, policies and procedures regarding the action to take during inclement weather such as snow or flooding, to ensure the safety of patients. Staff were aware of where colleagues lived in relation to patients and we were provided with examples when staff worked across teams to ensure patients' care and treatment needs were met based upon a risk assessment to ensure their needs could be met safely.

Major incident awareness and training

- The provider ensured information and equipment required to manage and control a major incident was available and ready for use in Liskeard Hospital.
- Staff had been provided with guidance and training regarding their roles in the event of a major incident. Team leaders told us about the arrangements that would be put into place if a security breach occurred at any of the district nursing or therapy service bases. These arrangements were to ensure the safety of staff and/or patients.

Good

Are Community health services for adults 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

Patients were provided with an effective service.

Care and treatment provided was based on national guidance and best practice recommendations. Staff used assessment tools to help determine patients' care needs, for example, regarding pain relief, pressure relief, mobility and nutrition and hydration. Care and treatment was provided to patients in line with their individually assessed care needs.

Tele health was in operation throughout the community services to assist people with their independence, self care and reduce the need for hospital admissions. There was good evidence to demonstrate multidisciplinary team working was effective when providing patients with care and treatment.

Evidence based care and treatment

- Care and treatment was evidence based and staff accessed up-to-date information regarding good practice recommendations. Examples of this were the guidelines produced by the speech and language therapists (SALT) for the use of thickened fluids and the re-ablement care and treatment provided by the SALT and physiotherapists for patients with motor neurone disease. The majority of staff with whom we spoke across the district nursing teams were able to tell us about the clinical guidelines and National Institute for Health and Care Excellence (NICE) guidance which helped to inform their practice. For example, staff were familiar with the wound management formulary. However, a small number of staff appeared unfamiliar with evidence based practice guidance but were able to use the required assessment tools in their daily practice.
- The therapy teams attended county-wide therapy meetings which provided opportunities for staff to update on new practices and evidence based care. All staff agreed that team meetings provided them with detail regarding new guidance or information from the provider, specialist nurses and link nurses. Staff told us learning from training courses was shared at team meetings to ensure they were kept up to date with practice and service developments. This supported their Continuing Professional Development requirements (CPD) and was in line with the Knowledge and Skills Framework which was in place for each of their roles.
- The Acute Care at Home team told us they used established pathways when caring for patients, for example, when caring and providing treatment for patients with cellulitis and urinary tract infections. These provided the staff with guidance on the treatments and care required for the patients.
- The tissue viability team were planning to launch an updated skin pathway in April 2015 which would be aimed at all community staff.
- The community based falls team worked in line with NICE guidance on the assessment and prevention of falls in older people.
- We were informed by physiotherapists, that while specialist respiratory physiotherapists provided a service to patients, they had not completed training as recommended by NICE guidance.

Pain relief

- We saw evidence across district nursing and therapy teams of patients' pain being managed effectively through the use of a pain assessment tool.
- Patients were supported and/or enabled to take their pain relief prior to treatment and care being delivered. For example, we saw district nursing visits scheduled to coincide with the patient taking their pain relief. Another patient had extensive dressings that were painful. An assessment of their pain was undertaken by the district nurse. Analgesia was administered by the nurse at least 20 minutes prior to the dressing change and a record of the pain score was documented and regular analgesia was given as required.
- One patient told us their pain was well controlled and the community staff monitored it with them. Another patient commented "The nurses always manage my pain really well and I know I can trust them when they are doing my dressings". The patient also said "If my pain becomes unbearable at any time I call the

palliative care nurse who either comes to see me or tells me what tablets to take. I am very well cared for and know that my pain will always be managed by my care team".

Nutrition and hydration

- Patients' nutrition and hydration needs were assessed in line with their clinical condition and were recorded on their care records. We saw evidence of where the Malnutrition Universal Screening Tool (MUST) had been completed for people at risk. For example, one person was continuing to lose weight, despite eating a healthy diet. This was being monitored by the district nurse and the person's carer. A full blood screen had been undertaken and a joint visit was planned with the GP. A referral to the dietetic service would be made following the outcome of the GP's visit.

