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

Our judgement is based on a combination of what we found when we inspected, information from our ‘Intelligent Monitoring’ system, and information given to us from people who use services, the public and other organisations. Where applicable, we have reported on each core service provided by Wye Valley NHS Trust and these are brought together to inform our overall judgement of Wye Valley NHS Trust.
## Summary of findings

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Overall summary

Overall we found that community services require improvement. Although staff understood the importance of reporting untoward incidents and were confident and willing to raise concerns, not all community teams received feedback from incidents and shared lessons learned to improve practice due to workloads pressures.

The majority of people working in community services said that they felt there were enough staff to keep people safe and meet their needs. However, some district nurse teams in the west of the county found it hard to meet demand and told us this significantly affected safe care delivery.

Support for teams with large caseloads and the protection of staff who work alone night could be improved.

Generally access to services was good and responsive to patients’ needs. There was insufficient capacity to meet patient demands at the Multiple Sclerosis and Parkinson’s disease clinics run by specialist nurses working alone. If the specialist nurse took sick or annual leave there was no service provision.

We found a high level of patient satisfaction across community services. The majority of people commented on the caring and compassionate approach of staff despite staff shortages in some teams. We saw highly motivated and committed staff who treated patients with dignity and respect.

There was good multidisciplinary and multi-agency team work in all community services.

There were examples of good team working and staff felt they were well supported by their immediate managers. But, we found the majority of staff were unaware of the trust’s objectives and values, did not feel well led or listened to and were unsure who was leading the trust.

Support for staff with annual appraisals, training development opportunities and provision of clinical supervision varied from team to team.
Summary of findings

Background to the service

Wye Valley NHS Trust formed in April 2011 by the merger of acute, community health and adult social services in Herefordshire. In September 2013 adult social services became the responsibility of Herefordshire Council. The trust provides services to 180,000 people in Herefordshire and to 40,000 people in Powys, Mid Wales. The catchment area is rural and remote. More than 80% of the people using the services live five miles or more from Hereford city or a market town.

We inspected the service because it is an example of a high risk trust and has had a rapid response review in the Autumn of 2013.

There are 20 trust-wide community services for adults provided from various different locations including community hospitals, outpatient clinics and patient’s own homes.

Seven district nursing teams based across Herefordshire care for housebound adults 24-hours-a-day, seven-days-a-week.

The occupational therapy service is part of the Multidisciplinary Neighbourhood team service. It provides advice and support to adults across the county to help patients with physical disabilities be independent and safe in their own homes.

The Gaol Street Clinic in Hereford houses both a nurse-led Multiple Sclerosis (MS) clinic and a Parkinson’s Disease (PD) service from 9am to 5pm, Monday to Friday. The nurses provide specialist advice and support for adults with MS and PD, their families and carers. This includes how to manage medication and symptoms and health promotion.

Our judgements were made across all of the community adult services visited, where differences occurred at particular sites we have highlighted them in the report.

Our inspection team

Our inspection team was led by:

Chair: Andrea Gordon, Deputy Chief Inspector (Hospitals) Care Quality Commission.

Team Leader: Tim Cooper, Head of Hospital Inspections, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: sexual health nurse; adult occupational therapist manager; district nurse manager; and community nurse.

Why we carried out this inspection

We carried out this scheduled inspection because Wye Valley NHS Trust had been identified by CQC Intelligent Monitoring as a risk; additionally, the trust was subject to a rapid response review by NHS England in autumn 2013 and so considered a high risk trust.

We inspected this core service as part of our comprehensive Wave 2 pilot community health services inspection programme.
Summary of findings

How we carried out this inspection

We visited six community services including: Multiple Sclerosis; Parkinson’s Disease; sexual and reproductive health; and dental services. We also accompanied community nurses and an occupational therapist from six teams on 12 home visits.

