

South Tees Hospitals NHS Foundation Trust

RTR

Community health services for adults

Quality Report

CQC Registered Location

Location ID

One Life Centre

The James Cook University Hospital

Langbaugh House

Tel: 01642 850850

Website: www.southtees.nhs.uk

CQC

RTR15

RTRAT

RTR40

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This report describes our judgement of the quality of care provided within this core service by South Tees Hospitals NHS Foundation 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 South Tees Hospitals NHS Foundation Trust and these are brought together to inform our overall judgement of South Tees Hospitals NHS Foundation Trust

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?

Outstanding



Are Community health services for adults responsive?

Good



Are Community health services for adults well-led?

Good



Summary of findings

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Summary of findings

Overall summary

Overall rating for this core service Good

Overall we judged community health services for adults were good. Incidents were reported across teams and learning was identified. The safeguarding policy was understood by staff and used as part of their practice. Equipment was used safely. The service had infection prevention and control policies in place. The service had a lone working policy in place and implemented procedures to reduce the risks to staff working alone.

The service regularly undertook a range of audits to improve performance and support safety. Clinical governance meetings were held monthly and performance of community services was reviewed using a performance score card. Community services had carried out a number of recent patient satisfaction surveys, with positive results. Several examples of new and emerging innovative practice were observed.

Staff understood their individual roles and responsibilities in the delivery of evidence based care. A recognised assessment tool was used for the review of patients with pain symptoms and nutrition and hydration assessments were completed. Staff appeared very competent in their contact with and treatment of patients. Multi-disciplinary working and joint arrangements worked well. Community nursing teams worked closely with GP practices and with social services.

Patients and their relatives were treated with dignity, respect and compassion. Staff respected patient confidentiality in discussions with patients and their relatives and in written records or other communications. Staff demonstrated good communication skills and were aware of the emotional aspects of care. Advice about self-care was available and we found some outstanding practice. Patients we spoke with were very positive about the care and treatment they received.

Staff were aware of complaints that patients had raised about their service area and of what was done to resolve the complaint. Action to be undertaken following the investigation of a complaint was identified, the action

proposed was discussed with the patient and the completion of actions was monitored. Staff could describe how services had changed as a result of action taken.

The service responded to identified risks and maintained a risk register. The service managed foreseeable risks and planned for changes in demand due to seasonal fluctuations. The service had contingency plans in place to respond to major incidents. Some staff were unaware of how the trust's risk management policy related to their area of work and felt the risk register was not readily accessible.

Staffing levels were sufficient in most areas. However, in some community locations staffing levels including cover arrangements required review to ensure adequate staffing arrangements for community nursing teams so that patients were not placed at risk.

Staff working in rural locations required consistent access to e-learning and face-to-face training based in the community and relevant to their area of work. In some rural locations, community matrons and community nurses could not share electronic patient records and experienced connectivity issues.

Patients could access community health services promptly. Discharge liaison arrangements between the acute hospital and community settings required some development. Training for clinical staff in caring for patients living with dementia required further development.

Staff felt there was clear leadership at executive level and the executive team were approachable. The senior management team for community services provided leadership although it was not always visible to staff. Managers and team leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was mainly effective and staff said their direct line managers were supportive although we also encountered some exceptions.

Managers and staff told us they felt there was a clear vision for the community services and a strategy of improvement and changes to services delivery.

Summary of findings

Background to the service

Community services for adults with long term conditions were part of the South Tees Hospitals NHS Foundation Trust. The trust runs The James Cook University Hospital in Middlesbrough and the Friarage Hospital in Northallerton, providing district general hospital services for the local population as well as delivering community services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland. The Trust also provides a range of specialist regional services to 1.5million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria. The Trust employ approximately 9,000 staff and have a purpose-built academic centre with medical students and nursing and midwifery students undertaking their clinical placements on site.

Community services were aligned with clinical commissioning groups and the operational organisation of services followed a restructure in September 2014. Services operated from seven centres, which were aligned with acute medical wards.

The Integrated Medical Care Centre operated within three service groups which delivered community nursing services at locality level across the trust area covering Middlesbrough, Redcar, Cleveland, Richmondshire and Hambleton. The service operated from a number of community locations, including community hospitals and primary care centres.

Community nursing services also operated through virtual wards in Richmondshire and Hambleton. Intermediate care was delivered through a rapid response and out of hours service in Middlesbrough, Redcar, and Cleveland and in Richmondshire and Hambleton, through a fast response service. Within service groups, localities were divided into community nursing teams which were aligned with GP practices, or groups of practices. In Middlesbrough, three teams of district nurses operated from one location. In Redcar and Cleveland, three teams of district nurses operated from three locations. The out of hours service covered the area for the six community teams. Community matrons and specialist services outreach teams also operated within the service group structure.

Deprivation in South Tees is higher than average, with some areas of considerable deprivation on a par with the most deprived areas of the country. Significant numbers of children live in poverty, with more than one in four children in Redcar and Cleveland and one in three children in Middlesbrough living in poverty (over 18,000 children across South Tees). There is substantial variation in life expectancy between the most and least deprived areas of South Tees (12.5 years lower for men and 8.5 years lower for women in Redcar and Cleveland; 14 years lower for men and 9.3 years lower for women in Middlesbrough).

Our inspection team

Our inspection team was led by:

Chair: Sandra Christie, Director of Nursing, Wirral Community NHS Trust

Team Leader: Julie Walton, Head of Hospital Inspection, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: doctors, nurses, therapists, a school nurse, a health visitor, district nurses, community matrons, a GP and experts by experience (people who had used a service or the carer of someone using a service).

Why we carried out this inspection

South Tees Hospitals NHS Foundation Trust was inspected as part of the scheduled programme of

comprehensive inspections. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

Summary of findings

How we carried out this inspection

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 held about the core service and asked other organisations to share what they knew. We analysed both trust-wide and service specific information provided by the trust and information that we requested to inform our decisions about whether the services were safe, effective, caring, responsive and well led. We carried out an announced visit from 6 to 9 December 2014.

During this inspection we met with in excess of 100 managers and staff representing a range of roles and seniority. We included qualified nursing staff, specialist nurses, allied health professionals (physiotherapists,

occupational therapists and speech and language therapists) health care support workers, team leaders and managers. Interviews were conducted on a one to one basis, in small groups of two or three staff within a service, or in group discussions arranged as focus groups.

Inspectors spoke with more than 20 patients in a number of settings. We visited clinics, and we accompanied district nurses to observe patients receiving care at home as well as to talk with patients and their relatives about their experience of the service. We contacted some patients by telephone to ask their views of care and treatment received. We also received feedback from patients who had completed comment cards.

We held a listening event on 2 December 2014 in Middlesbrough to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

What people who use the provider say

Patients we spoke with were very positive about the care and treatment they received.

We reviewed the patient satisfaction survey results for the rapid response team for November 2014 which showed a high level of patient satisfaction.

A patient satisfaction survey was carried out for the specialist skin service during 2014. The results showed a

very high level of patient satisfaction. A biannual GP patient satisfaction survey was last undertaken during 2013 for the specialist musculoskeletal service which showed patients were highly satisfied with the service.

The diabetes specialist service sought feedback routinely from patients at the end of their course of treatment. The service used an evaluation form for patients who attended the DESMOND training course. We reviewed the feedback received from patients, who consistently scored the service excellent or good.

Good practice

- Staff demonstrated a clear understanding of the Mental Capacity Act (2005), of their responsibilities under the Act and of Deprivation of Liberty Safeguards (DoLS) procedures.
- The respiratory service focused proactively on preventing admissions through meeting patient's needs and reviewing the quality and cost effectiveness of the service through audit.
- The falls and osteoporosis service received an award for its inpatient work in community hospitals. The

Summary of findings

service audited risk assessment tools twice per year using “focuses of the month” for example, lying, standing and blood pressure on admission. Education and protocols have been introduced in residential and nursing homes.

- Diabetes specialist nurses provided telephone support and advice and clinic sessions for patients with diabetes supported by a dietician. The DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) programme was

accessible to patients with diabetes or the risk of developing Type 2 diabetes to provide learning and support for the patient and the health care professionals involved with them.

- The tissue viability service participated in the chronic oedema project and leg ulcer collaborative to support prevention of these conditions. Specialist and maintenance clinics were held for patients with lymphoedema. The team leader for the service was a published writer and the service had been publicised through national conferences.

Areas for improvement

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

Action the trust **SHOULD** take to improve

- The trust should review arrangements to support adequate staffing of all community nursing teams to ensure patients are not placed at risk.
- The trust should review arrangements to support accessibility and staff understanding of the risk register.
- The trust should take steps to mitigate connectivity issues for staff working in rural locations.
- The trust should facilitate access to e-learning for staff working in rural locations.
- The trust should review training arrangements to support competencies of staff in the rapid response service and the relevance of training to community settings.

- The trust should review availability and access to information for patients whose first language is not English.
- The trust should review discharge liaison arrangements between the acute hospital and community settings.
- The trust should consider extending training for all clinical staff in caring for patients living with Dementia.
- The trust should review car parking arrangements at community locations for patients with restricted mobility.
- The trust should review guidance for referral to rapid response for the acute hospital and GP practices.
- The trust should review arrangements for clinical supervision in community nursing teams.

