# Lincolnshire Community Health Services NHS Trust

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# Community health services for adults

## Quality Report

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This report describes our judgement of the quality of care provided within this core service by Lincolnshire Community Health Services 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 Lincolnshire Community Health Services NHS Trust and these are brought together to inform our overall judgement of Lincolnshire Community Health Services NHS Trust

# Summary of findings

## Ratings

| | |
|---|---|
| Overall rating for Community Health Services for Adults | Good |
| Are Community Health Services for Adults safe? | Requires Improvement |
| Are Community Health Services for Adults effective? | Good |
| Are Community Health Services for Adults caring? | Good |
| Are Community Health Services for Adults responsive? | Good |
| Are Community Health Services for Adults well-led? | Good |

# Summary of findings

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# Summary of findings

## Overall summary

Overall we judged adult community services to be good.

Staff were familiar with the process for reporting incidents, near misses and accidents and were encouraged to do so. There were some inconsistencies in practice with regards to learning from incidents and sharing of that learning within individual teams and across the organisation.

Staffing levels in some services required improvement. The trust were aware of this and had plans in place to address this. However, in some instances this was impacting on patient care, for example the number of avoidable pressure ulcers, and on staff morale. Whilst the trust's rate for new pressure ulcers reported in a community setting was below the national average it was not achieving its own targets for 2014/2015 to reduce the number of pressure ulcers.

There were effective arrangements in place to manage and monitor the prevention and control of infection, management of medicines and safeguarding people from abuse.

Services were effective, evidence based and focussed on the needs of patients. We saw some examples of good collaborative work and innovative practice. However, data for completion of patients' risk assessments varied by business unit and most were not meeting their targets

The majority of staff were up-to-date with mandatory training however staff experience of clinical supervision was variable and some staff were not accessing regular protected time for reflection of clinical practice. Also appraisal rates were low for the year to date.

Almost all staff expressed significant concern about the effectiveness of the IT system for recording patient information and the additional workload that this added on a daily basis. The trust had recognised that improvements were required and actions were being implemented to increase clinical time spent with patients across the organisation.

Services were caring. Patients and relatives or carers told us they were well supported by staff in multidisciplinary teams. We observed a compassionate and caring approach of staff in clinics and in people's homes. Staff were aware of the emotional aspects of care for people living with long term health problems and ensured specialist support for people where needed.

Services were responsive to people's needs across the majority of services. Staff worked well in multidisciplinary teams and across organisations to provide support to patients in the community. Patients were on the whole able to access the right care at the right time.

Services encouraged patients to provide feedback about their care. Complaints procedures were in place. Information on patient experience was reported and reviewed alongside other performance data.

There was good leadership and support from local managers and most staff felt engaged with senior management.

Many AHPs we spoke with were concerned that there was no senior/Board lead for their professions and consequently their voices were not heard at a senior level.

During the course of the inspection we met with almost 150 staff across all designations and roles. This included qualified nursing staff, specialist nurses, allied health professionals (physiotherapists, occupational therapists and speech and language therapists) health care support workers, team leaders and managers. Interviews were conducted on a one to one basis, in small groups of two or three staff within a service, or in group discussions arranged as focus groups.

We spoke with about 20 patients in a number of scenarios. We visited some clinics, and we accompanied district nurses to a number of people's homes to talk to patients and their relatives about their experiences. We contacted some patients by telephone to ask their views of care and treatment received from the trust. We also received feedback from patients who had completed our comment cards.

We analysed both trust-wide and service specific information provided by the organisation and information that we requested to inform our decisions about whether the services were safe, effective, caring responsive and well led.

# Summary of findings

## Background to the service

Community services for adults with long term conditions were part of the Lincolnshire Community Health Services NHS Trust. The services were provided through business units which had recently decreased from four to three units. These were aligned to the clinical commissioning groups (CCGs) covering the county of Lincolnshire and together served a population of approximately 735,000 people.

There were community nurses and therapy teams together with specialist community services which included: podiatry, tissue viability, diabetes, respiratory, sexual health, continence, TB, stroke, independent living teams and rapid response. The services' aims were to provide healthcare that enabled individuals to increase and maintain their independence while remaining at home or in their place of care. The services helped prevent people having to be admitted to hospital or helped them rehabilitate after discharge from hospital by providing people with the knowledge, equipment and support to maintain their independence.

## Our inspection team

Our inspection team was led by:

**Chair:** Stuart Poynor, Chief Executive, Staffordshire and Stoke on Trent Partnership NHS Trust

**Head of Inspection:** Adam Brown, Care Quality Commission

The team included CQC inspectors, and a variety of specialists; school nurse, health visitor, GP, nurses, therapists, senior managers, and 'experts by experience'. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

## Why we carried out this inspection

Lincolnshire Community Health Services NHS Trust was inspected as part of the second pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

## How we carried out this inspection

To get to the heart of patients' experiences 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?

The inspection team always looks at the following core service areas at each inspection:

1. Community services for children and families – this includes universal services such as health visiting and school nursing, and more specialist community children's services.
2. Community services for adults with long-term conditions – this includes district nursing services, specialist community long-term conditions services and community rehabilitation services.
3. Services for adults requiring community inpatient services
4. Community services for people receiving end-of-life care.

Before visiting, we reviewed a range of information we hold about Lincolnshire Community Health Services NHS

# Summary of findings

Trust and asked other organisations to share what they knew about the provider. We carried out an announced visit between 9 and 11 September 2014. During our visit we held focus groups with a range of staff (district nurses, health visitors and allied health professionals). We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We visited 23 locations which included 4 community inpatient facilities and one walk-in centre. We carried out an unannounced visit on 10 September to one of the inpatient units.