During our visit we held focus groups with a range of staff in adult community health services. These included district, specialist and community nurses together with allied health professionals, healthcare assistants and administrative staff. We observed how people were being cared for by visiting them in their homes, talked with carers and/or family members and reviewed personal care or treatment records of patients.

We talked to 66 staff across adult community services, which included: consultants; directors of services; doctors; specialist, district and community nurses; allied health professionals; healthcare assistants; and administrative staff.

We talked to 21 patients during the inspection, and post-inspection we conducted a telephone feedback session with 25 patients who received district nursing care.

We looked at 10 sets of patient notes that included risk assessment and care plans and a variety of team-specific and service-based documents and policies.

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 service and asked other organisations to share what they knew. We carried out announced visits on 4 and 5 June 2014. During the visit we held focus groups with a range of staff who worked within the service, such as community matrons, district nurses, nurses and healthcare assistants. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the provider say

During and post-inspection we talked to 46 patients across adult community services. The vast majority of responses were very complimentary about the staff and the care and attention they had received. Examples of comments included:

- “Excellent, very friendly, very caring.”
- Feels they are “excellent, cannot fault them, polite and professional”.
- “I have no hesitation in telling you they were very good and I feel privileged to be under their care
- “Staff are very pressurised and busy and I want to fight their corner for them.”
- “Brilliant service, made such a difference to my life.”

Good practice

Staff across community services delivered compassionate and high quality care despite staffing levels being stretched across many of the teams.

Virtual wards, hospital at home and complex discharge coordinators had been established prevent patients from needing to come into hospital and to promote timely and effective discharges.
Areas for improvement

**Action the provider MUST or SHOULD take to improve**

**Actions the provider MUST take to improve.**

- Patients who received care from adult community services were not afforded regular and sufficient opportunity to provide feedback to the trust about the care they receive.
- District nurse teams were experiencing high staff shortages due to vacancies, sickness and maternity leave. There was limited support from the trust to cover absences, and many teams were instructed to deliver essential and critical services only on a regular basis. This was having an impact on the ability to deliver a quality service for patients and does not protect the care and welfare of staff involved.

**Actions the provider SHOULD take to improve.**

- Lone worker safety was not ensured, particularly 'on call' night staff due to ineffective mobile phone systems and loss of signal with current communications provider.
- Staff across adult community services were not supported in a consistent way to engage in regular and structured clinical supervision.

- District nurses were not always supported to follow the 'on call' trust policy and take sufficient time off the day following a call out shift to ensure they are properly rested to deliver safe and effective care.
- Patient result times for sexual health services were delayed due to staffing capacity.
Wye Valley NHS Trust

Community health services for adults

Detailed findings from this inspection

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

Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

**Summary**

Safety requires improvement. There was a wide variation in safety across community services, although systems were in place to train staff to identify and report incidents. However, staff from some community services did not receive feedback from incidents as they were not always able to attend or reflect on team brief communications due to workload pressures and were not given the opportunity to share lessons learned to improve their practice.

Staffing in some district nursing teams was stretched with staff frequently only been able to deliver essential and critical services. There was no cover for the specialist single-handed services such as Multiple Sclerosis and Parkinson's Disease. The trust was aware of the risks and monitored regularly, but had not addressed the ongoing issue of increased workload pressures and reduced staffing levels for some district nursing teams.

Individual teams were aware of safe systems, processes and practices such as safeguarding alerts. We found that infection control and pressure ulcer care in the community were well managed.

**Incidents, reporting and learning**

- Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Between January 2013 and May 2014 adult community service reported no (nil) never events.
- Between April 2013 and March 2014 the trust reported 139 serious incidents of which 62 occurred in community services. Nearly two-thirds of the incidents were graded 3 and 4 pressure ulcers.
- All staff we spoke with stated that they were encouraged to report incidents and were able to access incident reporting systems. However, Leominster and Bromyard...
district nurses told us they often had too much work and not enough time to complete electronic incident reports and did not always have time to attend team meetings to learn from incidents.

- Managers told us themes from incidents were discussed at regular team staff meetings, and heads of service attended professional lead meetings to share learning from incidents.

