

## East Sussex Healthcare NHS Trust

RXC

# Community health services for adults

## Quality Report

### CQC Registered Location

#### Location ID

Bexhill Hospital

Crowborough War Memorial Hospital

Uckfield Community Hospital

Lewes Victoria Hospital

Hastings Station Plaza

St Leonards Health Centre

Seaford Health Centre

Heathfield Community Health Centre

Hailsham Health Centre

Arthur Blackman Clinic

Tel: 01424 755255

Website: <http://www.esht.nhs.uk/>

### CQC

RXC03

RXCX1

RXC18

RXCLV

Date of inspection visit: 9 to 12 September 2014

Date of publication: 27 March 2015

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

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

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

# Summary of findings

## Ratings

Overall rating for Community health services for adults

Requires Improvement



Are Community health services for adults safe?

Are Community health services for adults effective?

Are Community health services for adults caring?

Are Community health services for adults responsive?

Are Community health services for adults well-led?

# Summary of findings

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# Summary of findings

## Overall summary

Overall this core service was rated as 'requires improvement'.

We found that community health services for adults was caring and responsive, but required improvement to be safe, effective and well-led.

East Sussex Healthcare NHS Trust delivers community-based services to adults across East Sussex. It provides a range of services to support people in staying healthy, to help them manage their long term conditions, to avoid hospital admission and, following a hospital admission, to support them at home. Services are provided in people's own homes, nursing homes, clinics and GP practices and include:

- Community nurses, including out-of-hours services
- Dieticians
- Health visitors
- Dentists
- Podiatrists
- Occupational therapists
- Physiotherapists
- Speech and language therapists
- Radiographers
- Pharmacists
- Cardiac rehabilitation
- Rehabilitation and intermediate care
- Specialist support services (for example, multiple sclerosis and respiratory disorders)
- Health and wellbeing services, such as sexual health services

Our key findings were as follows:

- Across community services, teams with reduced staffing numbers had to prioritise the treatment of patients. While patients categorised as requiring urgent care were always seen, others with non-urgent needs did not always receive the care they needed. During the inspection, we were told that the vacancy management plan had recently been lifted and managers told us they were now actively recruiting. However, there were some specialities, such as the speech and language therapists and community matrons, which had been understaffed for some time with no plans in place to fill these vacancies in the

foreseeable future. At the time of our inspection, many teams were understaffed and the situation continued to have an adverse effect on patient outcomes and staff morale.

- The Trust had mechanisms in place to report and record safety incidents, concerns, near misses and allegations of abuse. Learning from safety incidents was disseminated through bulletins, minutes of meetings and staff meetings. Locally, staff told us they usually received feedback from any incidents and patients were kept safe through robust safeguarding arrangements. The Trust worked well with partner agencies to protect vulnerable people from abuse.
- The Trust was in the process of moving to an electronic system to record care and support teams. We found that, in areas where the electronic recording of patient care was fully embedded, patient records provided good quality assurance and performance management. However, paper records were still in place for some of the community teams, specialist nurses and the therapists. The paper records we reviewed were not always fully completed by staff and did not give assurance that risks were always identified; assessed, monitored or reviewed.
- There was often a lack of connectivity for the electronic system, which meant that staff could not always record the care as it happened and waited until they were back at base to update the system. This meant there was a risk that not all elements of care or observations were captured or recorded accurately. We found that, although records were managed differently between the various teams and divisions throughout the county, the implementation of electronic records was reducing the opportunities for error.
- Although the Trust had systems and processes, including monitoring and auditing, to ensure patients received personalised care and treatment, the lack of staff in some areas had an adverse effect on some patient outcomes.
- The district nurses caseload management system and patients did not have a dedicated named nurse

# Summary of findings

responsible for monitoring and reviewing their care. Patients could see a different district nurse at every visit, which meant that continuity of care was a potential risk.

- The Trust provided opportunities for staff induction, learning development and appraisal. However, there was a lack of formal supervisory, clinical supervision or peer support arrangements in place. This meant that staff did not always have the support structure in place to enable them to discuss and review their role and the treatment they provided.
- There was good multidisciplinary and cross boundary working, which meant that patients were assured of receiving the right care by the right team. The specialist services and x-ray departments were especially praised for the support they gave, not only to patients but the other community teams and wider health and social care community.
- We spoke with 61 patients, or their carers, across the Trust from community hospitals, health centres, to visiting patients in their homes or contacting them by telephone. All the patients we spoke with, without exception, told us how pleased they were with the care and treatment provided in the community by East Sussex Healthcare NHS Trust. We were told about the kind and caring community nurses and therapists who “went above and beyond” and offered an “excellent” service. Every patient that we spoke with spoke highly of the kindness of the nurses and therapy staff. One patient summed up the views of all the patients by saying, “We just couldn’t do without them.” Patients sometimes experienced long waits, but when they did get to see healthcare professionals and clinicians, the care and treatment was excellent.
- During our visits with the district nursing teams into patients’ homes and in outpatient clinics, we saw good interactions with staff demonstrating knowledge and respect for the individuals care and emotional needs. The district nurses had a good rapport with their patients and involved them in any decisions about their care.
- Although few of the records we looked at included assessing patient’s emotional needs, or included care plans that addressed this, we found that, in practice, the community teams supported patients emotionally.
- There were systems in place to support patients to manage their own health and care and, where possible, to maintain their independence. Patients told us that, without the help and support of the community teams, they would not be able to remain in their own homes.
- Service planning and delivery was complex due to financial constraints, service reconfigurations and demands of the different clinical commissioning groups (CCGs). The Trust did not have a five-year plan and there was uncertainty amongst the community team about the future of their department or specialty. However, staff worked hard to plan and promote their services within this uncertain financial environment.
- We saw that patients reported few delays in accessing treatment in services that operated ‘walk-in’ clinics, such as the sexual health and x-ray department. Throughout the service, we found that, where delays occurred, staff worked hard to keep patients informed.
- The financial constraints meant there were restrictions on the services the Trust could offer, however, we found that staff were flexible and responsive to the needs of the community, where possible. For example, ‘pop-up’ clinics took place to reduce waiting lists in urology, x-ray departments opened seven days a week and staff in all departments prioritised urgent patient needs and responded appropriately.
- Although the Trust had systems and processes in place to handle complaints, we found that they were not always effective. The information for patients was often out of date, referring to obsolete contact details. Patients were not always supported to raise concerns and there were no systems in place to record or monitor the issues resolved at local level.
- The Trust had been through a sustained period of financial instability, change and reorganisation, leaving community staff feeling disaffected. Many staff were confused as to the new organisation structure. Few could identify who was in post above their immediate line manager. Although staff recognised the need for reorganisation, few staff had confidence that the Trust valued or promoted community services and were fearful for the future of their speciality or department.

# Summary of findings

- The staff's perception of Trust engagement was varied. Some staff told us that they had not been consulted about the recent changes and felt that the Trust had not listened when concerns were raised about the reconfiguration, while other staff spoke positively about the changes. However, the majority of staff we spoke with said they felt valued and supported by their immediate line managers. They told us they felt able and supported to raise concerns or whistleblow.
- We saw differing degrees of public engagement. In the community hospitals, we saw there were systems in place to gather patient feedback, such as comment boxes and information noticeboards, although there was little evidence of action taken. There was little evidence of staff awareness, or engagement with the value of patient feedback systems. We found that patients receiving care in their own homes were not generally encouraged or supported to provide formal feedback on the services they received.

We saw some good and outstanding practice, including:

- The specialist services and x-ray departments that were especially praised for the support they gave, not only to patients but the other community teams and wider health and social care community.

However, there were also areas where the Trust needed to make improvements.

## **Importantly the Trust must:**

- Review the staff compliment for community adult services to ensure there are sufficient numbers of appropriately skilled staff to meet patient's needs.
- Review the Trusts complaints processes to ensure that complaints are dealt with effectively.

- Provide information to patients and record and monitor complaints.
- Review engagement strategy with patients to enable patient feedback is used to improve services.

## **The Trust should:**

- Review and monitor record keeping. We found that, in areas where the electronic recording of patient care was fully embedded, patient records provided good quality assurance and performance management. Where paper records were being used, we found they were not always fully completed by staff and did not give assurance that risks were always identified, assessed, monitored or reviewed.
- Review district nurses' caseload management. The system presented a risk to patient care as patients did not have a dedicated named nurse responsible for monitoring and reviewing their care. Patients could see a different district nurse at every visit, which meant that continuity of care was a potential risk.
- Review supervision processes. There was a lack of formal supervisory, clinical supervision or peer support arrangements in place. This meant that staff did not always have the support structure in place to enable them to discuss and review their role and the treatment they provided.
- Review its communication strategy and processes with staff. Community staff felt disaffected. Many staff were confused as to the new organisation structure. Few could identify who was in post above their immediate line manager. Although staff recognised the need for reorganisation, few staff had confidence that the trust valued or promoted community services and were fearful for the future of their speciality or department.

# Summary of findings

## Background to the service

### Background to the East Sussex Healthcare NHS Trust

The East Sussex Healthcare NHS Trust provides both acute and community services in South East England. The trust operates from two acute hospitals and five community hospitals, as well as delivering community based services from 120 sites across East Sussex.

The Trust was formed by a merger of the local acute and community trusts in 2011 and has been subject to much reorganisation of services since then. The most recent being a programme of strategic service change in the past 18 months. The trust has reported a significant financial deficit for the past year and had planned for financial deficits for the future. The trust had a formal turnaround programme in progress, which was put in place from October. It is overseen by an external turnaround director, who reports directly to the chief executive.