Use of technology and telemedicine

- Tele health was in use throughout the region. This was where a number of patients with long term health conditions could monitor their own health at home. Patients sent in details of certain vital signs at set periods of time, dependent on their illness, to a monitoring centre via a telephone line. If a deterioration in their condition had taken place, the monitoring centre contacted the patient's relevant healthcare professional. Patients using this were able to commence treatment quicker and prevent hospital admission. The provider monitored the use of tele health activity and from records provided we found that from September 2013 to October 2014 the number of patients using this had increased by 28 to a total of 69 patients.
- Tele heath was used on the Isles of Scilly for a number of patients. This had been particularly positive for patients who lived on the "off islands" which had previously meant a boat journey to the hospital to see the medical/nursing staff. The matron from the Isles of Scilly shared with us the positive effects demonstrated for one person who since using tele health had required no admissions to hospital, whereas previously they had experienced frequent admissions. Staff on the Isles of Scilly had set up a working group to work towards the implementation of telemedicine. They were currently working with medical staff in the acute trust in Cornwall to move this forward.
- Another community matron gave us an example of the positive experience/use of tele health for one patient. This demonstrated they were able to stay in their home longer, rather than be admitted to a care home.
- Positive comments were made by patients and/or their relatives regarding how tele health assisted them to manage their own health conditions and treatment. One person said "My relative has repeated urinary tract infections which is very worrying for her and makes her feel very unwell. The use of tele health has enabled me to monitor her urine every day which has helped to minimise the effects of further infections. I have access to support from the tele health team if I need it and it has been a wonderful service and has helped to keep my relative at home".
- However there were some concerns raised about the tele health service. One person commented on the unreliability of the machine provided to them and said they had to wait three weeks for their machine to be repaired. Staff confirmed the reliability of equipment had been an issue for more than one person since the introduction of Tele health.
- Another person had experienced poor communication from the tele health staff and added that staff did not communicate effectively with each other regarding their results.

Approach to monitoring quality and people's outcomes

- The district nursing teams audited the percentage of patients seen within 0-5 working days and found that the target of 90% of all patients had been exceeded.
- Infection prevention and control audits had been carried out on a monthly basis and showed patients were provided with good standards of care which promoted infection control. An audit of MRSA (Methicillin resistant Staphylococcus aureus) screening of patients at the point of referral showed no patients had gone on to contract the infection following commencement of care and treatment. MRSA is a type of bacterial infection that can be contracted when receiving health care and is resistant to a number of widely used antibiotics.
- A community matron told us how the heart failure and chronic obstructive pulmonary disease NICE guidance was being used to stabilise a patient's condition and support them to remain at home which was their preferred choice. One patient informed us "If I didn't

have (community matron) and other staff visiting I would have been in hospital much more". This meant the outcome for this person was positive in that their wishes were respected.

- The district nurses were using a frailty tool which enabled the frail elderly to be continually assessed. We observed how a patient's medical condition had deteriorated and they were experiencing more frequent falls. The care team had used the falls pathway to assess the level of risk and had made reasonable adjustments to enable the patient to remain in their own home safely as they wished to do.

Competent staff

- A number of staff we spoke with identified training they had attended or were booked to attend that was additional to the mandatory training provided. For example, the nurse for the Health for the Homeless service had identified a need for training in caring for patients with autism and had been supported by their manager to attend a suitable course. The physiotherapy teams were able to provide additional services by staff who had been trained in acupuncture and were registered with the association of acupuncturists following their training. The Acute Care at Home team had received training in advanced nursing skills specific for their roles, for example, cannulation and respiratory assessments.
- The district nurses we spoke with said they were were supported to develop their skills and knowledge by requesting and attending training which was additional to the mandatory programme. There was a conflict with the practicalities of attending training as they were required to ensure colleagues covered their shifts whilst away. We were told this had sometimes impacted on their ability to attend training if no staff had been available to cover.
- The provider ensured staff had access to relevant update and clinical training from two clinical facilitators who worked throughout the county. Staff were positive about these members of staff and said they were approachable, supportive and always provided a prompt response. Staff were also encouraged and enabled to keep their skills and competencies up-to-date by spending time working with appropriate practitioners. For example, the Health for Homeless nurse ensured their competencies for carrying out cervical smears were up-to-date by working with a practice nurse on a regular basis.
- Staff on the Isles of Scilly relied on e-learning for much of their training, with face to face training provided on the mainland. Staff had identified link roles and attended link meetings when possible and cascaded information to their colleagues.
- Peer support was taking place in all disciplines. For example, the community matrons shadowed each other two days per year and reviewed each other's caseloads to ensure best practice.
- Electronic records were in place which demonstrated a system of annual appraisal for all staff was in place and up-to-date. Some staff said the appraisal system was about "tick boxes" and not useful for experienced staff. Other staff told us the system was beneficial for their learning.
- Arrangements for appropriate clinical supervision for clinical staff were in place. For example, the community matrons were supported monthly by the community geriatrician. Staff views on the appraisal system varied. The community therapy staff told us they had supervision sessions every six weeks with their line managers. All the therapy staff we spoke with were positive about these sessions.

Multi-disciplinary working and coordination of care pathways

- Throughout our inspection of the community services for adults, we saw excellent examples of multi-disciplinary team (MDT) working, both within internal teams of professionals and working with professionals from outside of the organisation.
- The Health for the Homeless service worked closely with voluntary organisations, GPs and the acute mental health trusts to provide support to patients and ensure they received healthcare appropriate to their needs. The nurse also liaised with other providers of health and social care services for the homeless within the south west region to ensure consistency and continuity of services when patients moved between areas.
- The community matrons and district nurses worked closely together and reviewed caseloads to ensure all patients were seen by the appropriate staff teams and supported each other with patient visits as necessary. When patients required the support of additional

professionals, the community nursing teams arranged joint visits whenever possible, to reduce the number of visits experienced by the patients. For example, when working with the Acute Care at Home team, tissue viability nurses, diabetes specialist nurse and GPs.