South Tees Hospitals NHS Foundation Trust

Community health services for adults

Detailed findings from this inspection

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

Good 

Are services safe?

By safe, we mean that people are protected from abuse

Summary

Incidents were consistently reported across teams and learning was identified from the investigation of incidents. Reporting of incidents for grade three and four pressure ulcers resulted in a reduction of these incidents. Policy relating to the duty of candour requirement was in place. The service had a safeguarding policy in place which was understood by staff and used as part of their practice. Equipment was used safely. The service had infection prevention and control policies in place. The service had a lone working policy and implemented procedures to reduce the risks to staff working alone.

The service were proactive in responding to identified risks and maintained a risk register of identified risks in community settings. A register of patients with pressure ulcers was maintained. Patient risk assessments were fully completed. The service managed foreseeable risks and planned for changes in demand due to seasonal fluctuations including disruptions to the service due to

adverse weather. A list of vulnerable, at-risk patients was updated monthly for the service's winter plan. The service had contingency plans in place to respond to major incidents.

Staffing levels were sufficient in most areas. However, in some community locations staffing levels including cover arrangements required review to ensure adequate staffing arrangements for community nursing teams so that patients were not placed at risk.

Staff working in rural locations required consistent access to e-learning as well as face-to-face training based in the community. Training for community teams needed to be relevant to their area of work, rather than hospital focused.

In some rural locations, community matrons and community nurses could not share electronic patient records and connectivity issues were experienced by staff working. Within patient's records, risk assessments were fully completed and information was up to date.

Detailed findings

Incident reporting, learning and improvement

- Between October 2013 and September 2014 the trust reported a total of 91 serious incidents in community hospitals or other settings in the community, including in patients' homes. The majority of these (85) were grade three pressure ulcers, 29 of which were reported by the community nursing team, and a further 27 by community services for people with long term conditions.
- The service identified and reported the incidence of pressure ulcers, including those occurring in the community, as an area to improve. The trust had achieved a 7% reduction in the incidence of pressure ulcers overall and a 25% reduction in grade three and four pressure ulcers.
- The service reported incidents using an electronic incident reporting system widely used in the NHS. We found incidents were consistently reported across teams and staff used the reporting system appropriately to record and report incidents.
- Staff in a focus group explained that they found the incident reporting system accessible, and all grades of staff were encouraged to report incidents. If feedback was required this could be selected on the incident form. Staff reported an open culture of reporting incidents, which ensured that any issues were escalated and learning was identified. Clinical leads gave feedback following investigations.
- We reviewed a sample of investigation reports submitted by the service. Root cause analysis (RCA) was undertaken as part of the investigation of incidents. The RCA's identified lessons learned, an action plan was developed and arrangements were made for sharing learning. We found RCA's were undertaken for pressure sores of grade three and above.
- We found evidence of staff learning from the investigation of incidents which had resulted in change of practice. For example, staff described an incident involving phlebotomy where the visit was not shown as completed in records so that visits to patients were reallocated to other staff the next day, resulting in bloods being taken twice. Learning from incidents was discussed in staff team meetings and learning was supported. A standard agenda was used for team meetings so that messages were shared between teams.

Team leaders also reviewed learning to identify immediate actions to take. Learning was disseminated for use in clinical supervision and reported to governance meetings.

- Learning was supported by sharing the results of the pressure ulcer audit and dissemination to staff. A pressure ulcer register was used and a pressure ulcer strategy group meeting was held monthly.
- Safety alerts were reviewed for their relevance by clinical leads and identified those which required dissemination to staff. Alerts relevant to the service were displayed on staff notice boards.

Duty of Candour

- In November 2014 the duty of candour statutory requirement was introduced and applied to all NHS trusts. The trust had in place a policy relating to these new requirements. Our review of the clinical governance meeting minutes for October 2014 showed a report on the duty of candour policy was presented to the meeting and a request was made for duty of candour to be included in the service group directorate meeting. We also saw that duty of candour was an agenda item for service group directorate meeting and recorded.
- The service had made arrangements to train staff in relation to duty of candour as part of mandatory training. We found some of the senior staff had already attended this training.
- Some staff we spoke with were able to explain their understanding of the requirements of duty of candour, although others were unaware of the requirement.

Safeguarding

- The service had a safeguarding policy in place which staff were able to explain and demonstrate they understood the policy and how they used this as part of their practice.
- Staff received training in safeguarding as part of their mandatory training. Safeguarding adults (level one) training was included in the corporate induction training. Staff received further training annually including update training, at a level appropriate to their area of work. For example, safeguarding adults (level two) training was attended by staff of band six and above. We reviewed evidence that compliance with mandatory training was 80% to 85%.
- Staff we spoke with could describe the different types of abuse, and how they reported and alerted potential

safeguarding issues. Safeguarding issues were reported to the safeguarding lead for further investigation. If safeguarding concerns were identified, the clinical lead was invited to attend the safeguarding strategy meeting with other members of staff involved and learning was shared with the team.

- Patients we spoke with felt safe and expressed confidence in the staff that worked with them.
- Information about safeguarding for patients in the community including contact information was displayed on staff notice boards.

Medicines management

- Medicines were observed to be prescribed, supplied, stored and administered appropriately.
- Controlled drugs were handled appropriately, with the involvement of the GP as necessary.
- Training in the administration of medicines was undertaken by appropriate staff groups. Training in prescribing was supported for staff who expressed an interest where this was appropriate to their role.
- We reviewed a selection of drug administration sheets. Patient group directions were checked for patient administration of medication. Staff were aware where medication errors had occurred, these were reported as incidents and were followed up so that learning points were identified.

Safety of equipment

- We found there were adequate stocks of equipment, and for some items of equipment, patients were offered a choice. In urgent instances, equipment could be supplied to the patient the same day. Patients were contacted by the supplying department if they were not able to deliver within timescales. A limited emergency stock of equipment was available for supplies out of hours.
- A revised system for ordering equipment had been recently introduced and staff attended training to support the ordering and use of equipment.
- Equipment was regularly cleaned, electrical tested and serviced. A database of service records of equipment was accessible on the trust's computer system. Each medical device was recorded on the medical device inventory which indicated the date it was due for service. Maintenance and procurement of replacement equipment was planned.

- Used equipment was returned to the trust's medical engineering department. Arrangements for the return of equipment presented a problem where patients may still require the equipment. To manage the non-return of some items of loan equipment, for example nebulisers and syringe drivers, the patient was asked to sign a usage agreement for 10 days only.
- We observed that resuscitation trolleys in community bases were clean and well stocked and daily checks of equipment were completed.
- Medical device alerts were displayed on staff notice boards.

Records and management

- We reviewed a sample of patient records on the computer system during our observation of patient care. Initial assessments, risk assessments, care plan reviews and consent information were fully completed. Most referrals were completed electronically. Actions taken were documented.
- Subject to the availability of a signal for connectivity, community based staff completed and updated records when they visited the patient using their laptop computer. Access to the trust's computerised records management system was difficult for some community based staff due to poor connectivity, particularly in the most rural areas.
- The computerised records management system used in most GP practices where community based staff worked was the same as the main system used in the trust, which enabled information sharing with some practices.
- Staff had mixed views about the use of the mobile computer equipment allocated to them. Some staff told us that their use of the computerised records management system was a positive experience that helped them directly with their care of patients. However, when the system or their computer equipment was not working correctly, staff needed to visit a community base to use a desktop computer to update records. This did not make effective use of their time, and risked introducing some delay in accessing aspects of care for patients.
- Staff based in one community hospital location were not connected to the main computer system in use elsewhere in the trust. As there were two systems in use which were not compatible, some staff, for example community matrons were unable to access patient records in the community nursing team and were

unable to share records with district nurses. When the computerised system was unavailable due to system problems, this presented some risk that aspects of patient care could be omitted.

- Paper versions of some records were maintained in the community bases and a minimum set of notes in the patient's home, including essential contact numbers and medication records.

Cleanliness, infection control and hygiene

- The service had infection prevention and control policies in place.
- We observed staff during home visits and clinic sessions. Staff demonstrated they had a good understanding of infection prevention and control. Medical and nursing staff we observed followed trust guidelines as to hand washing and wearing clothing bare below the elbow. Staff cleaned their hands and used hand gel prior to and after care was provided, and used gloves and aprons appropriately. Equipment was cleaned after use.
- Community locations we visited appeared visibly clean with evidence of regular adherence to cleaning schedules. The clinic environment was clean and tidy and sharps boxes were available.
- Mandatory training for staff included infection control.
- Cleaning audits were undertaken to identify risks and issues. Any lapses were identified and action taken. Hand hygiene audits were completed monthly.
- Information about infection control was displayed on staff notice boards and included guidance about correct waste disposal, hand hygiene techniques and methicillin-resistant staphylococcus aureus (MRSA) screening.
- We were informed that each team included an infection control link nurse. The link nurse's role included attending infection control meetings and providing feedback to their team.

Lone working

- The service had a lone working policy in place and implemented procedures to reduce the risks to staff working alone. The computerised patient record system included a marker (red flag) to identify addresses which were considered to represent a higher risk to staff working alone. Staff were alerted of the risk by a reminder on the first page of the patient's notes.