### Cleanliness, infection control and hygiene

- There was a clear infection control policy in place. Staff talked to us in all community settings demonstrated good infection control practices such as the use of personal protective equipment and regular hand washing pre and post-patient care. Dental services also followed the trust decontamination of equipment policy.

### Maintenance of environment and equipment

- The community clinics we visited were fit for purpose to deliver care and treatment.
- Generally, equipment used by clinicians was in good supply.
- We saw Leominster district nursing team had no syringe drivers. This problem had been raised with their manager.

### Medicines

- This area was not assessed because there was no evidence available.

### Safeguarding

- There was a clear safeguarding policy in place, and staff were able to tell us who their local safeguarding lead was.
- Staff provided examples of when and how they had raised alerts. They told us they felt supported by their immediate line managers with safeguarding issues and found the safeguarding team easy to access and helpful.

### Records

- All community teams held comprehensive patient records.
- The majority of records were stored in a locked cabinet, a room in community bases or kept at patients’ own homes for instant access during care and treatment.

- Leominster district nursing team had updated some patient records at the nursing base but had not returned them to patients’ homes. Staff explained they did not have the time because of workload pressures.

### Lone and remote working

- There was a clear Lone Worker Policy and staff demonstrated they knew the principles of safe practice when working and travelling alone.
- Staff called out at night told us the trust’s mobile phones often lost signal because of the inconsistent mobile service across the county, which meant they could not be contacted and left them feeling vulnerable.
- Many staff told us they are scared when working alone because safe and well checks from the out-of-hours night service did not always happen.
- One member of staff told us they had worked a whole night shift alone, the phone lost its signal at times and no one contacted them with a safe and well check.
- Lone worker devices had been issued to some community teams in the past, but the facility had been withdrawn as the evidence did not substantiate it improved staff safety or provided any benefits.
- Staff told us they had informed management about the poor mobile signals, but were waiting for a solution to the problem.
- Managers told us the trust had decided to change mobile phone providers to rectify the poor signal problem. However, managers had not communicated the decision to all community staff and had set no implementation timetable.

### Assessing and responding to patient risk

- Community teams saw patients as soon as possible after a referral. First assessment appointments were prioritised based on individual risk and patient need.
- Risk assessments were comprehensive, individualised and provided the basis for care and treatment.
- Not all risk assessments were updated appropriately. For example, risk assessments from Leominster district nursing team for falls, manual handling and nutrition had not been updated for nearly a year instead of every three months. Staff told us this was because of staff shortages and insufficient time to review records at patients’ homes however, we saw regular and up to date risk assessments carried out by the occupational therapy team which reflected patient’s needs.
We reviewed dependency figures for each district nursing team over a six week period leading up to the inspection. We found that many teams had been instructed to deliver critical and essential services only, and had suspended routine services until dependency figures improved. We were told by Leominster district nurses that typically a district nurse sister would work within a dependency score of 12 to 14 points per day. However we saw on one day two district nurse sisters had dependency scores of 26 and 35. This meant staff were working two to three times more than what was considered as safe and manageable.

Staff told us they felt this practice was unsafe and the quality of patient care was affected. For example, visits for continence assessments, checks for pressure areas and phlebotomy had been cancelled and rescheduled. However there was no clear evidence that the outcomes for patients had been affected.

**Staffing levels and caseload**

- Staffing levels and skills mix supported safe practice in some community teams. However, we saw some services such as Leominster district nursing team, the sexual health service and specialist MS and Parkinsons’ services were stretched, and staff told us they felt “unable to cope with demand.” Staff were frequently only able to deliver essential and critical services.
- Some district nurses were managing caseloads that meant they had to start work early and finish late. They said the trust relied on their good will to meet patients’ needs, and staff regularly work over their contracted hours.
- Staff told us when they work ‘on call’ they did not always get time off the following day in line with the policy because of workload pressures. They told us they felt this practice was unsafe.
- There was limited availability of bank staff (staff who work overtime in the Trust) and no agency staff to assist district nurse teams at peak pressure times. For example, one team had three nurses absent, two of which were on long term sick leave. Staff told us they had no additional help and had to absorb the additional patient visits between them.