- We observed the district nurses liaising with other professionals, including a social care provider, about a patient's needs. The social care provider told us they always had excellent communication with this district nursing team and community matron, who always visited when they said they would and could be contacted for advice at any time. Individual district nurses were linked to care homes and a communication book was in use in each care home. We saw this used effectively during one of our visits with the district nursing team.
- The Early Intervention Service (EIS) was a fully integrated health and social care team comprising nursing and therapy staff employed by the provider, in addition to social care workers provided by Cornwall Council. The EIS supported people to remain in their homes and prevent hospital admission. The service demonstrated outstanding MDT working both within the team and providing support throughout other services provided by the organisation. For example, they assisted with discharge planning for patients from the community hospitals and patients waiting to be admitted to the community hospitals from the acute trust.
- We spoke with the dedicated falls team. There was detailed criteria in place for referral to this team and it was shared with all professionals. Patients were invited to attend a clinic appointment but home visits were possible.

Referral, transfer, discharge and transition

- The Acute Care at Team received referrals from local hospitals and GPs by telephone and/or electronic communication. Following receipt of a referral, two senior members of staff visited the patient and assessed their care needs to ensure they met the criteria of the service. The team were able to refuse referrals if they did not meet their criteria. The purpose of the Acute Care at Home team was to prevent hospital admissions. Patients were discharged, to other services if required, once the 'acute' phase of their illness had passed.
- Referrals to the musculoskeletal therapy service were received by telephone, email or GP letter. All referrals were triaged daily by the lead physiotherapist. Urgent referrals were seen within one week. People who needed care or treatment sooner were seen within two weeks and the remaining referrals were put onto a waiting list.
- Where patients required a referral to a specialist service the district nurses used the provider's electronic recording system make the referral. We saw evidence of referrals made to the tissue viability service, the learning disabilities nurse or the dementia service lead for the organisation.
- We saw evidence of joint discharge planning with the district nurses and community hospital detailed in patients' care records. Team leaders told us they would start planning the person's discharge following their admission to hospital and attended the multidisciplinary meetings in the community hospitals. This was to aid the smooth transition from secondary to primary care settings.

Availability of information

- Staff were able to share information with colleagues from different specialties through the use of the provider's electronic system. Staff told us this had benefitted their working practices in that they were able to access more detailed information regarding patient care and treatment than had previously been available to them. There had been issues with the reliability and usability of this system when first implemented. The provider had recognised this and amendments to the system had been made and staff supported to use the system.

A daily conference call which focused on patient needs following discharge was attended by a number of staff across the organisation, for example, locality managers, hospitals managers, EIS, community matrons and district nurse team managers. Managers from the Council's Adult Social Care also attended this meeting to assist in patients' coordinated discharge plans.

- Records in use by community based staff were completed in different formats dependent on their role. For example, there were two electronic systems in use. The district nursing teams used the provider's computerised patient record management system which had been implemented in May 2014. Improvements had been made to the usability of the system since then and the next update with enhanced

care planning tools was planned for February 2015. The EIS used the Council's electronic system as the staff were part of an integrated health and social care team. It had been decided to use the Council's recording system as the EIS teams were set up prior to the implementation of the health electronic recording system. Some staff had access to both health and Council electronic records, while others did not. Therefore, staff relied on effective communication but were concerned that some information may be missed. One district nursing team told us how beneficial the provider's electronic system had been in supporting referrals across the multidisciplinary team as clinical professionals were able to review all the information held about their patients.