- Staff we spoke with felt the service's lone working procedures were good. Staff also used informal procedures, for example, within the team staff stayed in touch by mobile phone and sent a text message to colleagues to say they had reached home safely.
- Staff were issued with emergency contact devices to alert colleagues if they encountered a situation in which they were vulnerable. We reviewed the record of a recent health and safety meeting which included a report on the use of these devices, which identified that the lone worker devices were significantly under-used.
- Lone worker risk assessments were completed by local community teams and reviewed regularly. For example when an elevated risk was identified staff may decide to attend visits accompanied by a colleague.

Mandatory training

- We reviewed the trust records for training which were broken down by service and location. The information showed the percentage of mandatory training completed by type of training. Although we found records of mandatory training for some community locations were not up to date at trust level due to delays in recording, overall a very high proportion of mandatory training was completed.
- Locally maintained records for each member of staff in community locations included mandatory training attended. When we spoke with staff in community locations and reviewed their local mandatory training records, we found that training had been undertaken in most instances, or arrangements had been made to attend training. We reviewed evidence that compliance with mandatory training was 80% to 85%. We found for training which required attendance less frequently than annually, this was recorded as not completed after one year. Staff were supported to attend mandatory training within their working hours.
- Aspects of mandatory training which required remote access to a computer system (for example e-learning) was an exception to this. We found several instances where staff were unable to complete mandatory e-learning because of poor connectivity or other IT related issues.
- Staff we spoke with explained they were expected to attend the acute hospital for some parts of their mandatory training, but this was often impractical for community based staff.

Assessing and responding to patient risk

- The service maintained a risk register of identified risks in community settings. For example, where patients were assessed as presenting a higher risk to visiting staff, the address was “red flagged” on the patient record system.
- Community based staff we spoke with demonstrated a sound awareness of key risks to patients, for example, risks of pressure damage and falls.
- Depending on the risks identified, further support was arranged for the patient. For example, supply of additional equipment, or referral to further specialist assessments.
- Risk assessments were completed for each patient which included skin integrity, nutrition, falls risk, pain assessment, and activities of daily living. These assessments were completed within two visits, but staff usually ensured assessments were completed on the first visit.
- The service was proactive in responding to identified risks. Emergency treatment requests were evaluated to assess the urgency of the need. Management plans were discussed and patients whose risks represented a first priority for the team were identified. In this situation the frequency of visits for lower risk patients may be reduced.
- Senior clinical staff provided advice and a daily review of the patient waiting list took place to reassess the capacity of the team to respond to vulnerable patients with heightened risks in order to maintain safety. We observed a nursing team handover and saw that concerns were identified and escalated appropriately. Staff demonstrated confidence in being able to escalate their concerns about deteriorating patients.
- The risk of patients acquiring pressure ulcers was identified as a primary concern for community patients. Embedding pressure area prevention was seen as one of the key roles for clinical matrons. Pressure ulcers assessed as grade three severity or above were referred for investigation as a serious incident and a root cause analysis was undertaken. For falls, learning included for example, identifying the environment in which patients tended to fall so that measures could be taken to prevent falls in the future.
- A register of patients with pressure ulcers was maintained. Staff we spoke with were aware of the number of patients with pressure ulcers for which their

team had responsibility. Pressure ulcer prevention had featured as “focus of the month” for the service. A pressure prevention management plan was recently introduced. We observed information displayed on staff notice boards about risk alerts for unstageable pressure ulcers.

- The tissue viability team were also involved in providing support. Tissue viability specialist nurses facilitated training days for community based teams and provided telephone support. During the inspection an annual audit of leg ulcers for each patient was being undertaken in conjunction with the tissue viability nurse team. We saw the results of a pressure ulcer audit undertaken during 2014 and found that an action plan was prepared and action taken monitored and shared with staff across the service.
- We observed patients attending a pulmonary rehabilitation clinic. Nursing and physiotherapy staff undertook risk assessments related to the patient’s recovery from exercise. For patients with diabetes, a specialist nurse reviewed the risks for patients identified as at risk by community nursing teams. The specialist musculoskeletal service used triage protocols for community patients referred to them to assess the level of care that was appropriate.
- We reviewed the completion of patient risk assessments as part of our review of patient records. Risk assessments were fully completed and the information was up to date.

Staffing levels and caseload

- The service used an e-rostering tool to support the planning of staff workload. Staffing levels required to achieve safe staffing levels in community and specialist nursing teams reflected the skill mix of staff and miles travelled, as well as the number and needs of patients. However, staff explained there were limitations in planning staffing levels and skill mix for community teams, particularly in accommodating fluctuations in workload. A “complexity tool” to measure the complexity of caseloads was also used to provide support for planning caseloads.
- Caseload allocations were reviewed periodically to reassess the frequency and appropriateness of visits to patients with long term conditions. Some managers we spoke with felt e-rostering did not support adequately the planning of cover arrangements across teams and that gaps in cover could develop as a result. We found

senior staff mitigated the risk by asking a member of senior staff from a neighbouring team to review the roster and to allocate staff from their team to provide cover if necessary.

- Capacity compared with demand was reviewed in a commissioner's activity report prepared monthly which highlighted variances from the targeted level of activity. The year to date report for November 2014 showed, for example, that face to face contacts in the community nursing service exceeded planned activity by 3.6% (204,496 actual as against 197,107 target).
- Community staff from at least three community locations we visited identified to us that the shortage of staff in their team was a significant issue for them. Experienced staff were leaving the service and teams were carrying unfilled vacancies whilst encountering difficulties in recruiting staff to some rural areas. However, we found staffing was included in the risk register so that the impact on patient care was recognised and managed.
- During our visit inspectors received information describing staffing shortages in one district nursing team. They said the service was running at capacity and was reliant on the goodwill of staff missing breaks and working late as well as accumulating time owed, in order to meet its workload commitments to patients. This reflected our findings when we spoke with some staff.
- The rapid response service which commenced recently following a service restructure was resourced mainly by reallocating the workload commitments of existing community based staff. The service ran until 11pm.
- Some community teams were experiencing higher levels of staff sickness. We reviewed staff rosters for October and November 2014 which confirmed that almost all community teams had at least one member of staff absent due to sickness during this period, including a number on long term sick leave. Staff sickness exacerbated the situation in some teams which were already carrying staff shortages. The staffing deficits meant staff working excess hours and working extended shifts to cover work allocated to their team.
- Staff shortages were identified on the trust's risk register. Staff in a focus group stated that they did escalate issues related to staffing levels. An incident was raised in response to identified staffing shortfalls. When feedback from reporting the incident was requested, staff found this useful. However other staff we spoke with stated

they did not raise an incident in response to staffing and capacity issues. The criteria for reporting incidents related to staff shortages was not specifically defined in the incident policy.

- Arranging cover in the small and local specialist teams was often difficult in practice, particularly for the out of hours service. Identified staffing shortages were escalated to clinical leads when the revised roster was planned, which in turn were escalated to senior managers. Extra hours were offered to part time staff. The service used an NHS bank service to obtain temporary staff for other peaks in community nursing workload, subject to staff being available of the appropriate level of competence, to provide cover for day shifts but not out of hours. New bank or agency service staff were invited to shadow an experienced member of staff for one to two weeks.
- Specialist nursing teams we spoke with informed us that staffing levels were sufficient for current contact levels, although increases in referrals as well as the complexity of cases, required regular review. Increases in the referral activity for some specialist services, for example the falls service, was confirmed by our review of the commissioner's activity report.

Managing anticipated risks

- The service managed foreseeable risks and planned for changes in demand due to seasonal fluctuations including disruptions to the service due to adverse weather. We found the service was aware of emergency plans including winter plans to meet the needs of vulnerable patients in severe winter weather or heat wave conditions and during power cuts. Operational meetings for emergency planning were held monthly. Updates to the emergency plan were shared with the governance team and the manager on call maintained an action folder. Minutes of emergency planning meetings were shared with staff. Community staff we spoke with were aware of these emergency arrangements.
- A health and safety team risk assessment tool was available on the staff Intranet. Clinical leads reviewed any action to be taken and followed up any outstanding actions. Patients identified as high risk were marked on the patient record system.
- For the rapid response service, managers explained that for patients to remain at home, they must have been assessed as being safe to stay there with their existing

care package. A vulnerable patients list was maintained which included patients with electrical equipment. In the event of a power cut, staff could readily identify the patients who required a visit to provide additional support. This included, for example, oxygen users and diabetic patients. Oxygen users were already supplied with power battery backup packs with a duration of eight hours.

- Contingency planning for adverse weather was in place. The trust issued text messages to all staff to inform of deteriorating or severe weather. Emergency plans included providing for telephone access to specialist services to provide advice to patients and staff during adverse weather. Planning included using staff who may be snowbound to visit patients in the area where they lived who were within walking distance. Staff with off-

road vehicles were allocated to provide access to patients in some rural areas. A list of staff with off road / 4X4 vehicles was maintained and an independent rescue service was also used during severe weather.

- We were informed that a list of vulnerable, at-risk patients was updated monthly for the service's winter plan. The emergency plan for the trust was available on the trust Intranet. We reviewed the minutes of a locality winter planning meeting for October 2014 which showed that the vulnerable patient list was completed weekly. The record showed action was taken to ensure the list was accessible to lead members of staff on call.