The Trust provides adult community services to support people in staying healthy, to help them manage their

long-term conditions, to avoid hospital admission and following a hospital admission, to support them at home. Services are provided in people's own homes, nursing homes, clinics and GP practices and include:

- Community nurses, including out-of-hours services
- Dieticians
- Health visitors
- Dentists
- Podiatrists
- Occupational therapists
- Physiotherapists
- Speech and language therapists
- Radiographers
- Pharmacists
- Cardiac rehabilitation
- Rehabilitation and intermediate care
- Specialist support services, for example Multiple sclerosis and respiratory disorders.
- Health and wellbeing services, such as sexual health services.

## Our inspection team

Our inspection team was led by:

**Chair:** Dr Mike Anderson, Chelsea and Westminster NHS Foundation Trust.

**Head of Hospital Inspection:** Tim Cooper, Care Quality Commission.

The team included CQC inspectors and a variety of specialists: The team of 52 that visited across the Trust on 10, 11, 12 September and the team of five who visited the

two district general hospitals on 23 September 2014 included senior CQC managers, inspectors, data analysts, inspection planners registered and student general nurses and a learning disability nurse, a consultant midwife, theatre specialist, consultants and junior doctors, a pharmacist, a dietician, therapists, community and district nursing specialists, experts by experience and senior NHS managers.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive acute and community health services inspection programme.

East Sussex Healthcare Trust was rated as a band one risk in the July 2014 CQC intelligent monitoring data, (where band one is the highest risk and band six is the lowest risk).

# Summary of findings

## How we carried out this inspection

To get to the heart of patients' 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?

In order to assess the services offered by East Sussex Healthcare NHS Trust for adults in the community, we undertook a number of interviews, inspection visits, focus groups and public engagement exercises. During the inspection, we spoke with 61 patients or their carers across the Trust, from community hospitals, health centres, to visiting patients in their homes or contacting them by telephone. We held focus groups for the public and spoke with a number of people who contacted CQC directly to tell us about their experiences of care. We

spoke with all grades of staff, both individually and in groups. We spoke with administrative and portering staff, volunteers and domestic staff. We spoke with nurses, specialists, therapists, managers, consultants and GPs. We visited four of the community hospitals, six health centres and accompanied district nurses teams on their visits to patients' homes.

We visited:

- Bexhill Hospital
- Crowborough War Memorial Hospital
- Uckfield Community Hospital
- Lewes Victoria Hospital
- Hastings Station Plaza
- St Leonards Health Centre
- Seaford Health Centre
- Heathfield Community Health Centre
- Hailsham Health Centre
- Arthur Blackman Clinic

## What people who use the provider say

The majority of patients we spoke with were positive about their experiences of the community health services provided by the Trust. They spoke of kind and helpful staff across all areas of the service.

The level of complaints regarding community services was low and those that we saw related mainly to waiting times and car parking facilities. Few were directly related to the way staff delivered care.

People told us they would prefer greater continuity of care and would like the same nurse to visit whenever possible.

## Good practice

Our inspection team highlighted the following areas of good practice:

There were good multidisciplinary and cross-boundary working, which meant that patients were assured of receiving the right care by the right team. The specialist services and x-ray departments were especially praised for the support they gave, not only to patients, but to the other community teams and wider health and social care community.

We were told about the kind and caring community nurses and therapists who "went above and beyond" and offered an "excellent" service. Every patient that we spoke with spoke highly of the kindness of the nurses and therapy staff.

We witnessed and observed good interactions with staff, demonstrating knowledge and respect for the individuals care and emotional needs. Patients were full of praise for the teams that saw them at home. The district nurses had a good rapport with their patients and involved them in any decisions about their care.

# Summary of findings

Although the financial constraints meant there were restrictions on the services the Trust could offer, we found that staff were flexible and responsive to the needs of the community, where possible. For example, 'pop-up' clinics

took place to reduce waiting lists in urology, and x-ray departments began opening seven days a week. Staff in all departments prioritised urgent patient needs and responded appropriately.

## Areas for improvement

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

### Action the provider **MUST** take

- The Trust's financial position had led to a recruitment freeze across the community services, where vacant posts were not filled and long-term absences not covered. Across community services, teams with reduced staffing numbers had to prioritise the treatment of patients. While patients categorised as requiring urgent care were always seen, others with non-urgent needs did not always receive the care they needed. During the inspection, we were told that the recruitment freeze had recently been lifted and managers told us they were now actively recruiting. However, there remained some specialities, such as the speech and language therapists and community matrons, which had been understaffed for some time with no plans in place to fill these vacancies in the foreseeable future. At the time of our inspection, many teams were understaffed and the situation continued to have an adverse effect on patient outcomes and staff morale.
- Although the Trust had systems and processes in place to handle complaints, we found that they were not always effective. The information for patients was often out of date, referring to obsolete contact details. Patients were not always supported to raise concerns and there were no systems in place to record or monitor the issues resolved at local level.
- We saw differing degrees of public engagement. In the community hospitals, we saw there were systems in place to gather patient feedback, such as comment boxes and information noticeboards although there was little evidence of action taken. Outside of the community hospital setting there was little evidence of staff awareness or engagement with the value of patient feedback systems. We found that patients receiving care in their own homes were not generally encouraged or supported to provide formal feedback on the services they received.

# Summary of findings

## Action the provider **SHOULD** take to improve

- The trust was in the process of moving to an electronic system to record care and support teams. We found that, in areas where the electronic recording of patient care was fully embedded, patient records provided good quality assurance and performance management. However, where paper records were being used, we found they were not always fully completed by staff and did not give assurance that risks were always identified, assessed, monitored or reviewed.
- We found the district nurses' caseload management system presented a risk to patient care as patients did not have a dedicated named nurse responsible for monitoring and reviewing their care. Patients could see a different district nurse at every visit which meant that continuity of care was a potential risk.
- The trust provided opportunities for staff induction, learning development and appraisal. However, there was a lack of formal supervisory, clinical supervision or peer support arrangements in place. This meant that staff did not always have the support structure in place to enable them to discuss and review their role and the treatment they provided.
- The trust had been through a sustained period of financial instability, change and reorganisation, leaving community staff feeling disaffected. Many staff were confused as to the new organisation structure. Few could identify who was in post above their immediate line manager. Although staff recognised the need for reorganisation, few staff had confidence that the trust valued or promoted community services and were fearful for the future of their speciality or department.

East Sussex Healthcare NHS Trust

# Community health services for adults

**Detailed findings from this inspection**

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

Requires Improvement 

## Are Community health services for adults safe?

By safe, we mean that people are protected from abuse

### Summary

Across the community, teams with reduced staffing numbers had to prioritise the treatment of patients. While patients categorised as requiring urgent care were always seen, others did not always receive the care they needed. For example, speech and language therapists and community matrons could only see those patients with urgent needs.

Some specialities such as the speech and language therapists and community matrons had been understaffed for some time and there were no plans in place to fill these vacancies in the foreseeable future. During the inspection, we were told that the recruitment freeze had been lifted and managers were now actively recruiting to fill these vacancies. However, we heard that some specialities such as the speech and language therapists and community matrons had been understaffed for some time. Although there was a recovery plan in place the vacancies remained unfilled.

The Trust was aware of the understaffing and was working with managers and the turnaround team to prioritise the areas and teams for recruitment. However, the majority of teams remained understaffed and the situation continued to have an adverse effect on patient outcomes and staff morale. Staffing was recorded as a key issue on the Trust Risk Register with some strategies being considered to address the situation.

The Trust was in the process of moving to an electronic system to record care and support teams. We found that, in areas where the electronic recording of patient care was fully embedded, patient records provided good quality assurance and performance management.

However, paper records were still in place for some of the community teams, specialist nurses and the therapists. The paper records we reviewed were not always fully completed by staff and did not give assurance that risks were always identified, assessed or monitored. There were no records audit reports available.

There was also a problem with the connectivity of the electronic system, which meant that staff could not always record the care as it happened and waited until they were back at base to update the system. This meant there was a risk that not all elements of care or observations were captured or recorded accurately. We found that although records were managed differently between the various teams and divisions throughout the county, the implementation of electronic records was reducing the opportunities for error.

Care plans across community settings were completed well on the first contact the patients had with the service but there was a lack of consistent review or updating of the risk assessments and care plans.

The Trust had mechanisms in place to report and record safety incidents, concerns, near misses and allegations of abuse. Learning from safety incidents was disseminated through bulletins, minutes of meetings and staff meetings. Locally, staff told us they usually received feedback from any incidents and patients were kept safe through robust safeguarding arrangements. The Trust worked well with partner agencies to protect vulnerable people from abuse.

### **Detailed findings**

#### **Incidents, reporting and learning**

- We found that the Trust had mechanisms in place to report and record safety incidents, concerns, near misses and allegations of abuse. This included the online reporting tools, policies, procedures and audits. The trust worked with partner agencies such as the CCGs and social services to investigate any concerns and develop actions plans.
- Information regarding incidents was fed through to the Quality and Standards Committee, where safety and safeguarding concerns were reported, discussed and escalated to the trust board. This demonstrated that there were clearly defined systems in place for reporting safety incidents and allegations of abuse, which were in line with national and statutory guidance.
- The incident-reporting information available indicated that the trust reported within the national average for pressure ulcers, venous thrombosis, falls and urinary tract infections.
- We noted that the majority of the incidents reported in the community were grade three or four pressure ulcers, of which the majority occurred in the patient's own

home. We queried this with staff and managers and were told that the majority of pressure ulcers were acquired before the patient had accessed district nursing services.