- An issue regarding incomplete electronic documentation was included on the corporate risk register. An action had been identified and improvements made to the electronic system to assist with this issue and reduce the amount of templates on the electronic system.
- There were mixed views amongst staff in relation to the electronic recording system. We were consistently told that the IT department had made adjustments to the system to improve its use for staff, although it was acknowledged there were further improvements to be made.
- Training for the electronic recording system had been provided to staff prior to its implementation. 'Bite size' training provided by 'super users' through one to one support was ongoing to ensure staff were aware of how records were to be completed appropriately.
- No risk assessments or care plans were stored in the homes of a number patients we visited as these were now on the provider's computer system. Basic and key information was left in the home by district nurses following an initial visit for future staff and other teams or organisations to refer to.
- We saw records relating to the falls clinic. Staff told us a copy of the records was held in the patients' home so they could share it with other professionals. These records contained medical details, assessment of their risk of falls and the proposed plan. We saw documented in these the views and wishes of the patient.
- One patient told us they had liked having their notes in their home and they expressed concern that communication between staff did not seem as effective now that their paper records had been removed. Another patient said they did not like their information being stored on a computer. One staff member told us they updated the records in their car or at the office to avoid worrying patients. However, patients were required to sign a consent form to agree to staff maintaining their records on an electronic system. Other patients we spoke with did not raise any concerns with the system.
- Patients who were cared for or discharged to the Isles of Scilly had paper records. We were told the Isles of Scilly was not linked to the provider's electronic recording system. This may have reduced the effectiveness of communicating full information regarding the patient's condition and treatment to staff on the Island.
- During three visits with therapy staff and the EIS to patients in their own homes we observed they did not leave any records detailing the care and treatment in the house for other professionals to access. This meant staff attending the patient may not have been aware of any involvement of these teams and the care and treatment delivered. The EIS electronic records were made on Cornwall Council's electronic recording system so not all staff employed by the provider were able to review these records. We also saw that not all of these staff provided the patient with information regarding their service or contact details for future use. This meant the patient may not have been able to contact the service again if they needed to.
- Patients' notes and records were accessible to outpatient staff in community hospitals and no concerns were raised during our visits to outpatient departments.

Consent

- Through discussions with staff and inspection of records it was clear staff had an understanding of the Mental Capacity Act 2005 in that we saw mental capacity assessments had been completed where there was concern around patients' ability to make an informed decision.
- Patients were required to sign consent forms to agree to their information being stored electronically and shared between professionals. We saw evidence of these, with one copy kept in the patient's home and one in the office of the health professional. Patients who received treatment and support from the Acute Care at Home team had to consent to their treatment plan. If staff had

Good

Are Community health services for adults effective?

any concerns about the patient's ability to consent to treatment they would refer this to their GP. Written consent was obtained for certain care and treatment, for example steroid injections.

- During our visits with health professionals to patients in their own homes, we saw verbal consent was consistently sought prior to carrying out any care or treatment and when staff planned to share the patient's information with another professional. Staff demonstrated through discussions with us an understanding of when information had to be shared without the patient's consent, for example, if there were suspicions that abuse had occurred or was occurring.
- We spoke with patients regarding their experiences. One patient we spoke with in the outpatients department said "they've always asked my permission before doing anything". A patient we visited in their own home told us the district nurse had spent a long time with them planning their future care needs. The person said "The nurse talked to me about the best time for me to have my dressings changed and what help I needed with my mobility. I felt I was listened to and the nurse made sure I was happy with the arrangements we made together". Patients told us that staff were respectful to them when seeking consent and felt they were given choices in planning their care arrangements with all members of the district nursing team.

Good

Are Community health services for adults caring?

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

Summary

Patients received a kind and caring service from staff who showed empathy and understanding to those they cared for. Patients were consistently treated with respect and their dignity was promoted. Staff demonstrated patience and ensured patients fully understood their care and treatment and that they were encouraged to discuss anything they did not fully understand.

Patients we spoke with, without exception made positive comments about the staff who provided their care.

Dignity, respect and compassionate care

- All of the patients we spoke with told us the staff treated them very well. All praised the staff for the work they did. They told us the staff were compassionate and caring. We were told: "nothing is ever too much trouble", "I have known the staff for so long they are more like my friends and I look forward to their daily visit as it brightens my day" and "they go above and beyond with what they do for me. I could not ask for more".
- We observed staff interactions with people were friendly and welcoming. Where patients had built relationships with staff there was a good rapport and gentle humour between them and the staff member.
- We observed patients being cared for and treated in their own homes. We consistently saw that staff showed empathy, kindness and care towards their patients. One member of staff demonstrated real compassion and happiness that the person's condition had improved that day.
- The friends and family test (a survey providers use to seek the views of people using services) had recently been introduced to community services at the time of our inspection and no results were available at the time of our inspection. Each service sought feedback from patients regarding the quality of the service they received in different ways. The EIS had supplied patients with comment cards and an audit of returned cards showed patients had positive outcomes. The community Cardiac services had conducted a quality audit of comments received from patients up to August 2014 and positive comments were made by patients regarding the service provided to them.

Patient understanding and involvement

- During our observation of care and treatment to patients in their own homes and outpatient departments, we found patients were provided with full and detailed explanations of their planned care and treatment. Family carers, where appropriate, and care workers in a residential care home were also given detailed guidance and instruction regarding the care required.
- Patients were asked their views and given time to discuss any concerns or queries they had regarding the planned care and treatment. Staff checked the patient's understanding in a discreet manner and explained aspects of care again if required. Patients confirmed they were involved in their care, that the staff asked them for their views and that they were offered choices about their treatment. All said they were able to ask questions if they were unsure about anything.
- We reviewed patients' care records in their homes, on the provider's electronic records system and in the team offices. We noted they detailed the patient involvement in the planning of their care. One patient told us they had been involved in developing their care plan and understood what was in place for their future care management.
- We spoke with one person who told us they were the 'voice' of their relative who could not communicate verbally. They told us they were closely involved with every step of the care process and the district nursing team had involved them in the recent planning of their relative's transfer to another care setting. The relative said "I was so pleased that I knew exactly what was going to happen to my relative and that I could trust the nurses to ensure continuity of care for my relative in the new care setting".