Major incident awareness and training

- The service had contingency plans in place to respond to major incidents. The major incident plan included arrangements for the out of hours service.
- Operational leads for major incidents were on-call for a week at a time, which then rotated.

Are services effective?

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

Summary

The service used National Institute of Clinical Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support care and treatment for patients. Staff understood their individual roles and responsibilities in the delivery of evidence based care. A recognised assessment tool supported by national guidance was used for the review of patients with pain symptoms. Nutrition and hydration assessments were completed appropriately.

Audits of community services were undertaken to review the outcomes for patients of the care and treatment provided. Outcomes of treatment were monitored to assess the effectiveness of the service. Outcome measure reports were prepared for each service. Outcome measures which reflected realistically the prevention of hospital admissions were being developed.

Information to support staff practice and live information about patient care and treatment was available through the trust intranet, which provided an excellent source of information to support staff in their work. Patients were consented appropriately and correctly. Staff had an understanding of the Mental Capacity Act and used best practice procedures in the home settings of patients. Consent was audited annually.

Staff training and development was supported. There were some concerns raised about training arrangements to support competencies of staff in the rapid response service and the relevance of training to community settings.

Multi-disciplinary working and joint arrangements for accommodation worked well and was an advantage in supporting joined up working between community based teams. Community nursing teams had close working arrangements with GP practices and with social services in supporting care and treatment for patients in community settings. The service used multidisciplinary teamwork to support the coordination of care pathways for patients. Arrangements for recording of multi-disciplinary meetings required review.

Detailed findings

Evidence based care and treatment

- The service used National Institute of Clinical Excellence (NICE) and Royal College of Nursing (RCN) policies and best practice guidelines to support the care and treatment provided for patients. We saw evidence of references to and use of national guidelines within a number of services. Specific pathways and guidance were used for certain long term conditions which staff accessed on the trust intranet.
- For example, we found the skin care service used the World Health Organisation (WHO) surgical safety checklist when checks were carried out prior during and after surgical intervention. The respiratory service also used care plans based on the British Thoracic Society. We found the musculoskeletal service developed patient group directives (PGD's) based on national guidance for treatments including injections.
- The tissue viability service had prepared local wound formulary guidelines for wound dressing and care which reflected NICE guidance. A pressure ulcer leaflet for staff to give to patients was also based on NICE guidance. The respiratory team used local guidance which drew on NICE Chronic obstructive pulmonary disease (COPD) guidelines for pulmonary rehabilitation.
- Staff understood their individual roles and responsibilities in the delivery of evidence based care. Staff used nationally recognised assessment tools to screen patients for certain risks, and referred to relevant codes of practice, for example infection control procedures. Patient's assessments were completed using templates available on the trust's computer system which followed national guidelines for measuring harm reflected in the NHS Safety Thermometer. Skin integrity, nutrition, falls risk, pain assessment, and activities of daily living were included in assessments. Records we reviewed confirmed that assessments were completed at timely and appropriate intervals.
- We observed that when administering care and treatment and in handovers the use of pathways and guidance was followed. Staff we spoke with understood

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how NICE guidance was applied and supported local guidelines. When we observed staff administering care to patients we saw that assessment guidelines were used correctly.

- The falls and osteoporosis service followed national and international best practice in developing assessment guidance. The screening tools used by occupational therapists followed NICE guidance to measure effectiveness. A falls stage one screening tool and a stage two multi-factorial tool were used. The service adapted the “Otago” exercise programme to meet the needs of local patients by applying international evidence based practice. The programme supported patients exercising at home and in small group sessions to improve cognition and prevent falls injuries for older patients at risk of falls. The service followed NICE guidance which indicated that patients aged 75 years could access treatment directly.
- We reviewed several examples of PGD’s and other guidance used in the service to inform practice. Staff received the minutes of meetings where guidance was discussed and which included changes to practice which might affect their area of work. Audits were used in the service and informed the development of local guidance and practice.
- The tissue viability nurse team organised a trust wide away day attended by 60 staff representing each area to support the development of practice guidance.

Pain relief

- A recognised assessment tool supported by national guidance was used to support the review of patients with pain symptoms. We found care plans indicated if a review was required.
- Our observation of staff administering care and treatment and our review of patient records confirmed that patients were assessed appropriately for pain symptoms. We observed there was attention to pain during the patient examination and pain relief was offered immediately. Patients received treatment which applied pain relief effectively. Pain management plans were discussed with the patient to ascertain their pain levels and to provide advice.
- Specialist nurse teams may refer patients directly to the pain service. Community nursing staff liaised with GPs to ensure patients were taking medication as prescribed to control pain symptoms.

Nutrition and hydration

- A recognised assessment tool supported by national guidance was used to review the appropriateness of the patient’s nutrition and hydration. We observed that assessments were completed appropriately. The service monitored monthly the proportion of patients assessed for nutritional requirements at their first visit. Care plans were in place for nutrition and hydration.
- Community and specialist nursing staff referred patients to a dietician where the need for additional support and advice on appropriate treatment was required, for example for diabetic patients.
- Information leaflets about nutrition and hydration were available for patients. For high risk patients, a leaflet entitled, “Make every bite count” provided dietary advice to improve nutritional intake and help prevent weight loss. For patients at risk of pressure ulcers, a leaflet entitled, “Eating well for wound healing” was used. The service ran a nutrition and hydration week during 2014 to raise patient awareness of the importance of nutrition and hydration.
- Clinics for patients with diabetes were attended by a dietician to provide practical advice for patients about healthy food choices and to work with patient to change their eating habits.

Approach to monitoring quality and outcomes of care and treatment

- Audits of community services were undertaken to review the outcomes for patients of the care and treatment provided. Community services completed a range of audits and we reviewed the results of a selection of these and discussed the outcomes with staff. The trust’s information system provided access to data to support audit across the service. The trust provided information to the inspection team which showed that a total 26 recent audits had been completed by community services.
- The level of compliance with targets was reported for each team and action plans were prepared and monitored. Current actions were reviewed and arrangements for revisiting the audit were recorded. For example, we saw an action plan was prepared following the pressure ulcer audit. The catheter care audit reviewed whether a catheter care passport was provided for the patient on discharge. The audit showed

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that during 2014 the provision of catheter care passports had increased from zero to 100%. We were informed that the provision of passports for patients with long term conditions was in development.

- Staff in a focus group confirmed that all staff were engaged in regular audits and clinical leads provided feedback to teams. The results of audit were shared with staff which we observed displayed on staff notice boards.
- Regular audits undertaken for community services also included care plans and record keeping. A monthly audit of record keeping was undertaken by team leaders in which staff participated. Ten sets of records were reviewed for each team and the results fed back to staff. The clinical audit department produced a report of the results of audit which was distributed to each team to share learning.
- The community nursing teams undertook quarterly audits of hand hygiene, catheterisation and venepuncture. Audits were carried out for patients who were readmitted to hospital, where the community nursing service was involved in the patient's care and treatment. The essence of care audit of clinical effectiveness (following RCN guidelines) was also completed on an ongoing basis.
- For specialist nursing services, an annual audit plan was followed. The results of audit were discussed in team meetings. For example, the musculoskeletal service used a team approach for patients with knee problems and undertook a knee audit to review effectiveness. The specialist diabetes service undertook an analysis of outcome data and reviewed the results as a team at monthly meetings with the service manager.
- During our inspection the audit plans for some services were being reviewed following the recent restructure. An audit for the community matron service was currently being reviewed. Staff were meeting to consider a joint approach to audit for the Hambleton and Richmondshire, Middlesbrough, Redcar and Cleveland area teams.
- The tissue viability service participated in the management of the lower limb clinical audit in 2014. The service were also reviewing the development of a revised audit plan following the recent restructure and expansion of the service.
- Outcomes of treatment were monitored to assess the effectiveness of the service. For specialist nursing services, time from referral to treatment was monitored.

For example, the diabetes service monitored the referral to visit time achieved against the target of visiting within one month of referral. Monthly audits were undertaken to review the achievement of this target by specialist nurses. Outcome measures which reflected the prevention of hospital admissions were being developed. Staff felt that preventing admissions to hospital was often difficult to capture and was not fully reflected in outcome measures. For example, for the respiratory service, patient centred goals were set and assessed to measure the effectiveness of the outcome for the patient and the effectiveness of the service in preventing admissions to hospital.

- The cardiology specialist nursing service participated in a NICOR (National Institute for Cardiovascular Outcomes Research) national heart failure audit which assessed outcomes for patients which we were informed were good. For the skin service, the 2014 excision rates for skin lesions audit results demonstrated 99% complete excision rates which exceeded the national average when compared with other services.
- Outcome measure reports were prepared for each service. For example the community quality indicators reported the number of grade two, three and four pressure ulcers occurring within each community nursing team. The information was updated on a monthly basis.
- The rapid response nursing service used a summary of key performance indicators to monitor the outcomes of the service. Key indicators including the number of patients referred and discharged, time to assessment and length of stay were revised monthly and an exception report was prepared. We reviewed the year to date information for November 2014.

