Cambridgeshire Community Services NHS Trust

Quality Report

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Core services inspected	CQC registered location	CQC location ID
Community Health Services for Adults	Head Quarters Respite House Orwell sexual health clinic	RYV61 RYVX7 RYVY7
Community Health Services for Children, Young People and Families	Cambridgeshire Community Services NHS Trust at Hinchingbrooke Hospital Head Quarters Futures House	RYV05 RYV61 RYVY6
Community Inpatient Services	Brookfields Hospital Intermediate Care Unit North Cambridgeshire Hospital Princess of Wales Hospital	RYV01 RYVY4 RYV02 RYV03
End of Life Care	North Cambridgeshire Hospital Princess of Wales Hospital Brookfields Hospital Head Quarters	RYV02 RYV03 RYV01 RYV61
Dentistry	Cambridge Access Centre Dental Access Centre (Peterborough) Dental Access Centre (Wisbech) Princess of Wales Hospital	RYV07 RYVY3 RYV08 RYV03
Minor Injury Units	Doddington Hospital Princess of Wales Hospital North Cambridgeshire Hospital	RYV04 RYV03 RYV02

Summary of findings

This report describes our judgement of the quality of care at this provider. It 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.

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Overall summary

When aggregating ratings, our inspection teams follow a set of principles to ensure consistent decisions. The principles will normally apply but will be balanced by inspection teams using their discretion and professional judgement in the light of all of the available evidence.

We found that the provider was performing at a level which led to a judgement of Good.

We were pleased to find many areas of very good practice across all core service areas. Staff took an active role in delivering and promoting safety, learning and improvement. There was a clear picture of safety across most services. However in isolated areas there were inadequate infection prevention and control procedures and medicines management. Staffing establishments were actively reviewed but were not sufficient in all areas. Some staff teams were stretched and unable to meet people's needs in a timely way. The provider had in place strategies to manage risks and improve recruitment.

Care and treatment were effectively meeting the needs of patients, families and carers through evidence based practice, guidance and care pathways. There was very good multi-disciplinary working and initiatives to support people at home and avoid admission to hospital. Staff demonstrated a good understanding of the social and economic factors and cultural diversity of their local communities so that sensitive and respectful care could be provided. Staff monitored outcomes using a range of audits, assessments and feedback mechanisms.

Overall, staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. However, in some areas of rehabilitation staff did not have appropriate training and levels of staff attendance at mandatory training and appraisals were below the Trust's targets.

People using the services were treated with compassion, dignity and respect. People were consistently positive about their experiences of receiving care. We noted that there were mutually respectful working relationships between different professional groups. Patients were involved in planning their care and were supported to manage their own health and care when they could and to maintain their independence. There were systems in place within all teams for learning from experiences, concerns and complaints.

People were able to access care and treatment close to home in local community hospitals, clinics and treatment centres. District and community nursing services were flexible and worked across professional and organisational boundaries. The Trust ran a number of successful projects, including with other providers, which helped prevent hospital admissions. Trust staff generally had good working relationships with partner organisations, such as social services and the voluntary sector.

The Trust had a clear statement of vision and values. Staff were not consistently aware of these although the organisational values were widely demonstrated by staff across the Trust. The Trust had a two year operational plan for 2014-16 that set out intentions for quality, recruitment, finance and sustainability. Overall we found staff groups were aware of the current transformation programmes. Staff reported an open culture at the trust which gave them confidence to report concerns. Most but not all staff we spoke with felt they were consulted about changes to services and were able to contribute to service developments.

There was an effective governance system and the Trust used a range of tools to monitor quality and risk. In most clinical teams, senior staff showed a good awareness and understanding of governance arrangements, and they maintained local performance data, risk registers and audits. Most but not all teams were benchmarking themselves against other service areas in the Trust. In North Cambridgeshire Hospital, there was a lack of oversight of the mortuary and the Trust could not provide evidence that risks had been managed, or the quality of the service monitored. We raised these concerns at the time of the inspection and the Trust took immediate action to close the mortuary and put in place alternative arrangements for the care of deceased patients.

There was good clinical leadership throughout all units, and a visible, strong leadership at Board level. Work was

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ongoing to clarify and strengthen the Trust's strategic direction and governance structures to ensure the safe transfer in and out of services as a result of procurements which will take effect later in 2014 and early 2015.