Emotional support

- Positive comments were made by patients we spoke with regarding the warm welcome and helpful approach they received from the receptionists at Helston and Launceston Hospitals outpatient departments.
- Comments from patients regarding the physiotherapy outpatients team were positive and included "I felt listened to and my problems were addressed".

Good

Are Community health services for adults caring?

- We accompanied the community matron on their visit to a patient who had a long term health condition and who was approaching the end of their life. This patient had recently had their symptoms assessed and reviewed by the local hospice. The patient and their family member spoke with the community matron about the anxieties they were feeling about their condition. The matron provided them with advice and support and also suggested additional professional care that could be arranged for them. The patient told us they were very well supported by all the community team and they said the community matron was always contactable during her working hours.
- One patient's relative was very positive about the services received from the district nurses. They said "It can be a big emotional strain supporting someone to care for themselves when their abilities are severely limited. Without the wonderful staff I would not be able to manage at all".

Promotion of self-care

- The provision of tele health and support to patients from staff to use this system enabled people to manage their medical conditions and illness independently within their own homes. We were provided with examples where people had previously required hospital admissions for the same conditions.
- The therapy and district nursing teams consistently provided support and equipment to patients to promote self-care and independence, within their limitations. The district nursing teams identified patients' abilities and goals within their care plans. We observed a person receiving treatment from a physiotherapist in the musculoskeletal service. The person told us the physiotherapist really cared about them and was doing everything they could to ensure they were able to care for themselves. The physiotherapist had set the person clear outcome measures and would continue to re-assess the treatment effects over future visits.
- During our visits with the district nurses and community matrons we observed they encouraged patients to manage their medical condition when possible. For example, one matron was discussing with a patient how to recognise when their symptoms were changing and when to start the 'rescue' medicine they had in their home.

Good

Are Community health services for adults responsive to people's needs?

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

Summary

The service was responsive to patients' needs in that it was flexible and provided at locations convenient to them. Changes had been made to venues where clinics were held to meet the needs of people in geographically isolated areas.

Teams were located throughout the county to be able to respond promptly to patients' healthcare needs and staff worked as part of multidisciplinary teams to ensure the patients' needs were met responsively. The care delivered was holistic and individualised.

Planning and delivering services which meet people's needs

- The community teams, including district nurses, therapy staff and the Emergency Intervention Service (EIS) received referrals in a number of ways and had target times for responding to referrals. The musculoskeletal therapy service provided patients with a variety of options to access outpatient physiotherapy services. Patients were able to self-refer, attend a drop in clinic, be referred by their GP or contact Physio Direct. Physio Direct provided a telephone service that allowed people to talk to a physiotherapist for advice and guidance. One patient told us they was very grateful for the drop in service as it had avoided any wait for an appointment.
- The district nursing teams had been proactive in meeting the changing needs of patients and had piloted changes in working hours to include some members of staff working a 'late' shift. This involved members of staff starting work at lunchtime and working into the evening, thus enabling patients to receive planned and responsive evening visits. Two teams of district nurses were now working this shift pattern with other teams planning to follow. Staff in one team told us they were unable to implement the shift pattern as they did not have sufficient staff. They said this was acknowledged by the provider who planned to address the situation.
- We were provided with clear examples to demonstrate how the EIS, community rehabilitation teams, community matrons and district nursing teams worked together to ensure the most appropriate staff provided care and treatment to patients with complex needs. This meant patients were not receiving duplicate care visits and instead received individualised care and treatment. Staff were trained to carry out assessments and support colleagues in different professions. For example, district nurses were able to assess for and order mobility equipment and physiotherapists from the EIS could arrange packages of care. This meant that in many cases patients did not have to wait for a further referral to be made in order for their care needs to be met.
- Outpatient clinics were in operation around the county led by specialist nurses. These included continence, diabetes, stroke and cardiac care. Additional clinics had been set up in the more rural and isolated areas in the north and east of the county, to enable patients to attend more easily. Specialist nurses visited the Isles of Scilly to provide specialist care and treatment throughout the year and held clinics in the local hospital there. A cardiac nurse-led service was available on the Isles of Scilly each week with a support group in operation for patients to attend.
- A falls pathway was in place across all localities. Minor Injuries Units (MIUs) completed an initial falls check and referrals were provided to the community rehabilitation team through a single point of access. We saw a clear example of how this had worked positively for one patient who had attended the MIU following a fall and had been referred to the physiotherapy outpatients.
- At Falmouth Hospital the district nursing service ran a weekend dressing clinic. This operated from 10am until 12pm on both days. This was for ambulant patients who required dressing changes and meant patients did not have to wait at home for the district nurse to call.
- The musculoskeletal physiotherapy clinic at Camborne and Redruth Hospital had extended opening times on one day a week until 8pm to help patients who worked to be able to access the service.
- We found inconsistencies in the use of patient information leaflets. Some services provided information about their service and contact details to patients, for example, the EIS. Other services, such as the therapy rehabilitation team and district nursing team, did not. We saw information sheets regarding the care and treatment were provided to patients by the

musculoskeletal physiotherapist acupuncturist. Information on conditions that were able to be self-managed were provided to patients in outpatient departments by physiotherapists.