Competent staff

- Community and specialist nursing staff had received annual appraisal and staff development. For the community nursing teams we reviewed, at least 90% of staff in each team had completed their personal development review. For specialist nursing teams, personal development reviews were completed for 80% of staff. We reviewed the trust report of appraisal rates for each service and location. A high level of compliance was reported overall.
- A corporate induction was completed by staff joining the service. We were informed that from January 2015, new staff also received an induction at locality level. Staff

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new to the trust were supported through preceptorship. Work shadowing was used to develop team competencies. The trust provided inspectors with information about training events to support and enhance competencies in particular skill areas relevant to the service, for example staff attended a pressure ulcer learning event in 2014.

- Staff training and development was supported. Staff of different grades confirmed that training needs were identified as part of appraisal, and ongoing. Staff were supported to continue their education. We found the service encouraged skills development. For example, nursing staff were supported to attend training for prescribing. We spoke with staff members whom the trust had supported through further and higher education who had developed into more senior roles. Clinical shadowing was also used to advance the knowledge and skills of staff.
- Clinical matrons provided clinical supervision for staff and specialist nurses were also consulted for clinical advice. Staff in a focus group stated that clinical supervision took place across teams and for some teams, daily debriefs were held to support clinical decision making. For specialist services, individual supervision took place every four to six weeks and also regular clinical supervision with the consultant. In some community locations we visited we found the arrangements for clinical supervision were still to become embedded following the restructure. In one instance we observed a handover in which the senior member of staff offered minimal confirmation or challenge to the decisions of more junior staff.
- Staff expressed some concern as to the arrangements for training to enhance the competencies of practitioner staff to support their revised role in the rapid response service. Some aspects of training were intended for hospital settings and required development to be fully appropriate for community settings. In smaller teams, staff were not always able to be released for training when teams were short staffed. This could hinder some staff being able to achieve the required level of competency for their role. Staff told us that when the system or their computer equipment was not working correctly, they were unable to complete required e-learning.
- In some community locations, staff in specialist services shared accommodation with community matrons and district nursing staff. Staff told us they felt the joint arrangements for accommodation worked well and was an advantage in supporting joined up working between community based teams. Staff said they felt aligned with colleagues in other specialisms and part of an integrated team.
- Community nursing teams were aligned with GP practices and several community locations were shared with GP practices. The service had close working arrangements with GP practices and with social services in supporting care and treatment for patients in community settings. The service used multidisciplinary teamwork to support the coordination of care pathways for patients. For example, in the skin service, GP practitioners rotated to provide support. GP's were kept fully informed of specialist assessments for example for patients with musculoskeletal conditions. Community teams worked closely with practice nurses and specialist teams were available to provide advice. For example, a recently appointed community respiratory nurse liaised with GP practices.
- Specialist nursing staff provided support for community clinics and professional advice for community nursing colleagues to support multi-disciplinary working and the use of best practice for patients. For example, a dietician attended community clinics to provide advice for patients. When we observed visits to patients' homes we saw district nursing staff used the phone to contact specialists for advice and to arrange support for the patient. Nursing staff told us they felt well supported by other professional staff who provided multi-disciplinary support.
- Specialist clinical leads worked effectively in multi-disciplinary teams. For example, the clinical lead for the specialist musculoskeletal service worked with other specialists in orthopaedics, physiotherapists and podiatry and maintained links with occupational therapists and with the falls team. A quarterly meeting was held with radiology and rheumatology attended by consultants and included a training element. Team meetings were attended by GP's with a special interest to support case discussion.
- Clinical matrons attended a trust wide integrated workshop held monthly which included external partners, for example mental health, infection control and social services. A multi-agency approach was used

Multi-disciplinary working and coordination of care pathways

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to review support for patients with complex care needs, supported by live access to patient data. For example, specialist nurses linked with community matrons and community team nursing staff with access to GPs.

- For community nursing, multi-disciplinary team meetings could be convened to address the needs of patients with complex care needs. We reviewed two examples of meetings and actions recorded on the computer system. Multi-disciplinary, patient-centred care was evident and involved a range of specialist staff who may also be involved in joint visits to the patient. External partners included GP's, housing and social services, police, the prison service, and mental health.
- Staff in specialist services corroborated with neighbouring services to support networking opportunities to exchange ideas and benchmark the service to support improvement. For example, the lymphedema service worked closely with a local hospice who provided a similar service.

Availability of information

- Information to support staff practice and live information about patient care and treatment was available through the trust intranet, which also provided access to external internet sites. Staff felt the trust computer system provided an excellent source of information to support their work. Clear, comprehensive evidence based content was available on the website for all clinicians.
- We reviewed a sample of information on the trust intranet that staff used to support their work. The information was clear and accessible. Staff also received corporate emails with team briefings, newsletters and other updates about particular themes on a regular basis.
- We spoke with a service administrator who checked the completion of referral information in discharge documents. If information was missing, this was requested, and when the referral was seen to be correct it was assigned a traffic light code: red, if arranging to see the patient in two hours; amber, for the same day, and green for other referrals. The patient details were registered on the computer system and assigned to a community nurse according to the patient's GP practice. The allocated member of nursing staff was then tasked by the computer system and received a telephone call to confirm the arrangement.

- In community locations, information displayed in the staff area on the "KHWD" (Know how we are doing) board was up to date and relevant. "Focus of the month" and "Policy of the month" themes were used to draw attention to particular issues of current relevance to staff. A staff briefing included topical information about other services within the trust and other organisations nationally. Staff commented, however, that information seemed less inclusive of their views than previously.
- The same computer system as the trust was used in some GP surgeries, and staff had shared access, which supported the use of information across community teams. However, for staff in community teams who usually worked remotely, access to this information could be intermittent, mainly due to connectivity problems in rural areas.
- Some staff commented that information from the trust executive which was relevant to their work was not always disseminated, due mainly to the size of the organisation and the remoteness of some community locations.

Consent

- Patients were consented appropriately and correctly. Verbal consent was obtained before care was delivered. We reviewed consent information for a select of patients as part of our review of records and found this was obtained and completed correctly.
- Where nursing staff used photography to obtain a record of the patient's condition and symptoms, this was done with the patient's written consent.
- The Mental Capacity Act (2005) and Deprivation of Liberty Standards (DoLS) was included in mandatory training. We observed that consent and capacity courses attended were included in the member of staff's individual training log.
- Staff we spoke with demonstrated a clear understanding of the Act, of their responsibilities and of DoLS procedures. A mental capacity assessment was undertaken if the patient refused any treatment, or if the nursing staff otherwise had a concern that the patient might not have capacity to consent.



Are services caring?

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

Summary

Patients and their relatives were treated with dignity, respect and compassion. Staff were very considerate and empathetic towards patients, their relatives and other people and had a good understanding with patients. Staff respected patient confidentiality in discussions with patients and their relatives and in written records or other communications. The approach staff used in the home setting demonstrated compassion and consideration for the patient. Patients we spoke with were very positive about the care and treatment they received.

Staff demonstrated good communication skills during the examination of patients, with clear explanations and checking the patient's understanding. Staff answered any questions from the patient directly. Patients were involved in their own care plans where appropriate. Patients were given appropriate information leaflets although some brochures for patients were only available in English.

Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support for patients where this was needed. Patients' independence was promoted during visits from the service and patient leaflets and verbal advice about self-care were available.

Detailed findings

Dignity, respect and compassionate care

- During our inspection, we observed patients and relatives being treated with dignity, respect and compassion. We observed caring, compassionate care being delivered. Staff were seen to be very considerate and empathetic towards patients, their relatives and other people. Staff had a good understanding with patients.
- When delivering care and treatment, staff respected patient confidentiality. Confidentiality was maintained in discussions with patients and their relatives and in written records or other communications.
- We observed telephone calls made by staff to speak with patients. Staff consistently demonstrated good communication skills and a caring approach to the patient. Patients were advised in a caring, competent

and compassionate manner which maintained their dignity. When speaking by phone with another member of staff in the patient's home, the other member of staff started the conversation by asking, "Are you able to talk?" Patient's details were not left on answer machines. This demonstrated sensitivity and a focus on the patient.

- Throughout our inspection of the different services we found the approach staff used was consistently appropriate to the setting and demonstrated compassion and consideration for the patient.
- We observed care and treatment being delivered by tissue viability specialist nurses to a patient in a ward setting. The nurses respected and maintained the patient's dignity and administered care sensitively and with compassion.
- We observed care and treatment being delivered by consultant medical staff in a community location, and by physiotherapy staff. We found on both occasions staff ensured the patients privacy and dignity were maintained. Discussions with patients were conducted with appropriate sensitivity to their needs.
- Patients we spoke with were very positive about the care and treatment they received.
- We observed that letters and comment cards received from patients were displayed in community locations we visited. Consistently positive comments were made about the service. We reviewed a letter from a patient which expressed gratitude for help and advice from staff. It stated that their professional knowledge and caring attitude were very reassuring. The patient stated they had experienced remarkable improvements which had truly improved their quality of life.