## What people who use the provider say

We received a range of comments from patients and their relatives, both through comment cards as well as those we spoke with during the inspection. The comments were overwhelmingly positive.

We spoke with 20 patients or their families during our inspection. People told us that they were very satisfied with the service they had received. We were told that staff were very polite, friendly and caring. That they were knowledgeable and helpful.

The NHS Families and Friends test (FFT) had recently been introduced into community services with most services only participating in August 2014. The samples of the FFT results we saw were very positive.

## Good practice

Our inspection team highlighted the following areas of good practice:

- A comprehensive community nursing specification and catalogue had been introduced in 2013 which was underpinned by guidance and included eight care packages: holistic assessment; palliative care/end of life care; tissue viability; urological and bowel condition management; nutritional support; long term condition management; single intervention episodes and complex assessment and health needs management.
- Confidentiality was managed effectively within the sexual health service.
- A project to share specialist nursing knowledge and training with care homes in Lincolnshire had received national recognition. It received 'Highly commended' in the NHS Innovation Challenge Prize. Specialist nurses shared their skills in the areas of preventing falls, avoiding pressure ulcers and supporting continence care. A training pack was developed which was now being successfully used in other care homes across South Lincolnshire. In one care home, the changes meant GP visits reduced from 27 one month to 17 the next, there was a 50% reduction in falls and 66 % fewer community nurse visits.

## Areas for improvement

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

- Implement the newly agreed staffing requirements for community nursing teams and the new model of care called neighbourhood teams.
- Complete and implement any recommendations from the review of the specialist nurses and allied health professionals (AHPs).
- Continue to develop information technology systems to enable full integration and connectivity across the Trust.
- Take action to ensure all clinical staff have access to regular protected time for facilitated, in-depth reflection on clinical practice.

# Summary of findings

- Continue to ensure performance figures improve to meet agreed targets, especially within community nursing and genito-urinary medicine (GUM).
- Ensure that staff had an annual appraisal in line with trust policy
- Ensure that patients' risk assessments were completed as patients' needs may not have been fully met if risk assessments were not completed.
- Continue the work on reducing the incidence of pressure ulcers reported in a community setting to at least the agreed target.
- Ensure AHPs were confident and competent in using the patient assessment tools
- Consider a board/senior lead to further develop AHP vision and strategy across the trust.

Lincolnshire Community Health Services 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

### Incidents, reporting and learning

The rate of harm free care in community settings (in relation to district nursing services) had consistently remained above the England average in the last 12 months for the trust overall. The national target was set at a minimum of 95% and the trust had been above 92.3% since June 2013 with a figure of 93.4% for June 2014.

The service had well established systems for incident reporting and analysis using the Datix reporting system. Staff told us and we saw evidence in team meeting notes that incidents were analysed at a local level and learning was discussed within teams. However, staff were unsure how learning from other teams or business units was shared across the trust.

Between June 2013 and May 2014 the trust reported 395 serious incidents. The 2013 national staff survey indicated that the trust was above average for the percentage of staff reporting errors, near misses and incidents. The majority of the incidents, 218, occurred in patients' homes. Of the 218 incidents 208 related to patients having grade three or four pressure ulcers. The rate for new pressure ulcers in a community setting was below the national average from January 2014 to June 2014 apart from May 2014 when 15 incidents of new pressure ulcers were reported. However, the trust was not achieving its own targets for 2014/2015 to reduce the number of pressure ulcers.

### Cleanliness, infection control and hygiene

There were appropriate infection prevention and control policies and procedures in place. All the locations we visited were clean and tidy.

We observed staff during a clinic session and during home visits. Staff demonstrated they had a good understanding of infection prevention and control. We observed staff clean their hands prior to and after care was provided, we saw appropriate use of gloves and aprons.

People told us that staff wore gloves and aprons when providing care and they had witnessed staff washing their hands prior to and following any examination or treatment.

Requires Improvement

# Are Community Health Services for Adults safe?

Hand hygiene audits were completed by all the business units for community services and these were scoring green with a range of 91.4% to 96.9% compliance in July 2014.

### Maintenance of environment and equipment

The trust ran very few clinics; most of people's care was delivered within their own home. Staff we spoke with told us the equipment was well maintained and they knew who to speak with if they had any concerns. Almost all staff said they were able to access equipment to support people in their own homes Monday to Friday very quickly, however, there were some difficulties in accessing equipment after 2pm on a Friday and over weekends. Staff told us this was because the company providing the equipment did not operate on a weekend. Some teams were able to access a limited supply of equipment from small storage facilities the trust had set up.

People who used the services did not express any concerns regarding the cleanliness or operation of any equipment used during their treatment. Many smaller pieces of equipment were single use items; sealed until use and disposed of after use.

A board report from July 2014 indicated that the trust was not meeting its own targets of 95% for the servicing and availability of two specific items of equipment. Figures indicated there were 93% of nebulisers and 79% of syringe drivers available for patient use. This may have reduced the effectiveness of some clinical interventions or required a different treatment option for some patients.

We noted that at some sites expiry dates on equipment were not always checked, for example we found a podiatry item that was two years out of date and further equipment at the sexual health clinic that had expiry dates of December 2013 and November 2012.

### Medicines management

The bulk of medicines in the community setting were personal prescriptions which people kept at home in accordance with instructions from their GP. We saw how staff reviewed people's medicines with them at clinics and when visiting their homes. This was to ensure that people had not had any changes to their medication since they were last seen, to establish if they were taking their medication as prescribed and to ensure they had suffered any adverse effects.