- Ongoing support was provided to patients and their relatives through support and education. This was provided by the district nurses or the relevant specialist service. For example, we found the tissue viability service encouraged and/or enabled patients to care for themselves as demonstrated in patients' care plans.
- We reviewed the risk assessments for five patients around their mobility and ability to self-care. The district nurse told us they reviewed the risk assessments regularly as people's mobility could change daily. We saw examples where appropriate equipment was in place to help people to live independently, for example, walking aids, wheelchairs and stair lifts.
- We saw information about the external agencies which patients could use was freely available and we saw examples where such support was in place, for example, the British Red Cross transport service, Age UK and social services.
- Staff told us about an equipment loans system provided by an external organisation. We visited one loans store and saw there was plentiful equipment available for community teams to access and loan to patients. An emergency store was in place for community nurses to access equipment out of hours. It only included equipment that community nurses were able carry in their cars, for example, repose mattresses and commodes. The majority of staff were positive about the loans service in operation and said it was generally effective and efficient. There had been problems on occasions with getting equipment urgently, particularly out of hours and at weekends. If dynamic pressure relieving equipment was required this could be ordered from a rental service until 10pm. It appeared the efficiency of the loans provision in emergency situations varied throughout the county. At times there were issues with the delivery of equipment as this service was only available on certain days to each area. This could mean a delay in the patient receiving their equipment. Specialist equipment was ordered specifically for individual patients and could take up to six weeks to arrive.

Equality and diversity

- Staff had access to policies and procedures to ensure equality and diversity was respected during the provision of health services to patients.
- We saw information relating to the accessibility of translation services for people whose first language was not English.
- Access for people with disabilities had been considered in all of the clinics and outpatient departments that we visited. However, we observed that the main entrance area at Bodmin Hospital was not accessible to people who used wheelchairs. This was because the volunteer staff were located behind a glass window which was too high to be accessible by people who used wheelchairs. The main entrance was accessed by an automatic opening door. Once through that door a second set of doors led into the reception area. This, however did not automatically open and therefore would be a barrier to some people with a physical disability.
- We saw that staff provided care and treatment to people who were vulnerable due to their medical condition and/or the environment in which they lived. Staff were responsive to these situations and enabled patients to make choices and decisions when safe to do so and respected those decisions.

Meeting the needs of people in vulnerable circumstance

- Information was available to staff and patients regarding advocacy services. Staff liaised and referred patients to external agencies if required for the support of independent advocates.
- The provider had implemented a training programme for staff regarding the care of patients living with dementia. Staff spoke positively of this training. Dementia care leads / dementia champions were in place in all teams across the community services. We saw evidence to support that the role of the dementia champions had been developed in areas where specific needs had been identified. For example, two members of the tissue viability team were dementia champions as a high number of patients had been identified as at risk of/or had developed pressure sores. The Isles of Scilly had also appointed a dementia champion who provided training and support for staff of all grades and roles regarding care of the people living with dementia in the community. This reduced the risk of harm to patients living in their own homes.

Good

Are Community health services for adults responsive to people's needs?

- We saw outstanding examples where community teams had supported and/ or provided care to patients in vulnerable circumstances. One patient had been discharged from hospital to their previous accommodation, as this was their wish. The accommodation had no hot water or heating. The patient refused care or support following their discharge. Staff from the community rehabilitation team supported the patient home and then sensitively visited them the day following their discharge where the patient was offered help which they willingly accepted. A package of care was arranged to support the patient. This example showed the patient's wishes were respected and support offered appropriately when the patient was deemed to be vulnerable but had the mental capacity to make their own choices.
- One district nursing team led an outstanding multidisciplinary approach to protect and care for a vulnerable family following the referral to their service of a patient with a long term medical condition. The team arranged a multidisciplinary meeting with a range of professionals who supported the family with the person's medical care, short term respite, housing issues, nutritional needs for the whole family and engagement with youth services.
- The district nursing service used a frailty tool which enabled frail elderly patients to be continually assessed. We observed how a person's medical condition had deteriorated and they were experiencing more frequent falls. The care team had used the frailty tool and the falls pathway to assess the level of risk and had made reasonable adjustments to enable the person to remain in their own home safely.