- District nurses at Leominster told us “we are exhausted, we have told managers but we never let the patients know”.
- Staff told us the receptionist post for the Belmont Clinic in the Vaughan Building, Hereford, had been removed 18 months ago as a result of funding cuts. We talked to staff at five services based at the building who told us there is now no one to greet vulnerable patients or help them find the right clinic. They said that without this valuable service patients often became upset and angry. We saw a temporary receptionist had been placed at reception during the inspection.

**Deprivation of Liberty safeguards**

- There was no Deprivation of Liberty safeguards alerts raised by community teams.

**Managing anticipated risks**

- The trust had systems to identify the risks that could affect the delivery of safe care. However, we found the trust did not have the resources to manage the risks created by staff shortages and vacancies, or the cover for annual and sick leave for single-handed nurse-led clinics.
- Staff shortages at Leominster, Bromyard, Kington district nursing services and the sexual health service had been identified by the trust as a risk but they had not been resolved. To monitor the risk staff levels were reported to the senior nurse manager each week. Some teams were only able to deliver essential and critical services when we analysed their dependency figures over the six week period leading up to the inspection. Routine services were suspended until capacity improved.

**Major incident awareness and training**

- Staff were aware of policies to manage immediate and long-term emergency planning and systems to escalate issues. However, community staff were not aware who the trust’s health and safety and fire officer was, or how to contact them.
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
In general we found services were meeting the needs of patients through evidence-based practice, guidance and care pathways. There was good evidence of multidisciplinary working and initiatives to support people receiving care in community clinics and at home.

Some services were measuring their performance and effectiveness, but this was not well established in all services such as district nursing and specialist services.

Evidence based care and treatment
• We found all community teams delivered evidence-based practice and followed recognised and approved national guidance. Staff understood their roles and clinicians worked within their scope of practice and in accordance with their professional governing bodies. Teams made timely referrals to external health professionals to ensure patients were seen by the right person for the right treatment.

Pain relief
• There was evidence of staff assessing patient’s pain levels particularly in district nursing, occupational therapy (OT) and dental services.
• Staff were responsive when patients described pain, and provided evidence-based advice with pain management or efficient GP referrals for further pain advice.

Nutrition and hydration
• We saw good evidence of staff assessing patient’s nutritional and hydration levels in their own homes. However, not all nutritional risk assessments had been updated in a timely way by Leominster district nursing team.

Patient outcomes and performance information
• Staff from all community services told us they do not routinely carry out patient feedback but rely on verbal feedback during care delivery and thank you cards.
• Following the inspection, a selection of district nursing patients were telephoned for feedback to measure the quality of care they received. The majority were very happy with the care and treatment provided by community services, particularly OT, district nurse, MS and Parkinson’s Disease services.
  • Each district nursing team monitored their pressure ulcer rates on a daily basis by recording how many free of reported pressure ulcers days there were.
  • The number of trust patients with new pressure ulcers fell below the England average nine months out of 12.
  • The majority of community teams did not maintain a local complaints register for their services. However we saw sexual health service maintained a local register of complaints and responded quickly both verbally and in writing to resolve issues.

Competent staff
• The trust provided a comprehensive preceptorship (a period of guidance and support for all newly qualified practitioners to make the transition from student so that they can develop their practice further) programme for all new staff, and there was good uptake of mandatory training for the majority of services.
• Competency assessment frameworks to test a clinician’s clinical competency in specific areas were in place. For example: syringe driver management; male and female catheterisation; and compression therapy. However, staff and their managers were unsure how frequently competencies should be assessed.
• Clinical supervision varied across teams. The OT service had robust clinical supervision and appraisal processes. Clinical supervision is a requirement for continued registration by all clinicians to maintain safe and effective practice.
• There was no clinical supervision available for district nursing teams across the county.