- The Trust had a pressure ulcer prevention lead in post. All pressure ulcers were monitored and followed up as safeguarding incidents, if indicated. We saw that all the information relating to each pressure ulcer incident was reviewed to assess if it was avoidable and if trends could be identified and lessons learnt to prevent pressure ulcers in the future.
- We saw that two community teams were piloting a new pressure ulcer checklist to provide a root cause analysis and provide more information about the possible causes.
- We found that managers monitored incidents and undertook investigations and feedback as appropriate. All the managers we spoke with told us they had received training in investigating incidents and complaints. Managers told us about the governance and risk meetings they attended and how they disseminated the finding from any investigation to their teams.
- The community staff we spoke with were aware of how to raise concerns about untoward incidents. They were knowledgeable about the process and told us they usually received feedback either in an email, a meeting or in a report.
- We saw that learning from safety incidents was disseminated through bulletins, newsletters, the minutes of meetings and staff meetings. Although several managers told us there was no structured incident feedback process, they ensured their teams were aware of any learning from incidents. They gave the example of recent needle stick injuries following a change of needle design. They told us how additional information and training was given to alert staff to the risk.
- Most staff teams were knowledgeable about the process for gathering data as part of the NHS Safety Thermometer initiative. This tool monitored improvements in patients subjected to pressure ulcers, falls, venous thromboembolism (VTE or blood clots) and catheter-acquired urinary tract infections with the aim of improving clinical care.

- We saw that the information gathered for the Safety Thermometer was fed back to senior managers and directors of the trust, who used the information to inform them of the current risks and plan strategic priorities.
- In the community hospitals, we saw that information from the Safety Thermometer was prominently displayed for the general public.

### **Cleanliness, infection control and hygiene**

- The Trust had up-to-date infection control policies and procedures in place. This included disposal of clinical waste and sharps.
- We looked at infection control systems and practices and found that the Trust was within the national average for reportable infections such as MRSA, Clostridium Difficile and MSSA (methicillin-sensitive staphylococcus aureus).
- The patients we spoke with were all happy with their nurses' and therapists' standards of hygiene. They told us how the nurses used sanitising hand gel and/or used their own hand-washing facilities during visits to their home.
- During our inspection, we observed good hand hygiene and infection prevention practice within the district nursing clinics and by staff in patients' own homes. We saw that staff used personal protective equipment such as gloves and aprons. With the exception of the sexual health clinics, staff wore uniforms and adhered to the 'bare below the elbow' guidance to ensure that lower arms were kept clear of clothing and jewellery to help prevent cross infection.
- We saw the community hospitals, health centres and clinics were all generally clean and tidy, with appropriate infection control signage and hand hygiene facilities available. We saw that, generally, the public WC facilities across all the services were maintained to a good standard, although checklists weren't always evident.
- We observed some good infection control practice across the community, such as sharps containers, which were all dated and labelled appropriately. In Crowborough War Memorial Hospital we saw stickers to date and label when equipment was last cleaned. The radiology department had installed disposable curtains

in cubicles to replace material ones. This demonstrated that the community services were aware of infection control issues and, where possible, took action to promote best practice.

- We heard how the infection control champions undertook regular audits, such as the hand hygiene audits. The results of these were displayed. For example, the most recent hand washing audit for Crowborough War Memorial Hospital demonstrated 100% compliance.
- Infection control was included in the annual mandatory training for all staff. We saw that the Trust provided dedicated infection control training for community-based staff. However, not all staff were up to date with their mandatory infection control training.
- We saw there was a National Cleaning Standards audit team. Their role was to visit all areas within the Trust to audit and review of cleaning standards against the National Cleaning Standards set by the Department of Health. Areas were visited on a monthly basis with matrons and infection control personnel invited to attend and develop action plans. The reports from the audits fed into the trust's infection control group and quality performance review groups. The Trust also planned infection control awareness events which were open to all staff, such as the Listening into Action™ 'big conversations'.

### **Maintenance of environment and equipment**

- Patients were seen in a wide variety of locations throughout the Trust, ranging from GP surgeries, community hospitals, and clinics and in their own homes. We noted that, while the more modern facilities looked in good repair and were easier to maintain, some of the older locations were in the process of being updated and refurbished.
- We saw that equipment was routinely checked for electrical safety with portable appliance test (PAT) stickers on all electrical devices and equipment.
- Fire equipment, such as extinguishers were readily available throughout all the locations with evidence they were checked weekly by fire marshals.
- We saw that in some of the services, such as Seaford Health Centre and Station Plaza Health Centre, the layout and facilities were well thought out, with easy disabled access and WC facilities, comfortable chairs,

adequate space and low tables. This meant that patients could have confidential conversations with staff and the experience of attending the service was less stressful.

- However, in older buildings such as Bexhill Hospital, it was more challenging to provide a patient-friendly environment where there was inadequate storage space, narrow corridors and inadequate ventilation. Here, we saw queues of patients waiting in the reception areas and it was more difficult to maintain confidentiality.
- In Bexhill Hospital, we noted that the flooring in the outpatients department was being replaced during our inspection visit to the hospital. The flooring had been identified as a trip hazard on the Trust's risk register for several years without being rectified.
- At Bexhill Hospital, in the Dowling Unit there was no door to the area where eye tests were being carried out, meaning that patients waiting in the reception area could overhear confidential information.
- Staff and patients had identified that the Bexhill Hospital outpatients department was, at times, unbearably hot and stuffy. Although there were desk fans available this did little to alleviate the problem.
- We spoke with the senior managers responsible for the community hospitals and were told that, while no areas failed the health and safety audit, there wasn't a rolling maintenance programme in place and some areas required updating.
- We saw that resuscitation equipment across the community services were not standardised.
- For example, at Hailsham Health Centre, the equipment had not been signed as 'checked' since July 2014 and the emergency bag was opened and not documented as checked.
- In Crowborough War Memorial Hospital, we saw a comprehensive selection of resuscitation equipment, including: an automated external defibrillator, airways, anaphylaxis drugs and first aid equipment, which was kept clean and checked weekly.
- While at Bexhill Hospital, there was equipment kept on a dusty dressing trolley with little evidence available to confirm that the checks had been completed for some time. Staff eventually found a checklist stored in a nearby clinic room, but this was not up to date.

- This was brought to the attention of the matron for Bexhill Hospital, who provided assurance that the Trust's resuscitation officer would undertake a review and assessment of the hospital's resuscitation equipment requirements.

## Medicines

- There were systems in place for the safe administration of medicine in the community, including readily available policies and procedures.
- The Trust provided details of a report into improving medication error incident reporting and learning that was undertaken in July 2014. The report gave assurance that the Trust had made changes to improve medication error reporting in response to a joint patient safety alert issued by the Medicines and Healthcare products Regulatory Agency (MHRA) and NHS England.
- This demonstrated that the Trust responded appropriately to legislative and best practice guidance relating to medicines management.
- We noted that the drug fridge temperatures were monitored daily, at all the locations we inspected and we saw that drugs were routinely checked to make sure they were in date. For example, in the sexual health clinics, staff told us that, where drugs were within 12 months of expiry these were flagged on audit. We were told that a medicines management link nurse was in post who had a dedicated hour each week to audit medications in the unit and ensure they were stored appropriately.
- Community matrons told us that there was now a new policy in place to record the use of doctors' prescription pads. They told us that all staff were aware of the changes and were now working according to the new guidelines. This included individual prescription pads for each speciality and closer monitoring.

## Safeguarding

- The Trust had in place a safeguarding policy which had been reviewed and updated in June 2014. The policy addressed key lines of accountability, the procedures for staff to follow, details of the mandatory training and how compliance would be monitored. The policy included key contact numbers and reflected the plan set out in the Sussex multi-agency safeguarding policies.

- We saw terms of reference and minutes of meetings, which demonstrated that, through the East Sussex Safeguarding Adults at Risk Board, the Trust worked in partnership with statutory agencies, such as the local authorities and police, to safeguard vulnerable adults.
- The safeguarding lead worked with the local authorities to ensure that safeguarding in the community was identified, reported correctly, investigated appropriately and that actions were taken and followed up when necessary.
- We were told that reporting discrepancies had been identified where the Trust did not always receive notifications of alerts and reports that went straight to the local authority. They were working with the local authorities to put a system in place to rectify this.
- From the minutes of the Quality and Standards Committee and monthly departmental quality meetings, we noted that safeguarding was a standing item on the agenda and any issues were discussed, together with action plans.
- We saw that there were action plans in place to address the top three safeguarding issues in the community, which were pressure ulcers, falls and unsafe discharges.
- All the staff we spoke with, including administrative and portering staff, knew how to recognise signs of abuse and were confident about reporting concerns. Staff were given pocket guides as reminders about the actions to take if a safeguarding incident was suspected. We also saw safeguarding flow charts and reminders on staff noticeboards.
- At focus groups, the community staff described incidents where they had reported concerns and the action that was taken. Staff told us that safeguarding was well managed in the Trust. They told us, “Safeguarding is our ‘bread and butter’ – we do it well.”
- Therapists told us that safeguarding concerns were “always dealt with speedily and according to trust policies”. They told us that they usually received feedback following reporting an incident and any lessons learnt were disseminated through the team.
- Safeguarding vulnerable adults training was included in the Trust’s mandatory training programme and all staff were expected to attend training relevant to their role and responsibility. We heard that court room scenarios and practical tips on referring patients were included in the training.
- However, on reviewing training across the county we found that not all staff were up to date. For example, we noted poor attendance for safeguarding training in the Crowborough War Memorial Hospital and Heathfield Community Health Centre area district nursing teams.
- Although not all training was up to date, we found that the staff we spoke with understood the signs of abuse and were confident in escalating concerns and reporting through the trust’s safeguarding processes.
- Staff in various departments throughout the community gave us examples of raising safeguarding concerns and taking positive action to protect and support vulnerable patients. For example, staff in the sexual health clinic told us of recent referrals relating to domestic violence and district nurses told us about referrals relating to pressure sores.
- We found the Trust had robust arrangements in place to safeguard vulnerable adults.