Access to the right care at the right time

- A performance monitoring report from the provider, dated November 2014, showed that services provided care and treatment to an increased number of patients compared with previous years. This had caused some increases in waiting times and targets. Such issues were being discussed by the provider in contracting meetings.
- The cardiac specialist nurses had experienced an increase in referrals and activity which meant 30.2% of patients had experienced longer waits for an assessment than the target of within two weeks of referral. Fourteen per cent of patients who required an outpatient appointment for the musculoskeletal therapy teams had experienced a delay (as per data at November 2014) and had not received an appointment within 20 working days of referral. However, the most recent data showed that currently the team was meeting its targets.
- The district nursing teams had exceeded their targets with patients being seen within zero to five working days, despite seeing an increased number of patients from previous years. The community stroke team had exceeded their target of patients being contacted within seven working days. Patients who were referred to the falls team were seen within about five working days at one of their clinics, although this may not have been the most local clinic to the patient. Patients who wished to attend their local clinic did at times experience a wait for an appointment.
- The Acute Care at Home team was able to respond to referrals on the same day and they operated the service over seven days a week from 8am until 10pm.
- Patients we spoke with had varying experiences on the timeliness of visits by staff. Patients told us they knew the day the member of staff was due to visit but not always the time. Some patients knew the time of the expected visit and received telephone calls if the member of staff was going to be late. Patients who received a visit from district nurses told us their nurses were flexible and were willing to arrange visits at a time that was convenient to the patient, for example to fit in around GP or outpatient appointments. We heard a physiotherapist ringing a patient to rearrange a time of visit with them. The patient seemed satisfied with the rearranged time and was given the opportunity to say whether it was convenient or not.
- Patients we spoke with who were attending outpatients appointments, were satisfied with the manner in which their appointment had been arranged and that they had not had to wait at the department to see the health professional.

Complaints handling (for this service) and learning from feedback

- Patients we spoke with throughout the inspection told us that they would know how to make a complaint but had not had reason to. Not all services provided patients with information on how to make a complaint. However, patients told us they felt able to complain to the staff who visited them. In the outpatients departments patients told us they would be able to

Good

Are Community health services for adults responsive to people's needs?

raise any complaints with the staff but had not had the need to do so. The EIS and Acute Care at Home team provided written information to people on how to make a complaint.

- Patients were able to leave written cards in outpatient departments with suggestions or complaints. We saw action had been taken in one outpatient clinic in response to a complaint and chair raisers had been provided.
- The provider was aware of complaints and concerns that had been reported to the Patient Advice and Liaison service or via other routes. A monitoring report showed that seven complaints had been received in from April to June 2014. Information included detail of the method of investigating complaints and the outcome of that investigation. We saw the organisation was open in its approach to investigating issues and complaints raised and was prepared to acknowledge where care delivered could have been better. This meant that issues were identified and made improvement possible. Actions that arose from complaint investigations were shared with staff to help improve the services.
- The patient experience manager had met with representatives of external agencies who supported the public to share their views of health and social care services. The purpose of these meetings was to discuss ways in which the organisations could engage with patients to capture their views of the services provided.
- Where teams provided an integrated service, such as the EIS, complaints could be made to either the health or social care provider. The complaint would be assigned to the appropriate provider to be dealt with and learning shared with the whole integrated team.

Good

Are Community health services for adults 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

Services were well led by team leaders, team managers and locality managers. There were vacancies within the senior management team and the provider was taking action to address these issues. The provider's vision and values regarding care, compassion, courage, communication, competence and commitment, were known by all staff and we observed staff demonstrated these throughout the community services.

Risk registers were held at local team level and also at provider level. Managers were aware of any risk on the register that applied to their service and the action being taken to reduce the risk.

Service vision and strategy

- Staff showed an awareness of the provider's service vision, with many staff commenting that they believed the provider put the care of patients as their priority. The provider had signed up to NHS England's three year vison and strategy, Compassion in Practice, based around six values known as the 6 C's; care, compassion, courage, communication, competence and commitment. One community rehabilitation team we spoke with said they had adopted a seventh C which was 'can do'. Staff told us they would do what was needed to ensure the patient received a person centred service which met their needs.
- Many staff throughout the inspection told us how proud they were to work for the organisation.
- Staff were able to tell us who the directors and the chief executive were and told us about team briefing sessions they had attended where directors had undertaken presentations about the organisation. Information was cascaded to staff regarding the organisation and pertinent changes through email, newsletters and monthly team briefings.