Use of equipment and facilities
• Generally, community clinics were in a good state of repair and fit for purpose to deliver care and treatment. We saw staff had a good supply of equipment.
• Leominster district nursing team had computers which were broken and were waiting repair and the base was cluttered with new and old patient notes filed on shelves and not stored appropriately.
• There was no administrative support at district nurse bases and nurses told us they carried out many administrative tasks. This meant filing and general office administration work built up because patient care took priority.
• The equipment and adaptations OT service had moved to the local authority and the service was in a transitional stage which some staff experienced problems with. We were told by clinicians and managers not all staff had been trained how to order equipment and some staff had not received their passwords. We were told there was no description of the pressure relieving qualities for items such as pressure relieving cushions and airwave mattresses.
• Staff were not always sure what equipment they had ordered, which resulted in the delivery of the wrong item and a delay in patients receiving appropriate care and treatment.
• Managers confirmed there had been a few teething problems, such as training staff how to order online, but that this was work in progress.

Telemedicine
• This area was not assessed because there was no available evidence.

Multi-disciplinary working and working with others
• There was good collaborative working across all community services. We saw referrals and communication networks between district nurses, GP’s hospital and home service. Also health and independence teams were robust and patient-centred.
• There was good evidence of interagency working with social services for care packages and with the local authority for aids and adaptations to people’s homes.

Co-ordinated integrated care pathways
• Integrated care pathways across adult community services were well established.
• Staff demonstrated a good understanding of the roles and referral criteria of internal and external health professionals to promote a seamless transition for patient care.
• Services provided from clinics held throughout the county were effective, and there was good multiprofessional staff engagement and communication of key information.
By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary
Care delivered across all community services for adults was kind and compassionate. Staff treated patients with dignity and respect, despite some teams being stretched. Patients told us that they were involved in planning their care and we saw staff responded to patients changing needs with speed and sensitivity. Staff from all services were committed to providing good quality care and many staff went the extra mile to ensure patients received the right care at the right time. This was reflected in the comments made by patients and their relatives.

Compassionate care, dignity and respect
- Care and treatment of patients across all services was empathetic and compassionate. Staff promoted and maintained the dignity of all patients when the delivered care from various community settings such as community clinics and in patient’s own homes.
- Patients told us they received excellent care particularly from the OT and district nurse services, which acted quickly to organise further appointments for patients that relieved anxiety during the visit.
- Patients’ culture, beliefs and values had been taken into account in the planning and delivery of care. Staff ensured confidentiality was maintained when providing care.
- Staff developed trusting relationships with patients and knew their care needs well.

Patient understanding and involvement
- Staff took time to explain to patients the therapeutic use of treatment planned and delivered. For example: the importance of taking prescribed medication; using aids and equipment advised by services; and keeping appointments for referrals to other agencies.
- Staff delivered person-centred care in all services and patients were involved in, and central to, all decisions made about the care and support they needed. When we observed practice and reviewed records we found robust evidence of actions taken by staff to ensure patients understood their condition, and care plans reflected their individual needs.

Emotional support
- Adult community services delivered good emotional support to patients, particularly the sexual health, Multiple Sclerosis and Parkinson’s disease services.
- Patients told us that there was effective communication from staff and that any concerns were addressed quickly and appropriately. Guidance was available for patients about a range of support services if required.
- Staff also told us that they generally felt supported and cared for by their immediate line managers. They gave informal peer support but because of capacity and staff shortages this was not structured or planned.

Promotion of self-care
- There was excellent promotion of self-care delivered by the OT service. Patients told us OTs organised delivery of aids and equipment to their homes to maximise their independence and to remain safe.
- The OT service provided telephone support between visits to encourage independence and explained the importance self-care to patients for optimum quality of life.
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**

Generally services were accessible and responsive to people’s changing and diverse needs. There were good examples of person-centred care across all adult community services and that services were adapted to meet specific needs. Effective multidisciplinary teams working, including with external partners, ensured patients were provided with care that met their needs at the right time. Overall we found effective systems that ensured patients received the care and treatment they needed in the community, despite some capacity issues of some teams.