## Records

- The Trust staff told us that they were introducing an electronic system of care documentation. We spoke with nursing and therapy staff, who told us about the move to electronic records. Although we heard that connectivity in East Sussex was problematic, the majority of staff using the new equipment reported that, after initial problems, they felt it was working well.
- The therapists told us that they were looking forward to receiving the new IT equipment and working with one set of integrated care records. We saw that the trust had put in place training for staff before the system went live earlier in the year.
- During our inspection, we reviewed care records at varying locations across the Trust. We found that, in the community hospitals, the trust relied heavily on paper-based care and medical records.
- We noted that medical records in the community outpatients departments were not always kept secure. For example, at Bexhill Community Hospital, we found medical records left unattended in shopping baskets awaiting clinics. Following clinics, they were left in unsecured transfer bags in the hospital corridors.
- We spoke with staff who acknowledged poor practice and told us it “didn’t look good”. We raised our concern with the matron for the service, who informed us that, following our inspection, the system for the storage and transfer of medical records was being reviewed.

- We also looked at the storage and transfer of medical records in the other community hospital outpatients departments and found that there was a greater awareness of confidentiality issues.
- For example, in the reception area of Uckfield Community Hospital, laminated cover sheets were available to cover personal information if needed.
- In the sexual health clinics, we noted confidentiality was given a high priority. There were no paper records and patients were given numbers and not names. The managers told us that the importance of confidentiality was stressed at employment.
- We found that, across the Trust, the specialist, therapy and out-of-hours services kept separate records. Although staff across the Trust told us there was good communication between all services, we were told they were looking forward to the therapists and specialist nurses being included in the new electronic system.
- The district nursing records we reviewed documented the care given at the visits, with the daily notes completed at each visit either electronically, at the patient's home, or back at base when the electronic system was not available.
- There was no evidence that formal records audits had taken place to monitor record keeping across the community services, however managers informed us this would also be rectified through the electronic system.

### **Lone and remote working**

- The Trust had policies and procedures in place to protect staff when working alone or remotely.
- We spoke with the community staff, who told us that they communicated well with each other through their shifts to let each other know where they were. Staff did not feel that security was an issue as they worked well as a team to support each other.
- Other services within the community also had procedures in place to protect staff when working on their own. For example, in the x-ray departments, we saw that staff were issued with a key fob alarm as they worked mainly on their own in the community hospitals. At weekends, they had put in place a procedure to telephone ahead of referrals to avoid patients arriving unannounced at the x-ray department, as they no longer had clerical support to oversee the reception area.

- Staff were kept safe through being aware of the risks of lone working and putting in place systems to protect them.

### **Assessing and responding to patient risk**

- In the community nursing services, we found that the initial risk assessments and care planning were well documented. However, there was little evidence that these were consistently reviewed or updated.
- The Trust had identified this as a risk on their risk register and were taking steps to address the issue through implementing the electronic system across the community services.
- We found that the updating of patients' risk assessments were not always carried out in a timely or effective manner.

### **Staffing levels and caseload**

- Senior managers acknowledged that staffing in the community was a serious issue and was included on the Trust's risk register.
- The community nursing teams, who had been coping with a 19.4% band five vacancy, told us that two weeks ago the 'freeze' was lifted and they were now looking to recruit across the county. However, there were other specialities and teams, such as the community matrons and speech and language therapies who told us that the recruitment ban was still in place.
- Since the inspection visit the Trust has told us that there were 22 FTE vacancies in the community nursing teams. They also told us that 17 FTE nurses had been appointed from the current cohort of trainees and that these would start work in January 2015. Five other posts were being advertised.
- However, there were areas they had had a poor response to adverts and they were now looking at other ways to fill the vacancies.
- This meant that for many months low-risk patients requiring the care of district nurses and patients requiring therapy, such as those with speaking and swallowing difficulties, were not seen within a reasonable time frame and some of the community matrons were managing exceptionally large caseloads and covering up to 16 GP surgeries.

- Because of staff shortages, matrons in the community hospitals were undertaking clinical roles covering for staff vacancies, sickness and annual leave. On the day of our inspection visit, a matron was working in the outpatients clinic.
- We spoke with the matrons, who told us that, because of covering clinical staff, there was sometimes not enough time to undertake their management roles. They told us this meant that recording key performance indicators, team meetings and managing performance data slipped.
- We heard that community therapists were sometimes called in to assist in the acute hospitals. They told us that they were not trained in providing acute care and this was a risk. They told us that there was little appreciated and much misunderstanding of the therapists' roles. They gave examples where a new in post junior therapist was expected to undertake multiple tasks to coordinate a discharge, without any support.
- We found that all the understaffed services worked hard to ensure that staffing issues did not affect patient care, but there were instances where insufficient numbers of suitably qualified staff had impacted on patient outcomes. For example, long waits to access treatment for patients who were not assessed as requiring urgent care.
- Across the Trust, specialist nurses, therapists, matrons, managers and senior staff told us that much of their time was taken up with routine administrative work. They told us that up to 40% of their time was spent dealing with administrative tasks, such as filing, HR issues and dealing with telephone queries. They raised concerns that this had led to a significant increase in their workloads and was not the best use of their training, qualifications or of trust resources.
- The Trust informed us that the turnaround team used a generic staffing tool to provide guidance on staffing levels aligned to the acuity and dependency of patients.
- The majority of patients we spoke with commented on how many different nurses they had seen at home. They told us that the nurses were all "very good", and that they understood about the staffing pressures and why they didn't often see the same staff twice, but they all told us that they would prefer more continuity.

### **Consent, Mental Capacity Act 2005 and Deprivation of Liberty safeguards**

- The Trust had policies, procedures, advice and guidance for staff relating to the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and consent. These were readily available to staff on the Trust's intranet, together with best interest guidance and relevant forms to conduct mental capacity assessments.
- The staff we spoke with demonstrated understanding of the act with capacity and consent firmly embedded in practice.
- When we accompanied the district nurses and attended outpatient clinics, we saw that patients were all asked their permission before any treatment or procedure took place and that all necessary consent forms were signed.
- Staff gave examples of best interest meetings being held in order to support families and patients in unsafe situations.
- The Trust had robust policies and procedures in place to guide staff in complying with the Mental Capacity Act (2005), Deprivation of Liberty Safeguards and consent guidance, although not all staff were confident in applying this in practice.

### **Managing anticipated risks**

- The Trust maintained risk registers, which were discussed at the monthly management meetings. The majority of senior managers we spoke with were new in post and had yet to have a firm grasp on managing the risks within their teams.
- We spoke with senior managers and directors at the Trust and were told they had identified that recruitment and retention of suitably trained and experienced staff was a major anticipated risk to the organisation.
- The Trust reported that the financial constraints, sickness levels and recruitment difficulties meant that many of the teams were understaffed and had been for some time. The Trust was aware of the staffing issues and had plans in place to address them, such as recruiting from abroad and developing their own workforce. However, there were inherent difficulties involved, due to the rural locations of some of the teams, which made recruiting and retaining suitably trained and experienced staff difficult.

- We found that the Trust had systems in place to manage anticipated risks and had developed action plans to address the issues. These were monitored on a monthly basis.

### **Major incident awareness and training**

- The Trust had an emergency planning policy and procedure in place to deal with unforeseen events, such as adverse weather and unforeseen staff shortages.
- The staff we spoke with were aware of the policy and told us how the alert system worked.
- They gave examples of how well the emergency planning worked, following recent flooding in the area when non-essential services were cancelled and overnight accommodation was provided for staff, with back up food available. We were told there was a robust action plan in place with action cards that worked well when recently tested.
- The Trust had robust measures in place to deal with major incidents and maintain public safety.

# Are Community health services for adults effective?

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

## Summary

The Trust community health services for adults required improvement.

We found that the lack of staff in some areas had an adverse effect on some patient outcomes. These were: district nursing teams, therapists and community matrons; whilst patients identified at high priority were always seen straight away, lower risk patients may not be seen unless their condition deteriorated and they became a higher risk.

The Trust provided opportunities for staff induction, learning development and appraisal. However, there was a lack of formal supervisory, clinical supervision, or peer support arrangements in place. This meant that staff did not always have the support structure in place to enable them to discuss and review their role and the treatment they provided.

Data collation and analysis of Key Performance Indicators was incomplete, with local managers reporting insufficient time to collect and submit data. There was very limited local analysis of trends and the information that was collected was not routinely used to improve patient outcomes. In the community hospitals, the information displayed on ward information boards was inaccurate.

There were good multidisciplinary and cross-boundary working, which meant that patients were assured of receiving the right care by the right team. The specialist services and x-ray departments were especially praised for the support they gave, not only to patients, but the teams and wider health and social care community.

## Detailed findings

### Evidence-based care and treatment

- The Trust had a range of policies and clinical guidelines available for staff. These were held on the Trust's intranet and readily accessible for staff in the community. The policies were based on current best practice guidelines, such as those from the National Institute for Health and Care Excellence (NICE).
- We saw there were also guidance for GPs working with long-term conditions in the community. For example,

protocols for GPs treating acute relapses of Multiple sclerosis. This demonstrated that the Trust was proactive in working to implement new best practice guidelines.

- The Trust employed lead and specialist nurses, who supported education around best practice in their specialist areas. We spoke with specialist teams across the Trust, such as the falls prevention service, multiple sclerosis and heart failure teams. These teams used best practice guidance to inform their care and the service offered.
- We found that the Trust had appropriate guidance, policies and procedures in place, but there were few monitoring systems in place to provide assurance that staff worked according to the evidence-based guidance.