At one site we noted that the staff were not referring to the most up to date medicines reference book (BNF) as it was dated 2012.

### Safeguarding

There were effective safeguarding policies and procedures which were understood and implemented by staff. Staff were aware of the different types of abuse, and how to report or escalate issues. Staff had received safeguarding training at a level appropriate to their work. Trust data demonstrated that mandatory training levels for safeguarding were 95 -100% across all business units for 2013/2014. People who used services told us they trusted staff and felt safe in their dealings with them.

### Records systems and management

Staff in all focus groups and almost all interviews expressed concern about the IT system: its effectiveness, connectivity, lack of responsiveness and the additional workload that this added on a daily basis. Staff also commented that many of the templates were lengthy and difficult to use, that there were differing templates, and they were not always able to access assessments by other community professionals as the "share" function was not always enabled.

The trust had recognised that improvements were required to the effectiveness of IT systems and the challenges of coverage in widely remote geographical area. This was required to increase clinical time spent with patients across the organisation.

The trust was rolling out a new computer "mobile working" system which staff told us was meant to reduce the amount of paper records and improve information flow. Staff commented that new IT equipment had been distributed and that mobile working (inputting clinical information onto a computer at the time of patient contact) was starting in some areas. Concerns remained about the length of time taken each day to manually complete patient records and then update the computer systems at a later time. Staff cited that they frequently worked an extra five hours plus per week to ensure records were up to date.

Patient records were held mainly in electronic formats, but paper information had to be printed for community visits due to the constraints of the IT system. We checked patient

records at a number of sites. Patient records were updated and reviewed regularly, some records we saw had not had all the assessment sections completed (See detail in assessing and responding to patient risk section below).

### Lone and remote working

The trust had lone worker policies and staff we spoke with told us they were aware of and understood them. Staff told us about the buddy system in place which they said worked well.

Staff who completed home visits had an in depth knowledge of their patients and the environments they visited, they described how they discussed new patients and any risks prior to visiting and where necessary completed accompanied visits.

### Assessing and responding to patient risk

The trusts' risk register was used to monitor and target identified risk to services. Individual services used a combination of techniques to evaluate and respond to the needs of individual patients.

The trust had a target for the completion of a full falls risk assessment in the community for 95% of patients who required it. The trust had started recording this in January 2014 (27.3%) and was performing at 58.1% in June 2014. However this position had deteriorated in July and August to 53.4%.

Data for completion of other assessments varied by business unit but most were not meeting their targets, for example;

- 85.7% (target 95%) of Waterlow assessments were completed in June 2014 in the north-east business unit
- 87% of Waterlow assessments were completed in July 2014 in the East business unit
- A range of 69.8-82.7% (target 95%) of Nutritional assessments (MUST) in June 2014 across the business units
- A range of 75.4 – 85.7% of Nutritional assessments (MUST) in July 2014 across the business units

This was corroborated when we reviewed some patients' notes. For example at one location we reviewed five sets of patients' notes and found that nine of 15 assessments had been fully completed. Patients' needs may not have been fully met if risk assessments were not completed to the required levels.

We found that teams in the community were aware of key risks such as falls and pressure care. Staff responded to findings by referring people for additional assessments or for relevant equipment.

The trust was not on trajectory to meet its agreed targets in 2014/2015 for avoidable pressure ulcers. These were to reduce avoidable grade 3 and 4 pressure ulcers by 50% (to eight annually for grade 4 and to 84 for grade 3) and by 80% for grade 2 pressure ulcers (to 55 annually). For example, the trust's integrated performance report for June 2014 indicated that the majority of the grade three and four pressure ulcers had been recorded in the south-west business unit with 24 acquired or deteriorated pressure ulcers noted. Additionally, each business unit's performance management regime meeting reported on pressure ulcers, for example, in one business unit there were seven avoidable and eight unavoidable pressure ulcers reported in July 2014 and it was stated that this was due to staffing issues within teams and also due to staff education.

The trust had introduced measures designed to reduce the number of serious pressure ulcers by identifying them at an earlier stage and preventing them developing. We saw evidence that for each pressure ulcer identified there was a detailed root cause analysis undertaken and the results and learning were shared with staff locally and discussed at the business units' clinical governance meetings. The trust had created a temporary senior clinical manager post to drive up performance for six months to end March 2015.

Services had agreed standard responsive times to see patients who were urgent or non-urgent. These varied by service and were monitored within business units and by speciality.

Care plans contained risk assessments, most of which were completed, based on individual circumstances and need. We saw how people were advised about health risks including smoking, drinking and dietary choices, falls prevention and the use of equipment such as walking aids, frames and pressure relief cushions. We saw that most risk assessments were reviewed regularly and updated to reflect changes in people's health or ability.

People were able to make choices even though these may not have been the first choice of clinicians. These were recorded in patient notes, for example, if people chose not to use some of the pressure relief aids and strategies.

Requires Improvement

# Are Community Health Services for Adults safe?

## Staffing levels and caseload

Board minutes indicated that evidence based models had been used to underpin the staffing requirements for community services including the Department of Health Long Term Conditions pathway and population profiling and the NHS Scotland efficiency modelling and workforce planning models by Hurst (2006) and Buchan (2000). This work had established that there was a deficiency of band 6 (case managers) and band 3 (health care assistants) staff which was being addressed by a workforce transformation programme overseen by the deputy chief nurse.