Patient understanding and involvement

- We observed that staff demonstrated good communication skills during the examination of patients. Staff gave clear explanations and checked the patient's understanding. We observed staff appeared to understand the patient's symptoms well, they related the injury to the patient's occupational needs and function. Staff also checked the patient's understanding.
- Staff explained what the patient could expect to happen next with details of surgery and likely possible



Are services caring?

outcomes. They answered any questions from the patient directly. Re-visits were arranged where more information was deemed to be required to support and involve the patient in their care and treatment.

- Staff in a focus group told us community nursing teams involved the patient, family and carers in decision making. Patients with diabetes, for example, were involved in decision making about their care and treatment. We observed a diabetes specialist nurse give advice to a patient on medication. Using assessment, clinical specialists set goals with the patient's involvement and planned with the patient so that their needs were addressed to help them achieve their goals.
- Specialist nursing staff provided an educational resource for patients and carers, For example, we spoke with a patient who was accessing the musculoskeletal service. Information was provided following their procedure and had improved the patient's condition. The diabetes specialist nurse provided support and advice about diabetic care. We observed specialist nurses during telephone conversations with patients to provide support, which demonstrated that the patient's needs for information were addressed.
- We observed home visits by community nursing staff. Patients were involved in their own care plans where appropriate. The district nurse photographed all wounds every four weeks which were shown to patients to demonstrate wound progress. Nurses used their relationship with patients and carers to impart information to support the patient. They took time to enquire if the information was understood; carers were reassured by the nurse's knowledge and advice.
- Physiotherapy staff in community clinic settings used a management plan from the patient's previous visit and discussed with them how they had been managing exercises. We saw the patient was given positive feedback and more information and explanation of mobility and walking aids. The management plan was discussed with the patient and a patient information leaflet with new exercises and regimes was provided.
- We observed care and treatment being delivered by consultant medical staff in a community location. The patient was given an explanation of their condition which the consultant illustrated using a drawing of the procedure to be carried out and images from the

website. Models were also used to explain procedures. The cardiology specialist nurse organised a heart failure support group each quarter in a community clinic which 60 patients attended.

Emotional support

- We observed staff providing emotional support to patients and to relatives. Staff were aware of the emotional aspects of care for patients living with long term conditions and provided specialist support for patients where this was needed.
- Staff in a focus group explained that patients had access to 24 hour contact with the community nursing team if required. Staff provided emotional support and increased visits to patients if required. Patients and relatives would where necessary be referred to specialist services to provide support.
- A bereavement service was provided and a brochure was available entitled, "What to do when someone dies" which gave practical information for people who were bereaved. The brochure was available in other formats and languages other than English.

Promotion of self-care

- The trust's nursing strategy document included a diagram illustrating the role of self-care for all types of care and treatment. The promotion of self-care was of particular relevance to the care of patients in community settings. We observed that patients' independence was promoted during visits from the service.
- Clinical leads explained the approach of the service was, "Patients must be safe to remain at home with the current care package." Patient leaflets and verbal advice about self-care were available. Information leaflets were provided to patients for health promotion and self-management of long term conditions.
- Diabetes specialist nurses provided telephone support and advice and clinic sessions for patients with diabetes supported by a dietician. The DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) programme was accessible to patients with diabetes or the risk of developing Type Two diabetes to provide learning and support for the patient and the health care professionals involved with them. The objective of the DESMOND programme was to empower patients to become more informed about their condition and as a resource to assist them to manage



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changes in lifestyle. It also enabled patients with newly diagnosed diabetes to meet and share experiences. Courses were run twice monthly across a range of community venues and were delivered by four accredited DESMOND trainers. GP practices referred directly to the DESMOND administrator and a course date was usually offered within three months of referral. The programme was evaluated and audited to assess its effectiveness.

- Respiratory nurse specialists involved patients and welcomed contact from patients by telephone. A range of information leaflets were available for patients. For example, the specialist respiratory team had developed a patient information pack to help patients to manage their condition more effectively.
- The physiotherapy service supported exercise regimes for patients in community clinics. We observed a clinic session where the patient exercises regime was reviewed and improvements discussed. The patient's progress was discussed with them and encouragement was given to the patient regarding their progress with exercise. The patient's management plan was discussed

with them and equipment needs was reassessed. The patient was provided with new equipment. Patients' questions were answered and advice, including written advice, was given.

- We observed a clinic session for patients with COPD (Chronic obstructive pulmonary disease) run by physiotherapists for pulmonary rehabilitation. Participating patients were encouraged with self-management techniques, for example how to check their own blood pressure. Breathing exercises were related to self-care and how to do the exercises at home. A support group ("Breathe Easy") held monthly for patients with lung conditions was supported by The British Lung Foundation.
- Other examples we reviewed were the Falls and Osteoporosis service which supported an exercise programme for patients and the Lymphedema service which ran clinics for patients which emphasised self-management. Patients waiting to access the musculoskeletal physiotherapy service were given clear information about likely causes of pain and exercises to help.

Are services responsive to people's needs?

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

Summary

For the range of community services, managers and staff worked with local commissioners of services, the local authority, other providers, GPs and patients to co-ordinate and integrate pathways of care. A range of specialist teams were used to provide services in the community which met patient needs closer to home and were accessible particularly in rural parts of the area. For patients who required support for mental health or social care needs, arrangements for care and treatment was facilitated with mental health or social services. There were good working relations with the acute hospital so that patients benefited from joined up care when admitted to hospital.

The service used a single point of access to help ensure patients got the right care at the right time and where possible to avoid admissions to hospital. Patients could access community health services promptly. Services responded quickly and waiting times were low. Referral to community health services followed agreed pathways of care. For most services, service specifications were in place which included expected outcomes for patients. The service specification for weekend dressing clinics held in GP practices required review.

Staff were aware of complaints that patients had raised about their service area and of what was done to resolve the complaint. Action to be undertaken following the investigation of a complaint was identified the action proposed was discussed with the patient and the completion of actions was monitored. Staff could describe how services had changed as a result of action taken.

The rapid response service provided intermediate care to prevent hospital admission, early discharge support or to supplement other services from 8am to 11pm and aimed to respond within two hours. An out of hour's service was provided as part of the rapid response service and operated from 10pm to 8am. Discharge liaison arrangements between the acute hospital and community settings required development.

Staff were trained in equality and diversity. The trust had designated approximately 200 staff as dementia champions. Training for all clinical staff in caring for

patients living with dementia required some development. Car parking arrangements for patients visiting some community locations was limited for patients with limited mobility.

Detailed findings

Planning and delivering services which meet people's needs

- For a range of community services, managers we spoke with were aware of the risks they faced in their area in order to provide services which were responsive to the needs of patients. Staff told us they worked with local commissioners of services, the local authority, other providers, GPs and patients to co-ordinate and integrate pathways of care. Services included specialist nurses and therapists for particular conditions, for example, diabetes and respiratory, tissue viability, continence, falls and stroke teams. For patients who required support for mental health or social care needs, arrangements for care and treatment was facilitated with mental health or social services.
- A range of specialist teams were used to provide services in the community which met patient needs closer to home and were accessible particularly in rural parts of the area. Community nursing teams attended the needs of patients who were assessed as predominantly housebound or their needs were identified as best being met in their own home. For patients who were more mobile and able to travel to local centres, the service ran a range of community clinics. For example, respiratory clinics accepted patients with general respiratory problems, attended by a consultant. The falls team provided a service for patients over 65 years who had suffered a fall and attended the emergency department after calling an ambulance. The service also accepted GP referrals.
- We found there were good working relations with the acute hospital so that patients benefited from joined up care when admitted to hospital. Case managers also had a role in residential and nursing homes in arranging care and support which avoided the patient's admission to hospital. Some specialist services, for example tissue viability, were provided by an integrated acute and

Are services responsive to people's needs?

community team. The cardiology specialist nurse and skin service teams were further examples. Staff explained that this revised approach had the benefit of continuity of care for the patient. Links with the hospital service were developed and waiting times for services were reduced.

- When we observed care being delivered, we found that as well as following plans of care, community nurses were prepared to consider varying their approach to treat particular persistent conditions, for example leg ulcers. This might involve joint assessment with nurse specialist teams. We observed a community nurse undertake an electrocardiogram in the patient's home and two patients receiving intensive home support, which demonstrated the use of extended skills to provide care closer to home.
- For most services, service specifications were in place which included expected outcomes for patients. Staff told us that generally they had developed a good understanding with commissioners, other providers and stakeholders. We found that a dressing clinic was held at weekends for patients who required daily dressings although there was no formal specification for the service.

Equality and diversity

- Brochures and leaflets for some, but not all, services stated in the document that the information was available in other formats and languages other than English.
- Staff in a focus group informed us that translation services were available for people whose first language was not English. Staff were able to provide examples where the interpreter service was used. Staff said they asked what the patient's cultural needs were as part of their assessment.
- Staff we spoke with had received mandatory training in equality and diversity.

Meeting the needs of people in vulnerable services

- The trust had designated approximately 200 staff as dementia champions.
- Training in caring for patients living with dementia was available to staff, although it was not part of mandatory training. We were informed that all staff had undertaken a dementia awareness training session.