### Pain relief

- The Trust supported patients with chronic pain through the pain management service. This was a multidisciplinary service that provided care for patients' suffering from chronic pain symptoms.
- Patients were encouraged to self-manage their conditions, and were provided with educational support to assist in their choices of treatment and lifestyle adaptation.
- This was done through educational workshops, group drop-in sessions and pain management programmes. This service was not reviewed during our inspection.

### Patient outcomes

- We found that, in general, patients were achieving positive outcomes for their conditions following intervention by the Trust staff.
- The care and treatment provided usually achieved positive outcomes for people who used the service. We spoke with 61 patients during our inspection, reviewed details of serious incidents, safeguarding referrals, complaints and looked at patient feedback.
- We found that low staffing levels had impacted on patient outcomes. For example, in the speech and language team the core elements of the work were protected, but telephone triage was lost, which staff felt increased the time to treatment as the triage was now

# Are Community health services for adults effective?

done by letter. High priority cases were seen within four weeks, medium priority within 16 weeks. For patients with a swallowing problem, this long a wait may have significant consequences.

- District nursing teams told us that whilst patients identified at high priority were always seen straight away, lower risk patients may not be seen unless their condition deteriorated and they became a higher risk.
- We saw that, because the district nursing teams were managing heavy caseloads, their day was very task orientated. Patients did not have a named nurse and could see a different nurse at each visit. One patient we spoke with had seen over 25 different staff in the six months they had been receiving care. Although they had no complaints about their care, they told us they would prefer to have a familiar face attending to them.
- We found the corporate caseload management system presented a risk to patient care, as patients did not have a dedicated nurse responsible for monitoring and reviewing their care.
- The specialist nurse teams worked with patients with long-term conditions with the aim of preventing hospital admissions, where clinically appropriate, and helping patients to live with their conditions. We spoke with the falls prevention service, who worked with the ambulance trust and admitted vulnerable patients to local nursing homes with contracted beds, where appropriate. The community matrons told us that, because of lack of staffing capacity, they found it difficult to be effective in admission avoidance. Data to support or refute this not available.
- We saw that three multiple sclerosis nurses had helped to develop an assessment tool, which was used across the county and formed part of the single assessment process.
- In the sexual health clinics patients were kept safe, as staff monitored outcomes and took appropriate action when issues were identified. We heard how, following a concern raised, a number of patients were recalled to have their treatment reviewed. We were told that patients were reassured by the recall and that the clinic's practice was changed as a result, following a review of the nurses' practical skills.
- In the x-ray departments, we saw that there was good evidence of reporting and secondary checking of

diagnosis. There was a call back system for patients where a negative diagnosis by a clinician showed a possible fracture on the x-ray with call backs for extra tests, if needed.

- Community therapists told us that, with the new configuration of services, a lot of their time was spent travelling, which impacted on the number of patients they could treat. They told us of their frustration when inpatients were told by staff what would happen when they were discharged, but the community staff did not have the resources to meet patients expectations.
- However, all the patients we spoke with talked positively about the care they had received and told us about the way the community services provided had helped to improve their lives.

## Performance information

- The Trust used performance indicators to benchmark the outcomes for people using the service. However, because of the change and transformation programme, together with the rationalisation of services, we were told that the data collected was not always complete. Managers told us because they were often needed to work in a clinical capacity this did not leave enough time for the managerial roles, such as the collection and analysis of performance data.
- We saw performance information was available in the community hospitals. However, we queried the accuracy of the data. For example, one noticeboard stated that the matron or a deputy would conduct hourly rounds. However, the matron was not on site and there was no evidence available to confirm that the rounds took place. We asked staff who the matron's deputy for the day was, and staff didn't know. Other noticeboards gave conflicting information about key performance indicators.
- We spoke with managers, who told us about new initiatives to collect data and told us that the implementation of electronic records would improve data collection in the future. The community matrons who were using the new system told us they did a lot of auditing and monitoring using the electronic record system and it was a good way to capture data to inform practice. .
- The Trust had an annual clinical audit programme, which was made up of clinical audit projects undertaken within each of the Trust's clinical directorates. Each directorate agreed its own clinical

# Are Community health services for adults effective?

audit topics. For example, departmental records audits and national audits, such as the stroke audit. We saw that some audits were undertaken in response to local concerns, such as why patients did not attend outpatient appointments. Others were in response to safety incidents, for example, the multiple sclerosis specialist nurses conducted audits to gauge if their role was effective and to establish the benefit of their service.

- We spoke with radiographers, who told us about the audits they undertook, including auditing any unnecessary exposure to radiation. They told us that the findings of the audit had raised concerns, which were being escalated through the appropriate teams. Their audits had also identified that there were long delays in reporting on non-urgent cases. This had been escalated and the department was now allocated a designated radiologist who provided same-day reports. This demonstrated that the trust took action where monitoring identified areas of concern.
- The Trust had systems in place to monitor its safety performance through the electronic incident reporting system. The most common type of serious incidents reported were pressure ulcers (grades 3 and 4), which accounted for the majority of the incidents. We saw that the information was used to inform practice and prioritise resources.
- We found the Trust was collecting data to monitor performance. However, a period of stability was needed to embed the process and benchmark the information, both locally and nationally.

## Competent staff

- The Trust provided training opportunities for staff from induction and mandatory training to funding for bespoke specialist training. We saw that the trust produced a learning and development training brochure, which documented the training opportunities for the coming year. Staff were encouraged to apply and book courses, such as 'Breaking bad news', annual mandatory training, leadership and major incident training.
- Staff told us that their managers supported them in attending training, but with the staffing shortages and distances involved, it was sometimes hard to attend. In response to this, managers told us they were putting more training on locally and in house. For example, one

community matron told us how they arranged moving and handling, infection control and resuscitation training within the local community hospitals where it was more cost effective and more staff attended.

- Staff told us that, when there was new equipment, they had received relevant training. For example, all the district nurses we spoke with told us about the training they received for the new electronic records system.
- Qualified staff told us that there were lots of personal development opportunities available in the Trust. Specialist nurses told us that they were qualified to advanced practitioner level. They told us about further training and qualifications they had gained, such as foundation degrees, post graduate courses, individual modules and mentorship. One manager told us that, although there were budgetary constraints, all their teams mandatory training was up to date and they had secured funding for specialist dementia training.
- Following any training, the details and attendance was inputted onto each member of staff's electronic staff records and a copy kept by the manager. Training attendance was flagged by a traffic light system, making it easy for managers to identify staff who required training. The training records across the Trust showed that the majority of staff had undertaken their mandatory training, although where there were identified gaps managers were aware of them and were chasing them up. The managers we spoke with told us that they acknowledged that, due to staffing pressures, monitoring of mandatory training had "slipped".
- Staff told us that new staff received a good induction to the Trust. We spoke with staff who were new to the trust and they spoke positively about their recent induction, which included resuscitation, moving and handling and infection control.
- We spoke with administrative and support staff who told us they were given the training needed to deliver the service. One administrative member of staff told us, "I've just signed up to do an NVQ (National Vocational Qualification)." They told us that there was no problem with them accessing courses that were supported and financed by the Trust. They gave an example of 'Medical terminology' and 'First impressions count' courses, which they told us were very useful.

# Are Community health services for adults effective?

- The majority of staff we spoke with told us they had received an annual appraisal. This was confirmed by the records we saw. However, teams that had been without a manager for some time, told us over four years had passed for them without an appraisal.
- We spoke with senior nursing managers, who told us that clinical supervision was available for nurses if they wanted it. Although it was encouraged, it was optional. They told us they had managerial supervision from their immediate line managers.
- Due to the lack of available managers, appropriately qualified team leaders or allocated time, staff told us that they had not received clinical supervision and support for several years. One therapist told us that they had not received clinical supervision for over three years. As the Trust had not prioritised clinical supervision and there were few formal arrangements in place, staff had found other ways to support each other, such as using team meetings, peer review and sources from outside the Trust.
- The Trust provided opportunities for staff induction, learning development and appraisal. However, there was a lack of formal supervisory, clinical supervision or peer support arrangements in place. This meant that staff did not always have the support structure in place to enable them to discuss and review their role and the treatment they provided.

## Use of equipment and facilities

- There were systems in place to ensure the safe use of equipment and facilities across the community services.
- We spoke with staff with responsibilities for facilities management, who told us about the systems and processes in place to make sure equipment and facilities were maintained to a good standard.
- We saw that the community hospitals were well signposted with signage appropriate for patients with sight impairment.
- Therapy staff told us that there was generally no problem with accessing equipment, with an emergency store available if required. Apart from a two to three week delay in rails, most equipment was available when required. A podiatrist told us, "I have all the equipment I need to do my job – it's not a problem."
- We found there were robust arrangements in place to provide a safe radiological service. The x-ray service was supported by a radiation protection adviser, who

provided advice and support when required. We saw that each service had a local radiation protection supervisor, who was responsible for the local safety arrangements.

- We saw that the required checks on the equipment and lead aprons took place. For example, at Uckfield Community Hospital, we saw that the manager was also the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) lead and they ensured that the safety precautions, such as dosage badges and lead aprons, were adhered to. Dosage audits took place and were monitored by the radiation protection adviser.
- We saw that the IRMER 2000 policies, local rules and working processes were all updated and in place.
- This demonstrated that the x-ray service had robust systems in place to monitor the safe use of equipment and x-ray facilities.

## Telemedicine

- The Trust had introduced telemedicine into some areas of the community. For example, stroke patients could now be assessed and treated by specialist consultants 24 hours a day by using a video camera and television. This allowed the consultants to make quick clinical decisions from locations outside the hospital, such as their home or another hospital, at any time of the day or night. This was helping patients to receive emergency drug treatment quickly, increasing their chances of making a good recovery.