Evidence from staff, rotas and trust documentation indicated that there were deficits in staffing levels in some areas which were impacting on patient care. For example the north-west business unit (NW BU) clinical governance & scrutiny group minutes indicated that the community nursing establishment work carried out across the trust suggested that the NW BU had a deficit of approximately 14 whole time equivalent (WTE) posts and that it was under established by 4.8 WTE band 6 case managers, 5.5 band 5 nurses and 4.4 WTE band 3 support workers. In addition the teams were (in July 2014) carrying approximately four band 6 case manager vacancies with two WTE vacancies being covered by band 5 staff due to undertake district nursing training in September 2014. The teams were also experiencing large amounts of maternity leave. The staffing deficits meant staff working excess hours and working extended shifts. Record keeping delays were being experienced which produced an additional clinical risk.

Similar staffing issues were also highlighted in business unit improvement board action plans for Grantham and Sleaford. Caseload reviews have been done for all teams. The plans stated that more in depth caseload reviews were needed, but capacity was preventing this until recruitment was completed.

Board minutes indicated that a range of assumptions had been used to determine the basic safe staffing levels and daily patient contact had been agreed as: case management – six patients, care management – eight patients and interventions – twelve, to include patient consultation, documentation and travel using mobile working. In two of the teams we met with, these ratios were being breached: a case manager had eight patients and a care manager's daily patients ranged between seven to eleven. Additionally staff who worked the weekend 6th and 7th September 2014 had higher than the 12 interventions: their interventions ranged from 14 to 20 per person per day.

The staff survey for 2013 indicated that the percentage of staff working extra hours was 76% which is higher than the national average of 71%. Most staff we spoke with told us they had been working extra hours most weeks. Examples included community nurses regularly working five hours extra per week to ensure that the records were up to date. A team leader also told us they routinely worked the same hours as 1.5 WTEs.

The percentage of vacancies across the trust had shown an overall decrease over the last 12 months from 9.7% in April 2013 to 5.2% in May 2014. However, the staffing levels were very variable within the business units and between the services. In particular, staff working as allied health professionals (AHPs) and community nursing raised concerns about low staffing levels especially in the south and east of the county.

Prior to the inspection concern had been expressed about the staffing levels for the community nursing team within the Sleaford area. We reviewed the staffing rotas for August, September and October 2014 for this team. Staffing levels were lower than the planned levels, especially in August, which we were told was partly due to annual leave. This had been acknowledged by the trust and a number of actions taken including a review of staffing which resulted in an increase in the number of planned staff per shift. The planned levels were for three case managers and five band 5 nurses Monday to Friday and three qualified staff working on the weekends. We were told that the new posts had been recently recruited to and that the team would be up to full complement at the beginning of October 2014.

The service hours for the community nursing teams varied slightly across the county, most were 8am to 7pm Monday to Friday with reduced hours, 9am to 5pm, over a weekend. Staffing levels varied across teams and changes to staffing were being made in line with the safer staffing levels recently developed by the trust. For example in the Sleaford area there were more band 5 nurses than the levels required but not enough staff at band 6. Six whole time equivalent (WTE) band 6 nurses were required but there were only 3.2 WTE in post and one was about to leave. Two band 5 staff were acting up into the band 6 roles.

Requires Improvement

# Are Community Health Services for Adults safe?

Staff sickness was higher than average (rated nationally as in the worst 25% of community provider trusts) between the period of April 2013 to December 2013. The trust's June 2014 performance report indicated that the sickness absence rate target for the trust was 3% or less and it had been non-compliant for the year to date. However, within the community business units the rates were better than overall with long term sickness being 2.2-3% and short-term sickness being 1.4-2.4%. We were told action plans were in place across all business units to reduce staff sickness and an attendance management tool was in operation.

Prior to the inspection concern had been expressed about the lack of specialist Parkinson nurses within the Louth area in the north of the county. We were informed by the trust that there were two band 7 Parkinson nurses supported by a band 5. However, the trust had been unable to recruit to one of the posts. The trust said that patients' with Parkinson's disease in the north of the county were cared for by other community staff with support from GPs and/ or where required by specialists employed by United Lincolnshire Hospitals NHS Trust.

Staff told us that the lack of any local or national staffing criteria for allied health professionals (AHP) made it difficult to assess the actual requirements for numbers of staff. A number of examples were given by staff about AHP staffing levels and how this affected timely access to services for patients. Staff concerns included;

- the lack of AHPs to continue supporting stroke patients once they had completed their six weeks with the assisted discharge stroke service
- Reducing speech and language therapy (SLT) service in the south business unit as two of the four staff were leaving.
- There was only one occupational therapist to cover the Welland, Bourne, Stamford and Deeping areas.
- There was no community physiotherapist for the Spalding area.

We were told it was difficult to recruit AHPs to the trust and as a consequence the trust had set up a practice-based learning course with Sheffield Hallam University. This targeted people already working in the area and was a work-based course. Sixteen physiotherapy students and 16 occupational therapy students were recruited every two years which resulted in a higher retention rate of staff locally. The trust had also done capacity and demand assessments within the SLT service.

### Deprivation of Liberty safeguards

We did not see any areas within the services we inspected where people's liberty had been restricted. The service was based on the premise of assisting people to remain in the community with as much independence and freedom as their health would allow.

### Managing anticipated risks

We found there were systems and processes were in place to maintain patient safety.

There were specialist nurses leading services and clinics and within community teams. This meant that people with long term conditions were triaged and assessed accurately so that safe treatment and care was provided to guard against risks associated with their complex condition. Risk assessments in areas such as falls, nutrition, and pressure care were not all completed and updated as patient's needs changed.