**Service planning and delivery to meet the needs of different people**

- The trust and staff in clinical teams were aware of people’s complex health needs and services were well coordinated to meet those needs.
- Adult community services planned and coordinated care packages for patients who needed integrated teams to provide support at home. For example, we saw patients being supported by the district nurse, OT and social services.
- Staff told us that as an integrated health and social care team it facilitated setting up short and long term care packages and reduced delays in the transfer of care.

**Access to care as close to home as possible**

- The location of adult community services in Herefordshire made access across the county satisfactory.
- The dental and district nursing services provided care seven-days–a–week and the district nursing service also provided a night service from 10pm to 8am.
- One patient told us that staff had listened to their symptoms and concerns, helped them to manage their pain control effectively and worked at their pace to reach their therapy goals.
- We saw a pilot scheme where district nurses provided an ‘in-reach’ service to Leominster community hospital that facilitated early discharge for local patients. Staff said it worked well in identifying patients for discharge more effectively.

- Specialist services such as Multiple Sclerosis and Parkinson’s disease were unable to provide home visits because of capacity issues. This meant some patients had to travel across the county to attend a clinic; there was no evidence to suggest the patient had a poorer service.

**Access to the right care at the right time**

- Community services were provided in people’s home as needed and clinics and groups were established in community locations. OT staff undertook home visits.
- We saw good use of the interpreting service and language line to improve communication with ethnic groups and to minimise delays in delivering care and treatment.
- Patients told us they did not always know if the district nurse was visiting morning or afternoon. Some patients had their visits cancelled at the last minute and rescheduled because the nurse was very busy.
- The Multiple Sclerosis service supported a programme of enabling people to come together for group support in a local pub to encourage social interaction despite the difficulties of their condition.
- Patients who received sexual health services had to wait more than two weeks for staff to log patient details onto the system, which often delayed diagnosis, delayed partner notification and subsequent treatment. Staff told us this was a capacity issue.

**Flexible community services**

- Dental and sexual health services provided drop-in clinics to promote a flexible approach to care delivery.

**Meeting the needs of individuals**

- Staff in adult community services were focused on meeting the needs of patients and individualised care plans reflected this.
- We saw good evidence of patients being offered choices about care and treatment and staff actively sought best options to work around patients’ daily lives while balancing safe methods for best health outcomes.
Patients were generally very satisfied with care delivery through face-to-face feedback with clinicians. However, wider and more structured patient feedback could be improved in all community services.

District nurses told us that they felt their care was sometimes task-orientated, and individualised care was not always practised because of capacity issues.

Moving between services

Generally we found referrals between community services were timely and well managed with good communication between the disciplines involved. For example, occupational therapists (OT) and physiotherapists carried out joint assessments to reduce duplication for patients. Referrals to the local authority for key safes and pendant alarms for housebound patients were within satisfactory time scales.

The Equipment and Adaptations OT service was in the process of moving to the Local Authority and during this transition service provision was reduced. Staff were concerned about this reduction and said patient care would be affected because of long waiting times and it was not be responsive to patient needs.

Complaints handling (for this service) and learning from feedback

Patients in all locations were very satisfied with the quality of service they received and told us they felt listened to and heard.

Staff followed the trusts complaints policy and provided examples of when they would resolve concerns locally and how to escalate when required.

There was inconsistency in the way that community teams maintained a local register of complaints, and how they informed patients about raising concerns and complaints or who to contact. Information was not readily available for patients at all community clinics, nor did the patients’ notes kept at their homes contain that information. However, the sexual health and dental service managed complaints quickly and effectively.