## Multidisciplinary working and working with others

- We found many examples of good multidisciplinary working both within the Trust and with outside organisations. For example, staff from the sexual health team told us about their close working with the human immunodeficiency virus (HIV) specialist team from Brighton. They told us about the multidisciplinary team meetings that took place to support pregnant HIV-positive patients.
- Staff working closely with other trusts told us of the problems associated with working with different sets of records, policies and expectations. They said that, although staff worked under East Sussex Healthcare NHS Trust's policies and procedures, the different paperwork and medical records threw up challenges.

# Are Community health services for adults effective?

We saw minutes of meetings where the differences between other trusts and organisations was explored and a consensus met on the right process or documents to follow.

- Across the Trust, staff told us they had a good relationship with specialist teams who were a good resource for other health services. We heard from the specialist teams, such as the multiple sclerosis nurses who attended multidisciplinary meetings with physiotherapists, speech and language therapists and occupational therapists.
- We heard from the multiple sclerosis nurses who showed us the work they had done to develop a relapse protocol and flow charts for GPs to aid prompt treatment and diagnosis.
- The community matrons told us how they worked well with the local GP surgeries. They told us they were part of the community team and worked with the GPs to develop joint care plans.

## **Coordinated integrated care pathways**

- In the therapy and rehabilitation teams, staff described the patient-centred model of care and how they worked

collaboratively with other health and social care coordinators. We saw that patients followed integrated care pathways where appropriate. This was a plan of care written and agreed by a multidisciplinary team and designed to help patients with a specific conditions move progressively through the clinical experience.

- The Trust used an electronic system working with GPs and ambulance service to reduce admissions to hospital. This system alerted the right team and GP surgery if a patient had received care from the ambulance service. They could then quickly be referred to the right team in the Trust. For example, if a patient had a fall at home and called the ambulance service they could quickly be referred to the falls team to reduce the chance of them having another fall.
- The community matrons told us they worked closely with the ambulance service with joint training, shadowing and meetings, which they told us were really useful to share knowledge and best practice.
- Senior managers told us that their roles now included building external relationships with the local CCGs and acting as a single point of contact.

# Are Community health services for adults caring?

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

## Summary

We spoke with 61 patients, or their carers, across the Trust, from community hospitals, health centres, to visiting patients in their homes or contacting them by telephone. All the patients we spoke with, without exception, told us how pleased they were with the care and treatment provided in the community by East Sussex Healthcare NHS Trust.

We were told about the kind and caring community nurses and therapists who “went above and beyond” and offered an “excellent” service.

During our visits with the district nursing teams into patients’ homes and in outpatient clinics, we witnessed and observed good interactions with staff demonstrating knowledge and respect for the individuals care and emotional needs. Patients were full of praise for the teams that saw them at home. The district nurses had a good rapport with their patients and involved them in any decisions about their care.

Although few of the records we looked at included assessing patient’s emotional needs or included care plans that addressed this, we found that, in practice, the community teams supported patients emotionally, although this was not well documented.

There were systems in place to support patients to manage their own health and care and, where possible, to maintain independence. Patients told us that, without the help and support of the community teams, they would not be able to remain in their own homes.

## Detailed findings

### Compassionate care

- During our inspection, we observed the interactions between staff and patients in the community hospitals, health centres and in patients’ own homes. We spoke directly with 61 patients or their carers across the Trust, from clinics and outpatients to visiting patients, either in their homes or by contacting them on the telephone. We looked at patient feedback and the complaints the Trust had received. The information provided indicated

that staff in the Trust treated patients with care and compassion. We did see a few complaints in which staffing attitude was a factor, but these issues had been dealt with promptly and appropriately.

- Every patient that we spoke with spoke highly of the kindness of the nurses and therapy staff. One patient summed up the views of all the patients by saying, “We just couldn’t do without them.”
- Staff from the specialist nursing teams told us that they regularly received positive feedback from the GPs with compliments from the patients who used their services. Teams such as the multiple sclerosis nurses showed us thank you cards from grateful patients.
- Staff also told us that, as well as working for the Trust, they lived in the area and were sometimes ‘patients’ themselves, as well as their families. They said they would have no hesitation in recommending the community services because, they said, “We put the needs of patients first.”
- The staff in the x-ray departments told us they did not get complaints about their attitude as they always “went the extra mile” for their patients.
- In the outpatients and reception areas of the community hospitals we saw staff taking their time with elderly or confused patients, giving unobtrusive assistance in a kind and thoughtful manner.

### Dignity and respect

- We spoke with patients in the community hospital outpatients departments, those receiving care from the specialist care teams and district nursing services. All the patients and carers we spoke with told us that the staff always treated them with dignity and respect. We were given many examples in which nurses had taken time to explain things to them and treated them with respect and compassion.
- During our visits with the district nursing teams into patients’ homes we witnessed and observed good interactions with staff, who demonstrated knowledge and respect for the patients’ care and emotional needs. For example, we saw the nurses greeted the patients and explained the reason for their visit and delivered care in a room with the doors shut.

# Are Community health services for adults caring?

- One patient told us that they were always treated, “Like a human being, who, despite my disabilities has a contribution to make in the community.”

## Patient understanding and involvement

- Patients were full of praise for the teams that saw them at home. We observed that the district nurses had a good rapport with their patients and involved them in any decisions about their care. For example, the care records documented patients’ decisions, such as notes on a patient with leg ulcers discussing when they wanted their feet washed between dressings.
- Patients told us staff always explained the care that was given and the options that were open to them. They told us they were partners in their care and felt information was shared that enabled them to make decisions about their own care and treatment. Carers we spoke to told us they felt involved and that they were listened to.
- Patients told us they had had a very positive experience of attending the community hospitals. They told us, “It’s local, friendly staff and, although parking is sometimes an issue, it’s free.”
- We saw that, throughout the Trust, there were information leaflets available on various conditions, accessing services and the types of support available. The leaflets were available in other languages, where needed.
- Staff in the specialist teams told us how they had developed an educational package for patients to help them understand their condition and that this had been very well received. The trust provided information that supported people to make decisions about their care and treatment.
- We saw that the Trust used different coloured lanyards printed with the designation or role of the member of staff such as ‘matron’, ‘staff nurse’ or ‘admin’. This was a simple and effective means for patients and other members of staff to quickly identify who they were talking to.

## Emotional support

- Few of the records we looked at included assessing patient’s emotional needs or included care plans that addressed this. Assessments were focused on the physical aspects of patients’ conditions.
- For example, the 13-page multiple sclerosis specialist nurse assessment form included one section on ‘mood’ which gave two questions: ‘Was the patient’s mood affected and did they suffer from depression or anxiety?’ There was no formal assessment of the emotional impact of the illness included in the assessment.
- However, in practice, we found that the community teams supported patients emotionally, although this was not well documented.
- We were told by patients that the staff were knowledgeable, caring and, most of all, willing to listen.

## Promotion of self-care

- There were systems in place to support patients to manage their own health and care and where possible to maintain independence.
- Patients told us that, without the help and support of the community teams, they would not be able to remain in their own homes.
- We saw that therapists visited people in their homes offering advice on lifestyle, diet, exercise and equipment.
- Patients told us, “Most of all, they appreciated my limitations, but were supportive of the efforts I made,” and, “I’m hoping they can improve my mobility like they did last time,” and, “They are really helping me to get back into the world.”
- One patient told us, “I started off heavily dependent upon the NHS. Now I am able to live with a very limited need for NHS care. I believe that my progress has been greatly assisted by the staff and facilities available.”

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

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

## Summary

We found that, due to the staffing constraints many patients identified as non-urgent had their care and treatment deferred until they either didn't require the care anymore or their condition became worse so that it became 'urgent'.

All the patients we spoke with spoke highly of the community services and told us that, although they sometimes experienced long waits, when they did get to see healthcare professionals and clinicians the care and treatment was excellent.

For services that operated 'walk-in' clinics, such as the sexual health and x-ray departments, patients reported few delays in accessing treatment. Throughout the service, we found that, where delays occurred, staff worked hard to keep patients informed.

Although the financial constraints meant there were restrictions on the services the Trust could offer, we found that staff were flexible and responsive to the needs of the community, where possible. For example, 'pop-up' clinics took place to reduce waiting lists in urology, x-ray departments opening seven days a week and staff in all departments prioritising urgent patient needs and responding appropriately.

Pressure on beds at the acute hospitals resulted in rapid discharges to the community teams; sometimes this was before the necessary arrangements and equipment had been put in place. This left people at risk of care failings and harm from, for example, a lack of pressure relieving mattress.

Whilst services provided by the sexual health clinics were generally regarded favourably by patients, they did not meet the needs of parents who needed to attend with their young children.

The referral to appointment time for x-ray services within the community hospitals had been increased due to administrative changes that showed no obvious benefit to patients or staff. Letters that were sent out from the department now had to be franked in Eastbourne, causing increased staff handling time and delays.

Although the Trust had corporate systems and processes in place to handle complaints, we found that they were not always effective. The information for patients was often out of date, referring to obsolete contact details. Patients were not always supported to raise concerns and there were no systems in place to record or monitor the issues resolved at local level.

## Detailed findings

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

- We found that service planning in the Trust was complex, due to the financial constraints, service reconfigurations and demands of the different CCGs.
- We heard from the individual staff groups who were working to plan their service delivery in an uncertain and shifting environment. For example, staff in the community were uncertain if their service was financially viable or would be recommissioned in the future. In spite of this, we saw that staff were proactive in promoting their specialties and working hard to ensure they offered a good service.
- For example, staff from the sexual health clinics told us of the work they were doing to increase the attendance of men at the clinics. This included prioritising men being seen in the clinics to prevent them walking out before being seen and a pilot to undertake asymptomatic screening.