We reviewed the Trust's outstanding non-compliance with the essential standards of quality and safety. We found the Trust was now compliant with Regulation 22, Staffing, at Hinchingbrooke Hospital and with Regulation 10, Assessing and monitoring the quality of service provision at Head Quarters. We also found the Trust was making progress with addressing shortfalls of staffing in the community nursing services.

As a result of the concerns identified during this inspection, we judged the provider was not meeting Regulation 10, Assessing and monitoring the quality of service provision in End of Life Care, and Regulation 13, Medicines management on Inpatient wards. These findings are detailed in the core service reports. We have asked the provider to send us a report that tells us what actions they are taking to meet these essential standards.

Summary of findings

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

We always ask the following five questions of services.

Are services safe?

The Trust had systems in place to identify and manage risks to people's safety. Managers reported local risks which were escalated through clinical operational boards to the Trust Board. Learning from incidents generally took place. Staff were knowledgeable about safeguarding procedures for adults and children. Patient records were comprehensive and usually completed as required and stored safely. There were effective infection control procedures in most areas. In some teams there was low staff attendance at information governance and infection control training. In one hospital there was a small mortuary. There were poor standards of cleanliness and infection control in the mortuary, with no monitoring of these standards. The Trust took immediate action to address this.

There were staff shortages in the community and district nursing teams. The Trust recognised the ongoing risks related to staffing levels and recruitment was continuing. The Trust had identified areas where there were staff vacancies that were difficult to fill, and had recruited some staff in these areas. There were various recruitment approaches, as well as new models of mentoring and rotations in order to attract applicants.

Equipment and facilities were clean and fit for purpose, and medicines were managed safely most of the time. However, we found a number of medicine omissions on inpatient wards and inadequate monitoring of this. As a result of our concerns, we judged the provider was not meeting Regulation 13, Medicines management. We have asked the provider to send us a report that tells us what actions they are taking to meet this essential standard.

Are services effective?

In general we found services were effectively meeting the needs of patients, families and carers through evidence based practice, guidance and care pathways. There was very good multi-disciplinary working and initiatives to support people at home and avoid admission to hospital

Patients were sometimes admitted to the inpatient wards for rehabilitation following a stroke. In some wards, rehabilitation did not follow national guidance, staff did not have training in managing people recovering from a stroke and therapies provided were general rather than stroke-specific. The Trust had responded to the

Summary of findings

national withdrawal of the Liverpool Care Pathway and had developed their own personalised care plan to use for people during the last few days of life. There was clear staff guidance for using the care plan.

Staff demonstrated a good understanding of the social and economic factors and cultural diversity of their local communities so that sensitive and respectful care could be provided. People using the services received care, treatment and support that achieved good outcomes and promoted their well-being. Staff monitored outcomes using a range of audits, assessments and feedback mechanisms.

Staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. New staff received a comprehensive induction. Staff in general felt well supported by managers and there were systems in place for regular clinical and management supervision and appraisal in most service teams. However, Trust-wide figures for staff attendance at mandatory training and for uptake of appraisals were below the Trust's targets.

Are services caring?

People using the services were treated with compassion, dignity and respect. People were consistently positive about their experiences of receiving care. Staff respected people's individual preferences, culture and background. We noted that there were mutually respectful working relationships between different professional groups.

Patients were involved in planning their care and were provided with useful information. Information leaflets about the services were available, although not all of these were written in plain English. The leaflets were provided in languages other than English, or in large print if required.

Staff were responsive to people's emotional needs and included patients' friends and relatives in explanations and support where appropriate. People were supported to manage their own health and care when they could and to maintain their independence.

Are services responsive to people's needs?

Teams working in the community delivered care that was focussed on the needs and wishes of people using the service. Multi-disciplinary teams worked flexibly to ensure joined up children's services Staff had a good understanding of the local population and initiated ways of working with different community groups.