Patient feedback questionnaires were not available in all community services and managers told us they relied on thank you cards, staff feedback and informal telephone contact to find out patients’ views about the quality of care provided.

All staff we talked to told us this was an area for improvement.
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 in general were not well led and effective decision-making and strategic planning required improvement. The board and senior managers had oversight of the reported risks in adult community teams. There were risk management systems in place and staff had a clear oversight of risks to quality in the organisation. However, there were concerns about how the trust would manage identified risks now and in the future.

Staff engaged well with patients, but regular and structured patient feedback was not service specific or fully incorporated into service design and delivery. Staff felt generally well supported and valued by their immediate line managers. However, staff did not feel listened to by senior managers (band 8 and above) or supported in their roles to provide a quality service. There were some examples of innovation and improvements in practice, however, generally staff felt challenged to deliver both, balancing demand and capacity.

Vision and strategy for this service
- There was a vision for the organisation, trust values and corporate objectives. However, the majority of staff in adult community services were not aware of them.
- The trust had very recently completed a restructure of its executive board arrangements and set out a two-year plan for 2014/2015. Six strategic themes were identified, one of which was to fund community services appropriately to meet patient needs.
- To improve quality and accessibility across the county senior managers told us the trust had ongoing discussions with Herefordshire Clinical Commissioning Group in its review of all of services, including adult community services.
- According to the two-year strategic plan this included agreed joint-working on the redesign of community services, focusing less on community-based institutions and more on peripatetic services and the use of telemedicine.

- Staff were unsure of the future due to many service redesigns and wanted to be more involved in shaping and influencing the future of care, something which many staff told us had not happened in the past.
- Staff responsible for care delivery felt more work was required to redesign their service to meet the needs of local people and that effective liaison with commissioners was needed.
- Staff told us there were good reporting mechanisms in place to contribute to practice improvement, but they also told us communication from senior managers (Band 8 and above) was inconsistent.

Guidance, risk management and quality measurement
- We found generally that adult community services had satisfactory processes in place for carrying out clinical audits. This was particularly evident with district nursing services, which took part in the monthly safety thermometer campaign to measure and reduce harm to patients at risk of falls, pressure ulcers and catheter-acquired urinary tract infections.
- Managers told us that regular documentation audits were conducted to analyse the quality of recorded information in community services.
- Adult community services maintained a risk register that then fed into the corporate register so that the board had oversight of the main areas of risk for the service.

Leadership of this service
- We found there were inconsistencies with effective leadership across adult community services.
- Staff from occupational therapy and the dental service felt they were well led with robust management support systems in place. However, staff from the sexual health service, Multiple Sclerosis service, Parkinsons’ service, Leominster, Ledbury and Kington district nursing teams told us they felt senior managers did not listen to them and did not fully understand their daily challenges.
- There was inconsistency in how much funding and protected time was provided for staff to access courses. Some staff told us it was a balance between meeting the
demands of the service and current capacity. Not all requests had been granted, particularly when services experienced long term absences due to maternity leave, sickness and vacancies.

- We were told by managers and staff that monthly meetings between adult community services took place to promote effective two-way communication of information across the trust. Staff told us it was not always possible to attend meetings due to workload. Some staff felt unable to discuss issues because of a lack of opportunity and their issues went unheard.
- Staff told us their immediate line managers were visible, accessible and approachable.
- We saw board members had recently aligned themselves to a specific service and visited staff bases to improve board visibility and improve communication networks. Each service had details of their respective board member and date of the next visit displayed at their base.

Culture within this service

- In general we found the culture of care delivered by staff across all adult community services was dedicated and compassionate, despite the majority of staff feeling despondent. We found staff were hard working, caring and committed to the care and treatment they provided. Staff spoke with passion about their work and conveyed how dedicated they were in what they did.
- During one-to-one staff interviews and focus groups we heard that staff morale was low, and this was supported in the NHS Staff Survey carried out by the trust. Staff told us the trust’s ongoing negotiations with commissioners about the type of services to be delivered left them feeling uncertain about future service design and direction of travel.
- Some staff reported positive job satisfaction. However, we found this to be the minority.
- We found that saw staff sickness rates across the trust were 3.9%, below the national average of 4.1%. However, nurse sickness rates at 4.7% were higher than the national average of 4.0%.