Governance, risk management and quality measurement

- Risk registers were in operation at both organisational level and locally within teams. Staff were familiar with risks that had been identified on the registers and any action that had been taken to reduce the risk. For example, prioritising patient care based on risk as identified during daily handover.
- We spoke with a district nurse manager who oversaw the running of three teams in their area. They told us about the risks they had on their risk register. These were not directly patient focused and related to the IT system and other equipment issues. Action had taken place to reduce the risks. For example, extension leads had been replaced to reduce the risk of tripping and the IT system had had amendments made to it to address the issues raised.
- The community nursing teams, in conjunction with the tissue viability nurses, had a Commissioning for Quality and Innovation (CQUIN) target in place for the reduction of all grades of pressure ulcers. A CQUIN is the payment framework which enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. All grades of pressure ulcers were documented on the provider's computer incident reporting system, and those that were assessed as a grade three or four had to be investigated. Learning from the investigation was shared with the community staff through meetings. The tissue viability nurse lead told us that they had reduced the number of grade three and four pressures ulcers from over 10 a month to about four to five per month.
- The majority of senior staff were able to describe the organisation's governance arrangements. Staff told us they participated in monthly locality meetings, for example, the community matrons meetings, district nursing forum and musculoskeletal therapy leads meetings where audits, complaints and performance issues were discussed. Minutes of these meetings were available and showed the issues discussed and actions taken.
- Team leaders used a number of tools to gather data needed to meet the organisation's governance

arrangements. Incidents, accidents and near misses were recorded and investigated using the provider's electronic system. All staff we spoke with were aware of the system and were using it effectively.

Leadership of this service

- Team leaders and managers were encouraged to attend a leadership course to support both them and their teams. Time was made available for them to attend such training courses.
- Staff were positive about the local management support available to them and told us that their line managers were accessible to teams and supportive. Team leaders told us they were part of the wider teams across community services and said there were never any difficulties in accessing support and guidance if they required it.
- There were vacancies within the organisation in relation to the district nursing team management and the support provided to the community matrons. This was due to secondment and retirement of the previous post holders. While the provider was in the process of addressing this issue, staff were not clear on the future of the posts which caused concern to them. Community matrons and district nurse leads commented this was detrimental to services in that there was no representative on the organisation's board.
- Recent restructuring had left some staff not clear about the lines of accountability and responsibility. Staff were extremely positive regarding the new interim director of operations. We were told repeatedly that this person was open, accessible, approachable and listened. Staff were concerned regarding how the person's previous role as locality manager was to be carried out. The provider told us this was being addressed.
- The Chief Executive was visible to staff in the organisation and had attended team meetings and met with staff.

Public and staff engagement

- All staff were provided with information on a weekly basis from the provider through the electronic system. The information included policy updates, issues arising from the weekly executive meeting, staff wellbeing, important updates and a news round-up. Managers were encouraged to print this out to support staff who had limited computer access. Staff teams had monthly meetings with additional meetings in place for county wide staff of the same grade and role to provide consistency across the county, for example the community matrons and district nursing leads.
- A staff 'friends and family test' had been developed which staff accessed via an online form and/or paper copy made available if requested. This had been promoted through the staff communication channels as detailed above. The result from the survey had been collated centrally with the outcomes due to be shared with staff in February 2015. We were informed by the provider that approximately 45% of the responses were from community based staff.
- The friends and family test had recently been implemented to obtain the views of patients who were in receipt of a community based health care service. No results were available at the time of our inspection.
- Individual services requested feedback from patients in different ways. Managers of teams audited feedback received. We were shown evidence from audits which identified patients had expressed positive comments regarding the services provided to them.

Innovation, improvement and sustainability

- Staff told us they were encouraged to share ideas about service improvement and spoke positively about how they were actively involved in service planning. Examples included management of on call arrangements, enhanced clinical skills training for new starters and development of new referral systems for GP referrals.
- The organisation had participated in a joint initiative that had received the Health Service Journal (HSJ) - Managing Long Term Conditions award. This project enabled the staff to work with voluntary and council workers to offer a combination of medical and non-medical support to develop a care plan which suited the person's life and helped them to maintain their health and wellbeing. This project had initially been developed in the Newquay and Penzance areas. Staff were positive about the outcomes they had witnessed and been part of.
- The Health for the Homeless service had been working with the gastrointestinal and liver department at the acute trust to arrange a clinic to be held in local communities. This was to target homeless patients who were known to be non-attenders at the clinic at the acute hospital.

Good

Are Community health services for adults well-led?

- A new training course had been developed by the organisation to assist community nursing and allied healthcare professionals identify and manage the care of deteriorating or acutely unwell patients. This was due to be piloted in February 2015.
- One team were proud of their team charter, the aim of which was to tackle attitudes and behaviour in the team. Staff told us it had been developed by the team for the team which led to a feeling of ownership.
- The tissue viability team were working on a project to make sure patients were using the correct pressure relieving equipment. This innovative project was also looking at the education of patients, staff and carers in how to manage pressure area care, rather than relying on equipment. The tissue viability lead told us that since this had started in December 2014 they had found 50 pressure relieving mattresses which were not required.
- The Truro based EIS team had received an award for outstanding team contribution under the Cornwall Council's 'Smarties' Adult Care, Health and Wellbeing Directorate Employee Awards 2014.