Summary of findings

People were able to access care and treatment close to home in local community hospitals, clinics and treatment centres. Some teams were short staffed and managing increasing workloads, so that they could not always meet waiting times targets. District and community nursing services were flexible and worked across professional and organisational boundaries. The Trust provided a small number of "step up" beds so that patients could have short term care without being admitted to an acute hospital. Community rehabilitation teams worked flexibly to avoid hospital admissions for people at risk in their own homes, such as people at risk of falling. The Trust had reviewed its minor injury unit services and was testing weekend opening at its Wisbech location.

The Trust was committed to ensuring people received their end of life care in their preferred place. The specialist palliative care team could facilitate a rapid discharge home for people who had identified a wish to be cared for in their own home.

People's religious and cultural needs were assessed and treatment plans were holistic and person centred, paying attention to individual wishes and preferences. We found that Trust staff generally had good working relationships with partner organisations, such as social services and the voluntary sector.

There were systems in place within all teams for learning from experiences, concerns and complaints. We saw how the Trust had managed and responded to a number of complaints by improving the environment, changing clinic opening hours or working with volunteers to assist patients.

Are services well-led?

The Trust had a clear statement of vision and values. Staff were not consistently aware of these but we found the values reflected in many conversations with staff and observations of staff acting with sensitivity and respect. The Trust had a two year operational plan for 2014-16 that set out intentions for quality, recruitment, finance and sustainability. Overall we found staff groups were aware of the current transformation programmes.

The Trust had an effective governance system. The Trust used a range of tools to monitor quality and risk, including the Quality Early Warning Trigger Tool (QEWTT), quality dashboards, risk registers and electronic incident reporting. In most clinical teams, senior staff showed a good awareness and understanding of governance arrangements, and they maintained local performance data, risk registers and audits. Most but not all teams were benchmarking themselves against other service areas in the Trust.

Summary of findings

Throughout our inspection we heard many examples of the visibility and commitment of executive and non-executive Board members. There was good clinical leadership throughout all units. Leadership development opportunities were available to staff through in-house and external programmes. The 2013 National NHS Staff Survey found the percentage of staff recommending the Trust as a place to work or receive treatment and who felt able to contribute to improvements at work was above average when compared with other community trusts. Staff reported an open culture at the trust which gave them confidence to report concerns. Most but not all staff we spoke with felt they were consulted about changes to services and were able to contribute to service developments.

Patient experience information was gathered through means such as feedback surveys, complaints, compliments and comment cards, external websites and service visits. Patient stories were presented at the Board meeting bi-monthly.

The Trust did not have a unified vision or strategy for end of life care. There was no Trust-wide policy on end of life care or on caring for patients after they have died. In North Cambridgeshire hospital, there was no guidance for staff responsible for transporting deceased patients to the mortuary and there were no procedures or schedules in place for cleaning and infection control. Risks in the mortuary had not been monitored and had been overlooked. We raised these concerns at the time of the inspection and the Trust took immediate action to close the mortuary and put in place alternative arrangements for the care of deceased patients. However, as a result of the concerns identified, we judged the provider was not meeting Regulation 10, Assessing and monitoring the quality of service provision in End of Life Care. We have asked the provider to send us a report that tells us what actions they are taking to meet these essential standards.

Work was ongoing to clarify and strengthen the Trust's strategic direction and to ensure the safe transfer in and out of services as a result of procurements which will take effect later in 2014 and early 2015. The Trust Board was developing plans for re-configuring governance structures in light of forthcoming changes.

Summary of findings

Our inspection team

Our inspection team was led by:

Chair: Gillian Hooper, Director of Quality & Commissioning (Medical & Dental), Health Education England

Team Leader: Ros Johnson, Care Quality Commission

The team included CQC inspectors, community nurses, a health visitor, specialist nurses including children's and palliative care, occupational therapists, a physiotherapist, a GP, and four experts by experience who have personal experience of using or caring for someone who uses the type of services we inspected.

Why we carried out this inspection

We inspected the Trust as part of our comprehensive Wave 2 pilot community health services inspection programme. The focus of wave 2 is on large, complex organisations which provide a range of NHS community services to a local population.

How we carried out this inspection

To get to the heart of people who use services' experience of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before visiting, we reviewed a range of information we hold about the Trust and asked other organisations to share what they knew. We also received comments from people who had attended a listening event prior to the inspection. We carried out announced visits on 28, 29 and 30 May 2014 and unannounced visits on 6 and 7 June 2014. We visited community hospitals, health centres, dental clinics and minor injury units. We went on home visits with district nursing, health visitors and community therapists. During the visits we held focus groups with a range of staff who worked within the service, including nurses, therapists and healthcare assistants. We talked with people who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records.