Contingency plans were in place in the event major events, such as outbreaks of flu or winter weather affecting staffs ability to travel.

Good

# Are Community Health Services for Adults effective?

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

## Evidence based care and treatment

The trust had a "best practice policy" which helped to ensure that there was a systematic process for implementing, monitoring and evaluating national institute of clinical excellence (NICE) guidance, national service frameworks (NSFs), enquiry recommendations and local and national guidance. A comprehensive community nursing specification and catalogue had been introduced in 2013 which was underpinned by guidance and included eight care packages: holistic assessment; palliative care/ end of life care; tissue viability; urological and bowel condition management; nutritional support; long term condition management; single intervention episodes and complex assessment and health needs management.

Individual roles and responsibilities were understood by staff in the delivery of evidence based care. This included involvement in the development of policies and procedures, and in the assessment and monitoring of the quality of care provided to adults with a long-term condition. Almost all care pathways we reviewed demonstrated they had referred to NICE or other nationally recognised guidelines to ensure patients were appropriately assessed and supported with their needs.

We saw evidence of references to and use of NICE guidelines within a number of services, for example, the heart failure and sexual health services. Additionally the trust's pressure ulcer prevention and management guidelines reflected current best practice in pressure ulcer prevention and management recommended by NICE Guidance (2014). The SLT service worked to the professional standards set by the Royal College of Speech and Language Therapy. The respiratory service used care plans based on the British Thoracic Society (2008). We were told these were being reviewed and guidelines updated. The diabetes service was working to NICE guidance but this was not referenced within their guidelines. Staff from this service told us they were rewriting their guidance to include NICE guidance. Additionally staff within the podiatry service indicated that the matrix assessment they used did not currently meet NICE guidance but this was being reviewed.

We saw that community staff used nationally recognised assessment tools in order to screen patients for certain risks, and referred to relevant codes of practice, for example infection control and mental capacity.

## Nutrition and hydration

Nutrition and hydration assessments mostly were completed on appropriate patients. These assessments were detailed and used nationally recognised nutritional screening tools. Dieticians, community nurses and SLT services all worked together to provide advice and guidance to people in the community regarding diet and health.

Swallowing assessments were completed by SLT staff that were able to explain to patients or their carers how best to prepare and present food and drinks to enable people to eat and drink well.

## Telemedicine

The trust used telehealth, electronic assistive technology service (EATS), within the community services. Telehealth enabled patients to provide information on their health without having to attend clinics or have staff visit them. The system alerted staff if the data indicated a decline or issue in a patient's health. Appropriate follow-up visits or advice were then provided. The EATS operated Monday to Friday which meant that patients did not have daily monitoring in place. Monitoring at weekends was by the patients themselves: we were told that patients had a self-management plan in place which included what to do if they had any concerns over a weekend. The complex care managers in the Grantham/Sleaford area showed us examples of care records from some of their eight patients who were using the telehealth service at the time of the inspection.

The diabetes service encouraged patients, where appropriate, to text in their blood sugar levels which helped patients manage their condition more responsively.

Good

# Are Community Health Services for Adults effective?

## Approach to monitoring quality and people's outcomes

Of the eight CQUINs (Commissioning for Quality and Innovation) agreed for 2013/2014 the trust achieved three: Safety Thermometer, Making Every Contact Count and VTE (venous thrombo-embolism). The trust failed to achieve three of its 2013/2014 CQUIN targets. These related to the friends and family test, dementia screening targets and clinical supervision.

The trust had identified key quality priorities for 2014/15 including;

- increasing patient facing time through increasing 'Time 2 Care'.
- reducing avoidable grade 3 and 4 pressure ulcers by 50% (to eight annually for grade 4 and 84 for grade 3) and by 80% for grade 2 pressure ulcers (to 55 annually).
- improving the uptake of clinical supervision.

Performance of services was monitored through geographically based business units to the board. We saw evidence of the monthly meetings of each business unit and evidence of executive level challenge to each business unit in the form of a routine performance management review against quality, operational performance, finance and workforce.

We saw evidence that community teams monitored the performance of their treatment and care, both informally within teams and from the trust's annual clinical audit plan. In the plan for 2013/2014 we identified a number of audits for community services which included clinical records, the assisted discharge service for stroke; training competencies for allied health professionals; a continence audit of patients on community nurses caseloads; a cardiac rehab quarterly review; community diabetes service outcomes audit; pulmonary rehabilitation quarterly review and a leg ulcer management audits. Learning and action points related to the audits were fed back to heads of clinical services at the quality scrutiny group. For example it was noted that record keeping audit results were reviewed as part of an on-going supervision programme for staff and to support training and development needs. Additionally the audits were discussed with commissioners, for example at the Lincolnshire East clinical Commissioning Group / Lincolnshire Community Health Services NHS Trust Quarterly Quality Contracting Review, and actions agreed to improve services.

Some services used the Barthel index/score as a mechanism of monitoring patient outcomes. It consisted of ten items that measured a person's daily functioning: specifically the activities of daily living and mobility. The items include feeding, moving from wheelchair to bed and return, grooming, transferring to and from a toilet, bathing, walking on level surface, going up and down stairs, dressing, continence of bowels and bladder. Patients are assessed and scored at the start, during and end of a service's input. We saw evidence of this being used in the assisted discharge service for stroke and the independent living teams.

## Competent staff

The trust used the nationally recognised skills for health competency mapping to help ensure that levels of competence, knowledge and skills were up to date and appropriate for clinical environments. A community nursing specification, based on nationally recognised best practice, had been introduced in April 2013 underpinned by a catalogue of competencies to ensure standardised practice was delivered across the county.