### Access to the right care at the right time

- We spoke with patients, who told us that whilst, mostly, they received the right care at the right time, there were sometimes long waits when their care and treatment was assessed as non-urgent.
- We spoke with staff in the various specialist clinics and most were able to see urgent patients within the target times for the service. However, we were told of, where patients were identified as non-urgent their care was deferred until they either didn't require the care anymore or their condition became worse so it became 'urgent'. For example, for speech and language therapists, the waiting time for non-urgent cases was between 12 to 16 weeks. They told us this was a concern

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

as the majority of their patients were referred with swallowing difficulties. They told us that the long waiting times were the only complaints the service received.

- We found that the x-ray departments and sexual health clinics operated walk-in clinics where few appointments were organised. Many patients told us how convenient this was and that they usually didn't have to wait long.
- One patient told us they were very happy with the x-ray service, as they had gone to their GP first thing in the morning and were sent straight to x-ray where they were seen within 20 minutes. They told us, "It's small, local and I really like it."
- Staff in the x-ray departments told us that there were no delays in accessing their service and most people were seen within ten days of referral. Staff also told us that, more recently, there had been delays with GP letters and appointments, due to administrative delays. They told us that, where letters used to be sent to patients directly from the community hospitals, they were now sent to the post room at Eastbourne District General Hospital for franking. This had led to delays and appointments now needed to be booked at least two weeks in advance to allow for the delay.
- In the sexual health clinics, we noted there were busy times when patients sometimes had to wait for over two hours. Staff told us that this increased the risk of patients walking out and not returning. The clinic kept a record of 'walk outs' and monitored the situation. Certain groups, such as children under 16 were always given priority and were seen first to avoid this vulnerable group walking out.
- We heard from patients accessing the sexual health clinic with young children. They said that it was sometimes a problem in the waiting room with large numbers of young students accessing the service and acting in a loud and inappropriate manner in front of young children.
- In the community hospital outpatients departments, we found that when there were delays to clinic times staff worked hard to keep patients informed. In Bexhill Hospital, there was a television screen which gave waiting times and general information, although this didn't include the reason for the delay. We spoke with staff at Uckfield Community Hospital, who gave an example where a patient had presented with complex issues and had taken longer than expected. The

receptionist informed any waiting patients about the delay. We spoke to patients waiting in the hospital's outpatient departments who told us, "It's efficient and we don't have to wait long."

## Flexible community services

- We spoke with the specialist nursing teams, such as the falls prevention service. They told us that they were able to prioritise referrals and attend patients requiring an urgent visit within an hour. They gave examples of attending patients requiring urgent blood tests or who had a blocked catheter.
- The staff in the sexual health clinics told us that they would stay late after a clinic if they were needed urgently and gave examples where this had happened. They told us that there were systems in place with the local GP clinics, A&E and pharmacies to provide emergency help and advice out of hours, if needed.
- There was no sexual health service available on the far East of the county and patients who lived there would need to travel to Hastings or into Kent to access a sexual health service.
- The specialist nurse teams told us how they prioritised referrals. The multiple sclerosis nurses were able to see high priority cases within two weeks with a one month delay for patients assessed as low priority.
- The x-ray departments told us that they responded quickly to increasing local demand and gave the example of opening seven days a week, rather than three.
- Matrons told us that the service was becoming more responsive with the advent of 'pop up' clinics. These were clinics arranged at short notice to address a particular demand to meet the 18-week deadlines. They gave the example of urology clinics, where the clinical services manager would telephone patients to arrange the appointment.

## Meeting the needs of individuals

- At Bexhill Hospital, we noted that there was an issue with car parking availability, with only three disabled car parking spaces close to the entrance. We observed frail, elderly patients being left unsupported in the entrance of the hospital while their carers went to find a space for car parking. We spoke with the portering service and administrative staff and noted that, due to the shift system there were often times when there were no staff available to support frail patients in the reception area.

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

- There were a range of information leaflets available in the locations we visited from the GP clinics to community nursing hubs and community hospitals. We saw that leaflets were available in a variety of languages, if required.
- The patients we spoke with all confirmed that their needs were being met and were full of praise for the service they received.
- Most patients we spoke with knew how to contact their district nursing teams if they needed to. Some said it would be good to know at what time of day a nurse would visit, but in cases where this was crucial, such as the administration of medication, the team clearly did stick to the same time of day.
- Managers told us they were proud of their staff and their “can do” and flexible attitude, which enabled them to meet the needs of their patients even when working under pressure and when they were understaffed.

## Moving between services

- The Trust looked for ways to ensure that patients were safely transferred and discharged into the community. For example, discharges from the acute hospitals were often complex, resulting in delays of transfer or unsafe discharges.
- Community staff told us how they worked with the staff in the acute hospitals to ensure every discharge was safe, but the pressures on both the acute and community services meant that sometimes patients were discharged in a hurry before everything was in place.
- Delays in discharges recorded by the Trust as, “Awaiting equipment and adaptation” was 3.8% compared to the England average for all trusts of 2.9%
- Patients we spoke with told us about their experience of transfer between services and, in general, no problems were highlighted with the community services.

## Complaints handling (for this service) and learning from feedback

- The Trust had policies, procedures and guidance available on the staff intranet to support staff when

dealing with complaints. This demonstrated that the Trust had mechanisms in place to inform patients and guide staff when dealing with complaints about services.

- We saw there were leaflets and posters giving details on how to complain about community services available in most of the locations we visited, from GP surgeries and specialist clinics to the community services hubs and hospitals. However, when we looked at the complaints leaflets and posters across the trust's locations we found that they were out of date, giving the contact details of non-existent organisations with obsolete phone numbers and email addresses.
- In the community hospitals and health centres, the complaints information was not always obvious. For example, in Bexhill Hospital reception area, we asked various members of staff to show us how patients would raise concerns about the hospital and eventually staff found some complaints forms in a locked cupboard in an office.
- In the outpatients department, we saw there was clear information on display about who was in charge and who to speak to if needed.
- Staff at Seaford Health Centre told us that a ‘Blue Box’ for patient comment slips was installed in the past two weeks. We noted that there was no signage or information on the box explaining what the box was to be used for.
- The community teams in general received a low volume of complaints. However, we noted it was difficult for patients to raise concerns or make a formal complaint because patients were not supported to make complaints and the information was not always readily available.
- Staff told us that if a patient or carer expressed a concern they would try and rectify it immediately, or if they wished to make a formal complaint they pointed them to the trust's complaints process.
- We found that there was no system for recording or monitoring concerns, or the issues resolved at local level. In practice, the complaints system did not encourage patients to raise concerns.

# Are Community health services for adults well-led?

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

## Summary

East Sussex Healthcare NHS Trust had been through a sustained period of change and reorganisation leaving community staff feeling disaffected. Staff told us they appreciated that the most recent reorganisation was clinically driven and change was needed, however, they told us the process was poorly managed. We heard comments, such as, “Who is our manager this month?”

Many staff were confused as to the new organisation structure. Of those we spoke with, few could identify who was in post above their immediate line manager. Although staff recognised the need for reorganisation, few staff had confidence that the Trust valued or promoted community services and were fearful for the future of their speciality or department. We were shown several different versions of the Trust’s organisational charts, which demonstrated that the Trust’s vision, strategy and organisational strategy, particularly for community staff, had not been adequately communicated. Many staff felt disaffected, telling us they didn’t know if their role, speciality or department would be continued as their services were out to tender or consultation

The staff’s perception of Trust engagement was varied. Some staff told us that they had not been consulted about the recent changes and felt that the trust had not listened when concerns were raised about the reconfiguration with other staff speaking more positively about the changes.

Throughout our inspection, the community staff told us that, apart from the weekly newsletter from the chief executive, they felt there was little communication from the board and senior managers and that the constant reorganisation of community services had led to them feeling demoralised and undervalued.

They told us that they felt that leadership “imposed change” without listening. Staff told us they felt “out of the loop” and gave examples of trying to find patients on certain wards, only to find it had been closed..

The majority of staff told us they felt valued and supported by their immediate line managers and in the absence of

any other information would just continue doing what they always did, “Look after the patients until we’re told otherwise”. All the staff we spoke with told us that they felt able and supported to raise concerns or whistleblow.

We saw differing degrees of public engagement. In the community hospitals and Joint Community Rehabilitation Service we saw there were systems in place to gather patient feedback such as comment boxes and information notice boards. However there was little evidence of engagement with the public in any of the other community teams we inspected. With some staff aware of the patient feedback forms, others were not aware of any system for patient feedback and saw little value in it. We found that patients receiving care in their own homes were not generally encouraged or supported to provide feedback on the services they received.

## Detailed findings

### Vision and strategy for this service

- We were told that East Sussex Healthcare NHS Trust’s vision was to be the health provider of first choice for the people of East Sussex and to deliver better health outcomes and an excellent experience for everyone who used their service. The Care Quality Commission (CQC) was provided with details of the mission statements. However, it was clear that the staff we spoke with were not sure what the vision, strategy or aims were, as there had been so many changes. This was confirmed by the information given to the CQC not being the same as on the Trust’s website or in various corporate documents and leaflets found throughout the Trust.
- The Trust covered wide and disparate communities, from busy towns to isolated rural settlements with poor transport links. We noted the difficulties in providing parity of services across the county.
- We spoke with senior members of the Trust, who told us that it was a challenge to deliver consistently good care across the county. They discussed the Trust’s three objectives which were:
  - To improve the quality and clinical outcomes by ensuring safe patient care is the highest priority.