- Physiotherapists in the specialist musculoskeletal service provided services for patients living with a learning disability and for patients with long term conditions such as cerebral palsy.
- For patients who used mental health services, community nursing services undertook joint visits with mental health staff.
- Staff in a focus group explained that two members of staff attended visits with some patients, depending on the assessment of their need. This included patients living with a learning disability with complex needs where joint visits could be made with staff from learning disability services, and bariatric patients.
- Disabled access was provided to the physiotherapy department.
- Posters with information for patients were displayed in community clinic settings. Some brochures for patients were only available in English although a translation service was available. Patient information leaflets made extensive use of illustrations. Information was included in some brochures about other formats and other languages, with contact details in several other languages.

Access to the right care at the right time

- The service used a single point of access to help ensure patients got the right care at the right time and where possible to avoid admissions to hospital. We found patients could access community health services promptly in the areas we visited. Services responded quickly and waiting times were low.
- Quality indicators for community services showed that patients were assessed promptly for care and treatment, and this was consistently within the expectations of patients and commissioners. For example, the diabetes specialist nursing team visited patients requiring routine visits within one month; for patients with urgent needs the service visited the same day.
- We saw across services they were meeting referral to treatment targets. For example, the specialist musculoskeletal service was meeting a waiting time of three weeks, which matched the service specification. Patients could also choose to attend the clinic they preferred. The referral to treatment times achieved were reviewed on a monthly basis. For example, for the musculoskeletal and skin service, information for November 2014 showed that overall 98.6% of patients

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were seen within 18 weeks of referral. The falls service saw patients within approximately four weeks compared with a service specification waiting time of 18 weeks. The respiratory team were achieving a referral to treatment time of six weeks, which allowed for the patients with priority needs to be seen within two weeks. The tissue viability team visited community referrals within three working days and urgent referrals the same day.

- Staff in a focus group explained that if necessary they would work across areas to meet targets for responsiveness. Patients we spoke with confirmed they had experienced only a short waiting time to access the service and they appreciated care closer to home.
- At the referral centre we observed a nurse undertaking call triage for incoming calls from hospital and GP practices. The triage nurse linked with district nurses within clusters of GP practices to arrange visits and care for patients. Triage decisions were informed by the schedule of nursing visits already planned, and the rapid response service was used when the number of unplanned calls exceeded capacity, typically after six unplanned calls were received, or calls were deferred to the next day. Staff phoned the patient if a visit was deferred. We observed that between visits, the community nurse adjusted the visiting schedule to meet the patient's needs and communicated with the GP practice about any changes to their schedule.
- The Rapid Response service was introduced in 2014 and provided intermediate care to prevent hospital admission, early discharge support or to supplement other services. The service was available from 8am until 11pm and aimed to respond within two hours. Referrals were accepted until 9pm and the service operated until 11pm. In order to prevent admission to hospital, a health integrated team ("HIT") included generic staff based in social services.
- From January 2015, community matrons were to provide specialist advice in the rapid response service for patients with long term conditions. Some community matrons we spoke with expressed concern as to the impact on patients with long term conditions when they commenced support for the rapid response service. However, staff in a focus group told us that although the start of rapid response was a big change, they felt positive about the benefits to patients.
- An out of hours service was provided as part of the rapid response service and operated from 10pm to 8am. Staff

working in the out of hours service started at 10pm which enabled them to complete a handover with staff from the day services teams. The service was available to take calls from 10.30pm. A similar period was allocated for handover the next day before the end of their shift.

- Car parking arrangements for patients visiting some community locations was limited. This particularly presented a difficulty where the patient had limited mobility.

Referral, transfer, discharge and transition

- Referral to community health services followed agreed pathways of care. Referrals were from a variety of services including GP's, practice nurses, and district nurses, patients being discharged from hospital wards who required intervention, and complex cases in nursing homes, residential homes, and police and prison services. District nurses could refer patients urgently for assessment to the rapid response service in order to prevent a hospital admission. Staff in a focus group explained there were clear criteria for referral of patients which meant that inappropriate referrals could be identified.
- Specialist services confirmed referral pathways were generally followed and they received few inappropriate referrals. For example to support referrers the tissue viability service had shared their referral guidance with GP practices. However referrals to the rapid response service from the acute hospital included some inappropriate referrals, for example, requests to physiotherapists for mobility assessments. Referrals from GP's were not always supported with sufficient information.
- The transfer of patients to other services also followed agreed pathways. The skin service, for example, identified and supported one member of staff in each GP practice who could identify symptoms of skin cancer and facilitate admission to secondary care for prompt treatment. Musculoskeletal specialists working with the pain clinic service could refer patients to physiotherapy specialists working with hospital departments, for example neurology. The service linked in turn with the falls team and occupational therapists to arrange appropriate support for patients.
- Discharge arrangements from hospital were supported by community teams. For example, the cardiology

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specialist nurse attended monthly multi-disciplinary team meetings at the acute hospital with cardiology consultants and liaised closely with community nursing teams about discharge arrangements.

- The COPD outreach team supported discharge arrangements for patients with severe symptoms. If the patient was not seen or assessed prior to their discharge the outreach team visited them the next day or sooner if there was an urgent need. The outreach service maintained the patient on their caseload for 30 days to ensure they were in a stable condition and not likely to need readmission, before discharging to the care of the GP practice. A fall-back arrangement enabled the patient to contact the GP practice if they became unwell and were unable to contact the specialist nurse. The service re-referred the patient if they encountered issues with their care.
- Patients were discharged from the community nursing caseload if they were admitted to hospital, and the district nurse liaised with the ward to support their admission. If the patient was due to be discharged to a home setting the community nurse may visit the ward to check that the patient was comfortable to return home and to arrange for intervention from the community team for patients needing support.
- We found the arrangements for discharge liaison between hospital and community settings were not always fully integrated. A discharge care plan was prepared for patients and recorded on the trust's information system. The discharge pathway could involve self-care with GP support with access to a range of other support services, such as physiotherapy. A discharge letter from hospital was sent to the patient's GP but copies of the discharge letter were not shared routinely with community nursing teams. Community staff found it could be difficult to access the hospital referrer to liaise about information to support the patient's discharge.
- We found joint assessments were not completed on wards where the patient required a community matron or social services re-enablement team immediately following discharge. The patient's diagnosis was often not discussed with community staff. Specialist community teams also stated that discharge information could be poorly written or contain little useful information. Some sections were not completed. Patients may be told the community team was available to see them, but community staff may not be notified of

the patient discharge in a timely manner. When patients were discharged from specialist services the GP received a discharge letter although this was not sent to the patient. This could result in inappropriate referrals for community teams.

- We were informed that discharge improvement workshops were being held with each ward as part of the "Productive ward" initiative to support the planning of discharges from the day the patient was admitted and to review referral arrangements from hospital. However, some community nurses observed that they had not been included in this event, although they expected it would have a significant impact on their work with patients.

Complaints handling (for this service) and learning from feedback

- For the period 1 December 2013 to 30 November 2014 the community nursing team received one complaint, which was about the attitude of staff.
- During 2014 the trust had identified the timely resolution of complaints as a priority area for improvement. We saw that communications shared with staff in the chief executive's core briefing for December 2014, included information for staff about recent compliments staff and services had received. A review of the clinical governance meeting minutes to October 2014 showed that complaints received were discussed. Half of the complaints related to care and treatment and no particular theme was identified. Further analysis was to be undertaken to establish the degree of progress with complaints and prepare an action plan.
- Information for patients about services included information about how to make comments and compliments or raise concerns or complaints and information about the Patient Advice and Liaison Service (PALS). Patients we spoke with were mainly aware of the complaints procedure. In community locations we saw copies of the PALS leaflet were available.
- Staff in a focus group were aware of the trust's complaints policy and of their responsibilities within the complaints process. Apart from formal complaints patients were directed to the trust's patient advice and liaison service. Staff were aware of complaints that patients had raised about their service area and of what was done to resolve the complaint.

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- Action to be undertaken following the investigation of a complaint was identified and the action proposed was discussed with the patient. The completion of actions

was monitored. Line managers fed back learning from the investigation of complaints at team meetings. Staff could describe how services had changed as a result of action taken.

Are services well-led?

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

Summary

The service regularly undertook a range of audits to improve performance and support safety. An annual plan for clinical audit of the service was in place and progress was reported monthly. Clinical governance meetings were held monthly at which risks, audit and actions taken were reviewed. The performance of community services was reviewed using a performance score card and reported at locality level. Regular locality and team meetings were held which were also attended by specialist nurses. Actions taken were documented and reviewed in subsequent meetings.

Community services had carried out a number of recent patient satisfaction surveys, with positive results. Several examples of new and emerging innovative practice were observed during our inspection.

Managers and staff told us they felt there was a clearer vision for the community services and a strategy of improvement and changes to services delivery.

Staff felt there was clear leadership at executive level and the executive team were approachable. The senior management team for community services provided leadership although it was not always visible to staff. Managers and team leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was mainly effective and staff said their direct line managers were supportive although we also encountered some exceptions.

Some staff were unaware of how the trust's risk management policy related to their area of work. The risk register was reviewed regularly although not all staff felt the risk register was readily accessible, were aware of the risks in their service area, or of the action taken to mitigate risks.

Staff were supportive of each other within and across teams, although there were shortfalls in communication. Staff who recently commenced working in the rapid response service felt challenged by the demands of the role and unsupported which affected morale. Some staff told us that during the recent restructure they had not been consulted about changes to their role.