The majority of staff told us access to mandatory training and specialist external courses was good. Trust-wide training requirements for mandatory training, infection control and information governance were almost on target; all were above 92% with a target of 95%. Staff commented positively about the support they got from the trust to develop themselves and their services, especially those working within specialist community services.

Some staff commented that some specialist training was only organised by the trust once a year, for example, non-medical prescribing, which meant that not all staff could attend and keep up to date with current practice.

Appraisal rates were low for the year to date. The trust's June 2014 performance report indicated that only 8.4% of staff had received an appraisal this year which was significantly lower than the same time in the previous year.

The trust has identified improving the uptake of clinical supervision as one of their key quality priorities.

It did not achieve its 2013/2014 CQUIN goal to ensure that 95% of staff had had clinical supervision. There was an expectation that for 2014/2015 all professional groups achieved a target of 80% of staff accessing clinical

supervision and that clinical supervision should take place at least once every three months and may take the form of individual or group supervision. The trust had introduced a new model of clinical supervision for 2014/2015.

Staff experience of clinical supervision was variable and some staff were not accessing regular protected time for facilitated, in-depth reflection on clinical practice. When we spoke with staff, many were unclear as to what was recognised as clinical supervision and whether they had received any. Some teams evidenced that they were almost meeting the standard of 80%, for example the Horncastle/ Woodhall Spa community team was at 76.5% in August 2014 whilst other staff told us they had not received supervision in over three months. The trust's quality and risk report dated August 2014 indicated that overall 37.9% had received supervision over a three month period by July 2014. The trust had already taken action to improve performance in this area; however, further work was needed to ensure supervision was effectively implemented in line with trust policy.

Many of the AHPs commented to us that they were not confident in using some of the assessment tools, specifically the ones for skin/pressure area care (Waterlow, SKINN) and nutrition (MUST).

### Multi-disciplinary working and coordination of care pathways

Multi-disciplinary team working was evident throughout the services we inspected. Care plans indicated where staff had referred patients to other disciplines. Outcomes of the referrals were shown with guidance and information for patients. The majority of teams we spoke with described having good relationships with other disciplines both within the trust and externally, for example, working with local GPs and the continence service working with women's health services in other trusts.

One area where staff told us co-ordination of care could be improved was working with GP practices for diabetic patients. The specialist nurses indicated there were 670 patients on the case load for the north-west business unit and that over 50% of these patients could be discharged if there was better support available in primary care for patients.

Good

# Are Community Health Services for Adults caring?

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

### Compassionate care

We observed a number of telephone consultations by staff with patients, all of which demonstrated the caring nature of staff and good communication skills.

We reviewed 28 CQC patient comment cards and all except one were positive comments.

### Dignity and respect

We observed that staff treated patients and their relatives with dignity and respect. Patient confidentiality was respected when delivering care, in staff discussions with patients and their relatives and in any written records or communication. In particular we saw that confidentiality was managed effectively within the sexual health service.

### Patient understanding and involvement

A patient and public involvement summary report was submitted to the trust board on a monthly basis. This report identified specific locations in the trust where scores or performance had slipped. Also reported were the results of service specific patient experience events that had taken place and the actions that have taken place as a result of feedback from patients. For example, for community services these included;

- community diabetes service
- heart failure service
- speech therapy stammering service
- independent living team (Louth)
- north east cardiac rehabilitation service

The May 2014 trust board minutes recorded that patient feedback continued to support the need for improvements in communication skills and involving patients and carers in making decisions. In response the trust's clinical senate was leading the development of an initiative to improve the skills of practitioners in building therapeutic relationships.

The trust had carried out a number of recent patient satisfaction surveys: east and north west community teams in December 2013, cardiac rehabilitation team in April 2014 and a patient satisfaction survey conducted by the Picker Institute.

The Picker Institute surveyed over 1,000 patients in October 2013 who had all used either community nursing, physiotherapy or podiatry services across the county. The survey found that 91% rated their overall experience as "excellent" or "good". Most respondents felt that the information that was provided was helpful and they were as involved in decisions as they wanted to be, and 97% felt they had been treated with dignity and respect; 89% of those surveyed were also happy with the frequency of appointments and visits. However, podiatry service users were more negative in their responses compared with other services for involvement in decisions.

The trust had recently introduced the friends and family test into community services. Figures for August 2014 indicated that for the trust overall the score was 4.9 out of five from 923 respondents  For the majority of community based services the survey had been run for the first time in August 2014 and scores ranged from 4.6 to 5.

Another mechanism used to gain patient and staff views was called community 15 steps feedback. The reports we saw from these visits all gave positive patient feedback and indicated where processes could be improved.

### Emotional support

Staff were aware of the emotional aspects of care for people living with long term health problems and ensured specialist support for people where needed.

### Promotion of self-care

The staff when visiting people in their own homes promoted people's independence and provided meaningful information about self-care. For example, staff supported patients to learn and recognise early signs and symptoms of heart failure and chronic respiratory disease. We saw information leaflets were provided to patients for health promotion and self-management of their conditions.

Patients we spoke with during the service were very positive about their care. For example a heart failure patient described to us the diary they kept which was reviewed at each consultation. They were also aware of actions they could take should their condition change including changes to medication and who to contact.

Good

# Are Community Health Services for Adults caring?

Some staff had set up patient support groups, for example there was a heart failure support group, “Dicky tickers”, which met monthly. Patient feedback was very positive about the group and the peer support they received from other patients with similar conditions.