What people who use the provider's services say

Across all of the core services, people were very pleased with their care and treatment. They found services were provided close to home and that staff were respectful, caring and committed. Some people told us information about access and appointments, and signage could be improved in some areas.

Good practice

The organisational values of honesty, empathy, ambition and respect (HEAR) were widely demonstrated by staff across the Trust.

Staff demonstrated commitment and innovation in the context of significant organisational change. There was impressive clinical leadership in all services.

Summary of findings

The Rapid Response Team provided an outstanding level of care and support to babies and young children at home with acute illnesses, and their families.

The Infant Feeding and Breast Feeding Team demonstrated an outstanding commitment to provide feeding advice and support to families from culturally diverse backgrounds in the Luton area. Staff had been pro- active and flexible in the design and delivery of services, in order to engage effectively with the local community.

We saw examples of excellent needs assessment and care planning in children and young people's services.

The Trust had received the UNICEF stage 2 accreditation for the Baby Friendly Initiative, which promotes breastfeeding. The Trust was working to achieve stage 3. We saw particularly good practice in the paediatric and neonatal unit.

Children's community nurses and community neonatal nurses were based in the inpatient services. They attended daily handover within the neonatal unit and paediatric ward to ensure they were aware and up to date with up and coming discharges.

There was good multi-disciplinary team working throughout services providing palliative and end of life care.

Staff were enthusiastic, compassionate and committed to ensuring patients and their relatives experienced a good end of life care experience.

Through effective and creative multidisciplinary working, drug and alcohol services in Luton provided opportunities and support for people who used the service to develop their recovery pathways.

Physio Direct provided an effective service that promoted self-management whenever possible for people who used it. Assessments were comprehensive and were in line with nationally recognised guidance and current good practice. Positive changes were made to the service following feedback from people using it.

There was good use of the safety dashboard in all inpatient areas displaying performance information in relation to patient safety.

The use of the Northwick Park patient dependency tool to monitor patient acuity and plan staffing levels.

The community rapid response service pilot was effective in providing services in the patient's home and avoiding admission to hospital.

The 'Magic May' activity programme on Lord Byron ward used to support patients to develop social links and take part in activities.

Patient status at a glance board's provide a visual display of patient and team information allowing staff to constantly monitor the patients' progress throughout their stay.

Minor injury unit staff had adopted a new way of treating buckle or greenstick fractures in children. This had been rapidly adopted from novel practice at a local emergency department. The staff had proposed this change in protocol, it had been adopted at all three minor injury units and staff continued to audit the patient outcomes.

In dental services, priority was given to safety for all patients, particularly those that are vulnerable.

Dental decontamination and infection control facilities and processes were excellent.

There were good facilities and adjustments for people with particular special needs in the dental clinics.

Dental staff were passionate and really cared about the people who used the service

Summary of findings

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

1. The provider must regularly assess and monitor the quality of all services provided, to include care after death, so as to protect people using the service and others who may be at risk.
2. The provider must ensure there are adequate systems in place to monitor and prevent medicines omissions in inpatient wards.
3. The provider must continue to develop effective recruitment, caseload management, and staff support strategies so as to ensure satisfactory staffing levels in the district and community nursing teams.

Action the provider SHOULD take to improve

1. The Trust should provide clear guidance for staff in respect of which incidents are reportable to ensure that staff report incidents appropriately.
2. The provider should ensure that staff are supported in escalating concerns and that incidents identified by contractors and external agencies are incorporated into the Trust's risk reporting.
3. The provider should have appropriate policies for staff to follow when supporting patients with end of life care or when caring for patients after they have died
4. The provider should ensure that confidential records and papers are kept securely and can be located promptly at all times.
5. The provider should ensure effective infection prevention and control policies and procedures in place in all areas of the service.
6. The provider should review staff compliance with the deteriorating patient policy to ensure staff are recognising and managing patient deterioration confidently and competently.
7. The provider should review the national clinical guidance for stroke care to provide assurance that care delivery meets the ongoing needs of the patient and their family or carer.
8. The provider should review the training required for staff involved in the rehabilitation of stroke patients.
9. The provider should ensure that once referred to the service, children and young people are not waiting longer than expected for treatment.
10. The provider should ensure that staff are up to date with mandatory training.
11. The provider should closely monitor the risk to staff welfare and any difficulties patients may have in mobilisation around the bed spaces on Welney ward.
12. The provider should ensure all environments, particularly in community settings are child friendly and creates an atmosphere where children will feel at ease.
13. The provider should ensure all oxygen cylinders are stored in line with current Health and Safety Executive guidance.
14. The provider should ensure all quality data, including learning from incidents, complaints, audits and patient feedback is displayed in all areas.