Staff were aware of the financial pressures facing the trust. For some community services teams, there had been an increase in the levels of staff sickness although we found the risks associated with this were managed.

Detailed findings

Service vision and strategy

- The trust's strategy was to improve, innovate and develop services to meet the needs of patients and was in two parts, a clinical services strategy setting out services provided and four transformational themes describing how they were to be delivered. To deliver the vision, the trust had set 18 strategic objectives across the four transformational themes and the clinical services strategy.
- Managers in community services including those which had undergone changes in the recent restructure had developed a vision and strategy for the revised service and linked this to the trust's vision and strategy. We found that most staff we spoke with identified with this. Staff in a focus group said the vision and strategy was publicised on the trust intranet and on the whole it was relevant and embraced by staff. We saw that the trust's vision and values were displayed on notice boards for staff in the community locations we visited.
- Managers and staff told us they felt there was a clearer vision for the community services and a strategy of improvement and changes to services delivery. For some services, staff teams we spoke with said they had been engaged and included in developing the vision and strategy for their team, which adapted and interpreted the trust vision for the service and an annual plan for their service. The vision and strategy for their service centred on safe and effective care for patients, closer to home.

Governance, risk management and quality measurement

- The trust had a risk management policy in place which was revised in October 2014. Community services maintained a risk register. The register was reviewed regularly and some staff were aware of the risks in their

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service area, of the action taken to mitigate risks and the role of the corporate risk manager. However, other staff we spoke with were unaware of the risk register and felt it was not readily accessible.

- We reviewed the minutes of community locality meetings held quarterly which evidenced that risk registers were reviewed monthly and assessed according to perceived high, medium and low risk. Ongoing locally managed risks were discussed and trust wide risks were also linked to clinical governance meetings. Items to be added to the risk register were recorded. For community services, key risks included IT connectivity and lone working.
- The service regularly undertook a range of audits to improve performance and support safety. Minutes of clinical governance meetings evidenced that an annual plan for clinical audit of the service was in place and progress was reported monthly. Locality and specialist team meetings also evidenced that audit plans were in place and were reviewed by the service at monthly meetings. Updates were provided for audits in progress, for example of records and falls, and of actions taken as a result of audit findings. The specialist musculoskeletal service used patient reported outcome measures (NHS PROMS) in regular audits to show the effectiveness of the service; for example, an audit on knee was reported which demonstrated improvement for patients.
- Clinical governance meetings were held monthly and recorded. We reviewed copies of minutes from the three most recent meetings. Items covered included risks, audit, and a nursing update, for example actions which had been put in place to address an increased reporting of falls incidents.
- The performance of community services was reviewed using a performance score card and reported at locality level, at clinical governance meetings and at a wider “cluster” group level of joint team meetings which included specialist services. Wider governance meetings for the service were attended by senior managers only. Clinical matrons met with the head of nursing fortnightly for an update meeting at which governance issues were discussed. Staff in a focus group confirmed that they received feedback as to the outcome of governance meetings.
- Managers and staff told us regular locality and team meetings were held which were also attended by

specialist nurses. Our review of documents showed that these meetings were recorded and included case discussion. Actions taken were documented and reviewed in subsequent meetings.

Leadership of this service

- The chief executive was well established in her role and known to staff in community services, including from her previous roles in the trust. Staff felt there was clear leadership at executive level and the executive team were approachable. Managers had attended staff briefings by the chief executive and staff were aware of the chief executive’s core briefing which was also visible in the community locations we visited and was discussed at clinical governance meetings.
- Managers and team leaders demonstrated a clear understanding of their role and position in the trust. Local team leadership was mainly effective and staff said their direct line managers were supportive although we also encountered some exceptions. The senior management team for community services provided leadership although it was not always visible to staff. The service had recently undergone a significant reorganisation of services and some of the working relationships that we observed or were reported to us still reflected this recent change. Some more senior clinical staff had experienced their roles being changed as a result of recent changes and felt less well supported as a result.
- Staff in specialist nursing teams felt their line managers were supportive and accessible. Although they did not often encounter senior management, they felt they knew how to access them if required.
- Staff were mainly positive about the clinical leadership they received and about the practical ways in which their clinical role was supported by the trust. Professional practice forum meetings were held monthly. The head of nursing chaired a quarterly senior nurse forum and facilitated leadership days for community services teams. For example, during 2014 a leadership forum event was held with the theme of reducing pressure ulcers. We observed the clinical leadership provided for staff during handovers and in general staff were supported appropriately, for example by managers of specialist services. In the falls and osteoporosis service we observed concise and appropriate handover between staff which included the recording of actions agreed.

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- We found there were some shortfalls in communication. For example, during our visit inspectors received information from a small number of staff which stated they received little positive feedback and staff who recently commenced working in the rapid response service felt challenged by the demands of the role and unsupported, which affected morale.
- Health care assistant staff felt comfortable in their role and well supported in their development.
- Community services had carried out a number of recent patient satisfaction surveys. We reviewed the patient satisfaction survey results for rapid response for November 2014 which showed a high level of patient satisfaction. A patient satisfaction survey was carried out for the specialist skin service during 2014. The results showed a very high level of patient satisfaction. A biannual GP patient satisfaction survey was last undertaken during 2013 for the specialist musculoskeletal service which showed patients were highly satisfied with the service. We were informed that patient satisfaction surveys were completed for the respiratory service and positive feedback was received. The respiratory team reviewed patient feedback quarterly and action was taken as needed. Patient feedback results were available on the trust's IT system and displayed on notice boards.

Culture within this service

- Staff were supportive of each other within and across teams. Staff said they were proud to work for their team and enjoyed their role. There was good team working. They were able to put forward ideas and discuss them as a team.
- Some staff were receptive to change and felt positive about working for the service. They said the trust was good to work for, with an open, no blame and patient focused culture. They felt that in their community location, they had an excellent culture. Staff were enthusiastic and felt involved in the decision making process. They felt they had the time to spend with patients and provide the care required.
- Staff generally reported a positive culture in community services although we encountered exceptions in some locations, where staff felt uncertain about changes to their role and less valued as a result.
- Staff were aware of the financial pressures facing the trust. Some staff told us they could feel a change due to the financial pressure.
- The diabetes specialist service sought feedback routinely from patients at the end of their course of treatment. The service used an evaluation form for patients who attended the DESMOND training course. We reviewed the feedback received from patients, who consistently scored the service excellent or good.
- Some services used comment cards to capture feedback from patients. The notice board in some community locations displayed thank you cards demonstrating that patients and relatives had taken the time to write and thank staff.
- The staff bulletin provided staff across the trust to share news and information with each other about events.
- During the recent reorganisation service managers were briefed and they felt senior managers were receptive to their comments. We were informed that support was available for staff during this process through weekly meetings, although some staff told us that during the recent restructure they had not been consulted about changes to their role.
- For some community services teams, there had been an increase in the levels of staff sickness although we found the risks associated with this were managed.

Fit and proper person requirement

- The introduction of a statutory fit and proper person requirement applied to NHS trusts from November 2014. The trust had in place a policy relating to these new requirements.

Public and staff engagement

- As a result of the NHS staff survey 2013 the trust undertook a review of the appraisal process which took into account staff views and feedback. The NHS staff survey for 2014 had been distributed just prior to our inspection.
- Community services were to commence engagement with the public through the NHS friends and family test in January 2015.

Innovation, improvement and sustainability

- Several examples of new and emerging innovative practice were observed during our inspection.
- The trust used a scheme for staff awards and achievements, results of which were notified to staff

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through the chief executive's core briefing.

Opportunities for innovation projects to be considered for funding support were also notified through the staff intranet.

- The falls and osteoporosis service received an award for its inpatient work in community hospitals. The service audited risk assessment tools twice per year using "focuses of the month" for example, lying, standing and blood pressure on admission. Education and protocols have been introduced in residential and nursing homes. We were informed the local authority agreed to support that each care home followed the protocol.
- The tissue viability service had developed several examples of innovative practice. The service participated in the chronic oedema project and leg ulcer collaborative to support prevention of these conditions. Specialist and maintenance clinics were held for patients with lymphedema. The service was focused on the needs of patients and support for the patient's self-management of their condition. The team leader for the service was a published writer and the service had been publicised through national conferences.
- The skin service (within dermatology) was to commence a melanoma screening clinic in February 2015. The

service was to use a very clear pathway with immediate action for patients with appropriate lesions. A rota of dermatology leads from within GP practices was to support the clinic.

- Diabetes specialist nurses provided telephone support and advice and clinic sessions for patients with diabetes supported by a dietician. The DESMOND (Diabetes Education and Self-Management for Ongoing and Newly Diagnosed) programme was accessible to patients with diabetes or the risk of developing Type 2 diabetes to provide learning and support for the patient and the health care professionals involved with them. The objective of the DESMOND programme was to empower patients to become more informed about their condition and as a resource to assist them to manage changes in lifestyle. It also enabled patients with newly diagnosed diabetes to meet and share experiences. Courses were run twice monthly across a range of community venues and were delivered by four accredited DESMOND trainers. GP practices referred directly to the DESMOND administrator and a course date was usually offered within three months of referral. The programme was evaluated and audited to assess its effectiveness.