# Are Community health services for adults well-led?

- To play a leading role in local partnerships to meet the needs of the local population and improve and enhance patients' experiences.
  - To use resources efficiently and effectively for the benefit of patients and their care, in order to ensure services are clinically, operationally and financially sustainable.
- From discussions with staff and patients, observation of practice and review of documentation, we found that the Trust board was aware of the areas that presented the most significant challenges and had plans in place to deal with them. For example, addressing understaffing in some of the community teams and introducing new technology to improve record keeping and data collection across the county.
- However, we did not find that staff were aware of the Trust's strategies for meeting their objectives or how this impacted on community services. In particular, frontline staff were not aware of whether or not community services would be part of the Trust's future and this was leading to them feeling demoralised and undervalued.
- Managers told us about monthly core service reviews that took place, which included risk assessments and health and safety issues.
- We spoke with therapists, who told us about their monthly clinical governance meetings. They told us the meetings were really useful, not only to network with colleagues, but to connect to the wider Trust.
- We spoke with the district nursing staff who told us that they had not had any staff meetings since 2013. They told us this was the forum where incidents and complaints were usually discussed, but due to staffing constraints and changes of managers these had not happened for some time.
- We found that there were systems in place to monitor and review the service offered by the Trust. However at a local level, where services had been without a substantive manager for some time, there were few formal systems in place for dissemination of clinical governance and risk management issues.

## Leadership of this service

### Governance, risk management and quality measurement

- The Trust had available a full range of policies, procedures and guidance for staff available on the staff intranet. These were readily available for staff working in the community to access and those seen were in date and met with current best practice guidance.
- Risk management and quality measurement of services was monitored through the Quality and Standards Committee. Information was fed into this group who then reported directly to the Trust board. The Trust gathered information and data which enabled them to benchmark their performance against other similar trusts and the different areas within the Trust. The performance information included Commissioning for Quality and Innovation (CQUIN's) targets, which linked payments to local quality improvement goals.
- Although the Trust has been through a prolonged period of change and restructure, we found little evidence that regular reviews of the service had taken place to monitor the impact of the changes. Corporate and clinical governance systems were not fully integrated. There was little evidence to demonstrate how clinical audits were prioritised and carried out to improve the service
- Staff told us that, recently, the trust's board had become more visible, holding walkabouts in locations across the trust. For example we were told the radiology departments, outpatients and a therapy team had received visits by a member of the executive team in 2014.
- The chief executive officer held leadership events for managers within the trust, including matrons, clinical lead doctors and managers. The leadership events discussed issues such as quality and safety issues, performance and the trust's financial position. We heard that the group discussed quality issues, such as the integration of patient pathways, communications and motivating staff.
- The chief executive sent a weekly message to all staff via email. While some staff spoke positively about this, others told us that the language, tone and style of the weekly email was not conducive to raising morale. One member of staff told us, "We feel under pressure and out of the loop, and then we get a 'chirpy letter' from the CEO, which is meaningless." They told us they felt the Trust board knew nothing about the community services, what they did and the pressures they were under.

# Are Community health services for adults well-led?

- Individual teams told us that they were well led by their immediate line manager and felt that there was now a strong leadership team above that. They all told us that they received good support from their immediate team members.
- Staff in the community hospitals told us that the recent changes were a positive move and they now felt more supported and less isolated.
- However, some of the specialist nursing and community therapy teams told us they had had no stability of management, with one team having six managers in the past five years. One group of therapists told us that, during the reorganisation, they had been five weeks in a “vacuum”, not knowing who they should report to or who was in charge of them. They told us they had not yet had a meeting with their new manager or even received an introductory email.
- Senior managers told us that the leadership of the organisation had improved within the past two months. They told us that they now felt more supported and were confident that their voices would now be heard. For example, we were told that, in the past, only informal management meetings took place, but since the organisational changes these were now more structured and happened on a planned and regular basis. However, managers told us that it would improve the service they offered if they could be more autonomous within their role. They gave examples of recruiting staff. They told us that the recruitment freeze had affected most of the community teams and although it was now lifted for the district nursing services, there were still too many obstacles and delays in the recruitment process for it to be an effective process.

## Culture within this service

- The Trust had been through a sustained period of change and this had affected staff morale across the organisation. Many staff told us that the leadership “imposed change” without listening. However, the majority of staff told us that, although the past year had been difficult, they felt things were gradually improving.
- Staff in the community told us that they often felt like “the poor relation” within the Trust, losing out to the acute sector in funding and priorities. This included all the community teams from the therapists, radiological and nursing services. The majority of staff we spoke with told us they felt “side-lined” and “marginalised”. They told us there was little communication from the Trust relevant to community services. We saw that there were noticeboards, leaflets and documents within the community hospitals that were still headed with their previous organisation’s names. This indicated community services were still not fully integrated within the wider Trust.
- Staff across the Trust told us that they would have no problem in reporting concerns, complaints and whistleblowing if needed, especially where this affected patients. Many staff told us that their managers had an ‘open door’ policy and they felt able to raise issues with them. One member of staff told us that they would be happy to whistleblow if needed because, “In the end, I’m a user of services as well as a member of staff and we want to get it right,” This indicated that the open culture and ethos the Trust was promoting was fully embedded in the community teams.
- Across the community services, managers told us they were proud of their teams and the work they did to support patients and their families. Staff told us individual stories about how supportive managers were. We observed senior managers giving open and honest feedback about the inspection process to their line managers and noted there were no barriers or hesitation in the responses. This demonstrated that staff felt able to raise concerns with their managers and that the culture was open and honest.

## Public and staff engagement

- Matrons of the community hospitals told us that they encouraged feedback via the NHS Friends and Family Test feedback system. They told us that patients’ main concerns were parking and waiting times and that, in general, they received positive feedback about the staff and environment.
- In the community hospitals, we saw differing degrees of public engagement. In Uckfield Community Hospital, we noticed the comment box was full, when we queried this with staff they told us it was emptied weekly and the comments used to inform the NHS Friends and Families Test.
- We saw ‘How are we doing?’ comment boards in each of the community hospitals, but some of the information on these was conflicting, or did not give assurance that action was taken. For example, in Bexhill Hospital, the noticeboard stated that patients had complained about delays and waiting times. The action identified was to

# Are Community health services for adults well-led?

monitor the situation and provide updates every 15 minutes. We did not see evidence that this had happened. Another complaint was that air conditioning was needed in the outpatients department. The action was to provide fans and open windows. In both cases, there was no attempt to explain the lack of action or provide effective remedies.

- There was little evidence of engagement with the public in any of the other community teams we inspected. Some staff were aware of patient feedback forms, others told us they had been discontinued, while others were not aware of any system for patient feedback and saw little value in it. We found that patients receiving care in their own homes were not generally encouraged or supported to provide feedback on the services they received.
- The staff's perception of Trust engagement was varied. Some staff told us that they had not been consulted about the recent changes and felt that the Trust had not listened when concerns were raised about the reconfiguration. Although they recognised that change was necessary they felt it had been imposed upon them with little staff involvement or consultation. Other staff spoke more positively about the changes and told us the changes were needed and they were now looking forward to having a period of stability.
- We spoke with senior staff and managers about the findings from the CQC annual NHS staff survey. The survey for 2013 indicated 18 areas out of 30, where the Trust scored below the national average. For example, the number of staff reporting good communication between senior management and staff, the percentage

of staff feeling satisfied with the quality of work and patient care they were able to deliver and staff job satisfaction. Action plans were in place to address the worst scoring areas.

## Innovation, improvement and sustainability

- The Trust reported a significant financial deficit for the past year and had planned for financial deficits for the future. The Trust's annual audit letter presented to the board in June 2014 concluded that "in all significant respects" the Trust did not have proper arrangements in place to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2014. The Trust remained in breach of its duty to break even on a three-year cumulative basis. This was reported to the Secretary of State in June 2013.
- Staff had worked hard to try to ensure that the Trust's financial situation did not impact on the care of patients who required urgent care in the community. However, there was a perception amongst staff that frontline staff had borne the brunt of the financial situation. The effect of this was that many patients identified as low or medium risk either experienced long delays or did not receive the care they needed.
- We found that individual staff groups who were aware of the Trust's financial situation had worked innovatively to secure external funding for particular projects and work streams. Examples of this were the sexual health team researching an electronic testing system, which did not involve extra staffing, but allowed patients to forward their clinical tests remotely. The pain management service had benefited from an external donation, which was used to help fund a conference for patients with persistent pain and purchase physiotherapy equipment for patients with chronic pain.

# Compliance actions

## Action we have told the provider to take

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

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 22 HSCA 2008 (Regulated Activities)  
Regulations 2010 Staffing

The provider had not ensured that, at all times, there were sufficient numbers of suitably qualified, skilled and experienced persons employed in order to safeguard the health, safety and welfare of service users

This is a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

There were not always enough suitably skilled and experienced medical staff in community services at all times.

### Regulated activity

Treatment of disease, disorder or injury

### Regulation

Regulation 19 HSCA 2008 (Regulated Activities)  
Regulations 2010 Complaints

The provider did not have suitable arrangements in place to bring the complaints system to the attention of patients and to provide support with bringing a complaint.

This is a breach of Regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The information for patients was often out of date, referring to obsolete contact details. Patients were not always supported to raise concerns and there were no systems in place to record or monitor the issues resolved at local level..

### Regulated activity

### Regulation

# Compliance actions

Treatment of disease, disorder or injury

Regulation 17 HSCA 2008 (Regulated Activities)  
Regulations 2010 Respecting and involving people who use services

**The provider did not have suitable arrangements in place to enable service users to express their views of feedback to the service.**

This is a breach of Regulation 17 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Outside of the community hospital setting there was little evidence of staff awareness or engagement with the value of patient feedback systems. We found that patients receiving care in their own homes were not generally encouraged or supported to provide formal feedback on the services they received