Action the provider COULD take to improve

1. The provider could improve the environment of the apartments used for rehabilitation of people who used the service so as to promote their wellbeing.
2. The provider could review the use of curtains in treatment bays at some outpatient's clinics, so as to improve privacy and confidentiality.
3. The provider could put in place benchmarking against other wards within the service, to increase opportunities for learning across inpatient services.
4. The provider could consider systems to monitor 'intentional rounding' to ensure this practice is consistently applied across all wards.
5. The provider could consider the staffing capacity against demand and ongoing caseload management of the Health Visitor and School Nursing services in order to deliver the "Healthy Child Programme" outcomes effectively.
6. The provider could raise the impact of delayed provision of specifically designed mobility equipment to children and young people with service commissioners to seek to reduce the impact on those children and young people.

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7. The provider could consider providing a specific room for breaking bad news on the neonatal unit.
8. The provider could consider, during the refurbishment programme, providing bathroom facilities for mothers who are staying on the neonatal unit.
9. The provider could refine the dental clinic appointments system and ensure the people who use the service know how to access services
10. The provider could simplify dental clinic information leaflets to include more information regarding waiting times.
11. The provider could ensure any comments from dental patients are recorded and genuinely used to improve services.

Cambridgeshire Community Services NHS Trust

Detailed findings

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

Summary of findings

The Trust had systems in place to identify and manage risks to people's safety. Managers reported local risks which were escalated through clinical operational boards to the Trust Board. Learning from incidents generally took place. Staff were knowledgeable about safeguarding procedures for adults and children. Patient records were comprehensive and usually completed as required and stored safely. There were effective infection control procedures in most areas. In some teams there was low staff attendance at information governance and infection control training. In one hospital there was a small mortuary. There were poor standards of cleanliness and infection control in the mortuary, with no monitoring of these standards. The Trust took immediate action to address this.

There were staff shortages in the community and district nursing teams. The Trust recognised the ongoing risks related to staffing levels and recruitment was continuing The Trust had identified areas where there were staff vacancies that were difficult to fill, and had recruited some staff in these areas. There were various recruitment approaches, as well as new models of mentoring and rotations in order to attract applicants.

Equipment and facilities were clean and fit for purpose, and medicines were managed safely most of the time. However, we found a number of medicine omissions on inpatient wards and inadequate monitoring of this. As a result of our concerns, we judged the provider was not meeting Regulation 13, Medicines management. We have asked the provider to send us a report that tells us what actions they are taking to meet this essential standard.

Our findings

Incidents, reporting and learning

The Strategic Executive Information System (STEIS) records serious incidents and never events. Never events are incidents that should never occur and there is a defined list of 28 incidents. There were no never events at Cambridgeshire Community Health Services NHS Trust

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

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between April 2013 and March 2014. Serious incidents are those that require an investigation. There were 255 serious incidents at the trust between April 2013 and March 2014. Most of these (92%) were significant pressure ulcers.

We noted that pressure ulcers were monitored on a regular basis and that where an increase in ulcers had been identified, action was taken to address the issue. For example, in the meeting minutes of the Quality Improvement and Safety Committee for December 2013 an investigation was initiated in relation to an increase of pressure ulcers within the trust. A dedicated group called the Pressure Ulcer Ambition Group was in place to oversee all pressure incidents and provide feedback on learning and trends. The group ensured improvements were made, such as a different supplier for a heel appliance and providing digital cameras for community nurses so that tissue viability specialists could review ulcers without having to be present.