Public and staff engagement

- We found inconsistency in how services obtained patient feedback. For example, some community teams such as the sexual health clinic engaged in effective satisfaction surveys, but other services that carried out home visits did not.
- There was an inconsistency across services about giving patients information and details about how to raise concerns or complaints. Some community clinics displayed information in communal areas. However, we found limited information available to patients who received home visits because many patients’ notes contained no information.
- Comments cards were not available in languages other than English in the majority of community clinics, so full engagement with all people in the local community may not have been achieved.
- Some patients told us they would not know how to make a complaint but would speak to the person providing the care if there was a problem. One patient told us they had to complain about the care a nurse provided but had no information available so they contacted the GP instead.
- The results of the 2013 NHS Staff Survey revealed a high percentage of staff worked extra hours to meet patients’ needs, and communication with senior management and professional development opportunities was worse than the expected (within bottom 20% of acute trusts nationally).
- Despite this, staff told us that with good local peer support, effective team-working and knowing their care made a positive difference to patients was what they came to work for. The staff survey reflected this and demonstrated these areas were considered better than expected.

Innovation, improvement and sustainability

- Senior managers encouraged innovation and improvements in practice in some teams. For example, the district nurse services conducted ‘leg clubs’ to promote teaching and education for patients to self-care and reduce the risk of further skin problems.
- The trust had piloted a virtual ward that enabled people to remain in their homes while receiving multiprofessional care to improve health outcomes and avoid hospital admission.
The trust had created new band 4 assistance practitioner roles to support district nurse teams. This meant the staff promoted to that role could administer insulin to people with stable diabetes, provide complex wound care and routine re-catheterisation. Staff recruited to these roles told us it was an excellent professional development opportunity and provided extra support to their teams in workload delegation. However, other staff told us there was little opportunity for progression, particularly in teams with high absence rates.

The opportunity for clinical excellence to flourish across all adult community services depended on individual team’s workload. Many staff we talked to reported their focus was purely on delivering patient care.

We talked to one student district nurse who told us they were supernumerary until they completed their degree in August 2014. They had extra capacity and were able to review the district nurse caseload and discharge a number of patients who no longer required visits.
## Compliance actions

### Action we have told the provider to take

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

<table>
<thead>
<tr>
<th>Regulated activity</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>To safeguard the health, safety and welfare of the people who use service user the provider did not take appropriate steps to ensure that at all times there were sufficient numbers of staff within the district nursing service.</td>
</tr>
<tr>
<td></td>
<td>Regulation 22 HSCA 2008.</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>The provider did not make suitable arrangements to protect staff engaged in lone worker activity, particularly at night and supply reliable communication devices that were fit for purpose.</td>
</tr>
<tr>
<td></td>
<td>Regulation 16 (1) (a) HSCA 2008.</td>
</tr>
<tr>
<td>Treatment of disease, disorder or injury</td>
<td>The provider did not protect the service user against inappropriate or unsafe care and treatment by means of implementing effective operations of systems. To include a regular assessment and monitoring of the quality of care delivered by adult community services. To regularly seek the views of service users receiving care from adult community services to enable the provider an informed view in relation to the standard of care and treatment.</td>
</tr>
<tr>
<td></td>
<td>Regulation 10 (1) (a) (2) (b) (i) (e) HSCA 2008.</td>
</tr>
</tbody>
</table>
Compliance actions

Treatment of disease, disorder or injury

The provider did not have suitable arrangements in place to ensure all clinical staff in adult community services were supported with regular clinical supervision and safeguarded high standards of care that created an environment in which clinical excellence can flourish.

Regulation 23 (1) (a) (3) (b) HSCA 2008.