Good

# Are Community Health Services for Adults responsive to people's needs?

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

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

Managers we spoke with for each service were aware of the risks in their areas such as staffing levels and skill mix, geography of the various sites, and investment in community services. Some staff told us they worked with local commissioners of services, the local authority, other providers, GPs and patients to co-ordinate and integrate pathways of care that met the health needs of patients. Service specifications were in place which detailed the aims, objectives and expected outcomes for patients and were monitored against national and local performance indicators.

Staff reported good relationships with commissioners, other providers and stakeholders. For example the assisted discharge stoke service had in-reach service to all the local hospitals to help support patients leave hospital earlier.

The trust employed a wide range of specialist teams and nurses to support staff in the community to ensure patient needs were met. These included a range of nurse specialists, stroke teams and therapists.

Staff told us they had access to translation services for people whose first language was not English. However, no-one was able to give us an example of when the service had been used. Some patient leaflets were available in different languages.

The trust acknowledged the rurality of the area and the challenges that this brought in ensuring access to services. The trust ran very few localised clinics as the majority of patients were assessed as predominantly housebound or their needs were identified by the community teams as best being met in their own home.

It was noted that there was no community based service for the administration of intravenous antibiotics, patients had to travel to acute hospital sites (or Louth hospital) if they required this treatment. Patients therefore had to travel, often long distances, and be managed as an in-patient to receive this treatment.

## Access to the right care at the right time

The trust had developed contact centres (single points of access) and rapid response teams which were launched in November 2013 to help ensure patients got the right care at the right time and where possible to avoid admissions to hospitals. The contact centre operated from 08.00 hours to midnight seven days a week and was able to refer to other services such as rapid response, independent living and community nursing teams. There were protocols in place for staff to use in the contact centres which indicated which service and action best suited each patient's needs.

Some concern was raised by staff about the variability and capacity of these services. During our visit to a centre we noted that the capacity within the rapid response teams was green for all locations but there was no capacity for referrals in the Sleaford and Bourne community nursing teams. This meant patients requiring community nurse services in those areas may not have been able to access them. The independent living teams also had access to a specific number of step up, step down beds within care homes should these be required.

The trust had national targets for community nursing responsiveness which it was not meeting. However urgent performance had improved across the trust since April 2013 when it was 80.9% to 94.8% in August 2014 against a target of 95% of urgent patients seen within 24 hours.

Non urgent performance had also improved from 77% in April 2013 to 86% against a target of 90% of patients seen within 48 hours. There was some variability across the business units with figures ranging from 91% to 99% for urgent responses and 81% to 90% for non-urgent responses. Business units had developed action plans to address compliance for urgent and non-urgent responsiveness. The trust had not achieved two CQUIN targets in relation to referral to treatment times; for podiatry the RTT was 21 days actual against an 18.5 days target; and SLT (Speech and language therapy) 37 days actual against 27.5 target).

The trust had a national target for patients being offered a genito-urinary medicine (GUM) appointment (100% of patients within 48 hours) and for being seen (85% within 48 hours). The trust was failing to meet these targets, 98.1% of patients were offered an appointment and 61.9% were seen in August within 48 hours, compared with 56.4% in July 2014. However a phased trajectory had been agreed

Good

# Are Community Health Services for Adults responsive to people's needs?

with commissioners for 2014/2015. The target for quarter one was 60%, increasing to 75% by the year end. Trust minutes indicated that re-modelling of the provision at Lincoln has shown demonstrable improvements and the model was now being rolled out to other areas of the county.

The community diabetes service had key performance indicators of 90% of routine referrals to be seen within 4 weeks and 100 % of urgent referrals with 2 days. From April-June 2014 routine patients had been seen within 4 weeks with 273 of 275 referrals seen within timescale (99.3%). The exceptions were principally around patient choice. For urgent referrals there were 51 of 54 patients seen within two days (94.5%) timescale. One member of a team had been on long term sick leave which had affected capacity to meet the KPIs. This person was now back at work.

Trust data indicated that it was achieving the target for ensuring that patients were seen within 18 weeks by an allied health professional.

The community nursing teams operated a "red phone" system which was a phone number for patients to contact the teams on. We were told that teams allocated a nurse to the red phone on a daily basis and that this nurse had a reduced caseload for that day so they could respond to calls from patients. The success of this system varied in practice. Some teams had been too short staffed so had not been able to allocate staff to the phone which meant patients had to leave a message. In one team we observed no-one answering the phone despite a number of staff being in the office when it was ringing.

Community nurses visiting patients in their own homes did not routinely have timed appointments unless there was a specific clinical reason, for example insulin or eye drops. Nurses commented that this helped to manage caseloads and prioritise patients based on clinical need. A small number of patients commented negatively about not knowing when the nurse may attend.

The trust had identified on its June 2014 risk register that the TB service did not have the capacity or configuration to meet the increasing demand due to growth in the number of TB cases. Referrals to the service had increased from 134 in 2011 to 305 between January-August 2014. We spoke with the TB nurse specialist who told us that this was being addressed. An integrated model was being developed with the specialist respiratory teams and additionally support one day a week from a respiratory nurse. The service would also be included in the review of specialist nurse services across the county.

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

Complaints were handled in line with trust policy. Information was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at service level or through the trust's patient advice and liaison service. Staff were aware of the trust's complaints system. Staff understood what the processes involved and who to refer people to if they wished to complain and they could not resolve their issues locally.

During the reporting period 1 December 2013 – 20 June 2014 there had been a total of 97 complaints received by Lincolnshire Community NHS Trust. The most complaints received were in relation to clinical treatment (43); 35 complaints were received in respect of attitude of staff. For the reporting period 2013/2014, 325 contacts were made with the patient advice and liaison service (PALS) with a number of concerns being addressed by services directly; this is a decrease of three from the previous year. A significant majority of complaints in both 2011/2012 and 2012/2013 were in community health services. We saw evidence of learning at trust level from complaints but many staff commented that they did not get feedback from complaints local to their team/service.

We did not see evidence of routine learning from issues from other disciplines, teams or geographical areas of the trust. Important issues had been circulated as news items in communications by the trust and some staff described receiving emails about incidents.

Good

# Are Community Health Services for Adults well-led?

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

## Vision and strategy for this service

We found variation in the level of understanding of the trust values and visions in the services we inspected. The trust values were listed as FIRST: focus, impact, respect, safety and teamwork. Most staff were able to quote these values and we found that their practice, attitude and commitment reflected them.

Staff were less able to describe the vision and strategic objectives of the trust. In the specialist services most staff were able to articulate the vision for their individual service. Staff were aware of the introduction of the new neighbourhood teams but unsure as to how all the services fitted together under this new model.

All staff we spoke with were aware of the corporate quality priorities to reduce the harm from pressure ulcers and to improve clinical supervision. Many staff told us that there was less clarity between business units as commissioners often wanted variations on service specifications by geographical area.

Most allied health professionals we spoke with, unless they were in a specialist team, were concerned about a lack of vision and strategy for their professions.

## Guidance, risk management and quality measurement

We were told that the strategic and corporate risk profile was generated by the executive team and was considered on a monthly basis at the trust executive group prior to submission to the board. The top risks relating to quality identified in the June 2014 risk profile were;

- causing harm to patients through avoidable damage to pressure areas
- clinical supervision
- causing harm to patients as a result of a falls
- failure to act on lessons learnt with regard to all safeguarding reviews, RCA's (root cause analysis), serious incidents and high risk incidents

Additionally the risk register dated 6th June 2014 identified the highest rated risks as workforce capacity, information technology and sharing and the risk that the TB service did not have the capacity or configuration to meet the increasing demand. Staff we spoke with were aware of these risks and acknowledged that the trust was taking some action to mitigate the risks.

The business units held regular meetings where performance, quality and risk were discussed. We saw copies of monthly performance reports and notes from these meetings. We found managers were aware of the quality issues affecting their services. It was evident that some managers shared this with staff although we found understanding of quality issues were variable amongst different teams. Managers and staff told us they had regular team meetings which were evidenced by copies of meeting minutes. Staff told us these meetings were useful for sharing information.

## Leadership of this service

Staff commented that the new chief executive was visible and had visited many of the services. They were aware of the CEs weekly bulletin and the "Ask Andrew" email system for staff to ask the CE questions. Many nurses also commented on the visibility and support of the senior nurses, especially the deputy chief nurse.

Many AHPs we spoke with were concerned that there was no senior/board lead for their professions and consequently their voices were not heard at a senior level.

Staff were generally positive about the trust's clinical senate and said it was a good mechanism for feeding information up and down the organisation. Staff could put their names forward to join the senate and staff groups voted for their representatives.

Localised leadership was good. Managers and team leaders all demonstrated a clear understanding of their role and position in the trust. Staff said their direct managers were supportive.

Leadership was also developed and shared within teams by using team champions. These included champions for dementia, the IT system and infection control. Champions

Good

# Are Community Health Services for Adults well-led?

received additional training, met with their equivalent colleagues in other teams, disseminated information at team meetings and supported colleagues within their champion specialism.

### Culture within this service

Most staff reported a positive culture in the service. They reported increased engagement and felt they were being listened to. Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority. Staff told us they were encouraged to raise concerns about patient care and this was acted on. Staff were dedicated and worked well in their teams. We found some community teams worked in silos, particularly between the different business units, which meant sharing of best practice and concerns between teams was not as effective as it could be. Figures showed staff sickness levels were improving. Many staff told us they were proud to work for the trust.

### Public and staff engagement

The trust had a number of systems to collect and analyse feedback from the public. Patient surveys were routinely conducted and the 'Family and Friends Test' had been introduced into non-inpatient settings in August 2014. Staff explained how they received feedback from the surveys which they discussed at team meetings.

### Innovation, improvement and sustainability

There were a number of areas of innovation and improvement we observed during the inspection. Examples of these are described below.

The tissue viability nurse in the north east business unit was piloting the use of a pressure mapping kit. Patients were asked to sit on the mat with without using pressure-relieving equipment. The patient and the staff member then viewed on a screen a map indicating the pressure changes when the equipment was appropriately in place. The nurse was also working with an occupational therapist as this helped improve posture as well as pressure care.

A project to share specialist nursing knowledge and training with care homes in Lincolnshire had received national recognition. It received 'highly commended' in the NHS Innovation Challenge prize. Specialist nurses shared their skills in the areas of preventing falls, avoiding pressure ulcers and supporting continence care. A training pack was developed which was now being successfully used in other care homes across south Lincolnshire. In one care home, the changes meant GP visits reduced from 27 one month to 17 the next, there was a 50% reduction in falls and 66 % fewer community nurse visits.

Remote working and new IT systems were being rolled out across the trust in response to staff reporting difficulties and ineffective use of their time when recording patient contacts. Staff told us they believed that the new system would improve patient experience and safety by making information easier to input, find, update and share.

A poster had been developed by the heart failure specialist team to encourage clinical colleagues to both identify heart failure and to refer into the team.