In the March 2014 Quality Report to the Trust Board, the Chief Nurse presented National Safety Thermometer national comparative data from similar NHS trusts and compared to national averages, showing performance over a three month period.

Most staff we spoke with were familiar with reporting incidents and were aware of the investigation process, including the use of root cause analysis to investigate serious untoward incidents. Most but not all staff groups told us they received feedback on incidents and lessons learnt were shared with them. There were effective arrangements for reporting and responding to allegations of or actual abuse. There were systems in place to support staff out of hours and when working alone, and to provide guidance in cases of emergency, including individual staff responsibilities.

The Trust's safety team was led by the Head of Quality Performance. The Trust used an electronic reporting system, which had recently been upgraded and displayed information and produced reports efficiently. There was a coding system which flagged incident types, showing where they occurred and which external agency they should be reported to. The patient safety team analysed the reports and identified themes within the incidents. They told us all serious incidents were reported within 48 hours.

Two safety managers worked closely with the clinical leads in each Community Unit, and a compliance manager had responsibility for liaison with staff teams. Learning from incidents was shared with staff through these working relationships and through the Trust-wide weekly email called "Comms Cascade". For example one in May 2014 included a note on actions required following information governance incidents and a succinct update on reporting pressure ulcers. Learning and improvement from incidents was monitored through the clinical scrutiny group reporting to the Quality Improvement and Safety Committee. In addition, the Trust worked with other healthcare providers to improve care relating to pressure ulcers. A joint event was held with a local acute hospital to share best practice and innovations.

Cleanliness, infection control and hygiene

The Trust had an Infection Prevention and Control Policy to ensure that all staff were able to provide care and treatment using procedures and processes which minimise the risk of preventable Healthcare Associated Infections (HCAIs). The infection prevention and control committee reported to the Estates Committee, which met quarterly, and provided regular reports to the Quality Improvement and Safety Committee. Infection control was a thematic review at alternate Quality Improvement and Safety Committee meetings. Across the Trust, teams were failing to meet the target for mandatory annual training in infection prevention and control. Overall Trust data showed that only 63% staff had accessed this training.

There were effective infection control procedures in most areas. Premises were usually clean and free from clutter. Staff showed good understanding of infection control precautions, and carried out regular audits. We reviewed a range of audits across the different services and locations and saw high levels of compliance with required standards of cleanliness and hygiene. Personal protective equipment (PPE), such as disposable gloves and aprons were readily available in all locations and community staff told us they carried PPE with them on home visits.

In one hospital there was a small mortuary. The Trust did not have a policy relating to the care of a person following their death and there was no transfer policy for deceased patients identified as having an infection. There were poor

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standards of cleanliness and infection control in the mortuary, with no monitoring of these standards. When we visited unannounced ten days later we confirmed that the mortuary had been closed and no longer posed a risk.

Maintenance of environment and equipment

Overall the locations we visited were well maintained and fit for purpose. Most but not all of the premises where children's services were delivered were child-friendly and had age-appropriate toys, information and furniture. Buildings had appropriate security measures in place. Equipment was well maintained so it was safe for use. Staff told us the equipment they used was sufficient and regularly serviced. Where appropriate, staff used sterilised equipment that was disposable or for single use before being re-sterilised. Parents and staff in the community setting told us there had been some delays in receiving mobility equipment for children. Equipment was supplied by a third party provider. Staff explained to us this had been identified as an issue and the process of receiving equipment, in particular wheelchairs, was improving but the service continued to report delays to the head of service and the Trust board.

Medicines

In most areas medicines were safely managed. They were stored safely and pharmacy staff carried out regular checks. Controlled drugs were managed according to legal requirements and emergency medicines were in date and fit for use. Medicines, including first aid boxes, were kept secure and handled safely. Staff were aware of the Trust's protocols for handling medicines so that the risks to people were minimised. Prescription charts were completed correctly and staff completed weekly audits.

Staff usually administered medicines as prescribed and completed records of this. However in three out of four inpatient wards we found gaps in essential medication records, and senior nursing staff were not able to tell us if the medication had been given or not. Staff knew to report medication errors and described examples where this had happened and the action taken. We found that not all errors were reported as incidents and errors were not always picked up on checks of the medicines records.

Safeguarding

Staff could describe types of abuse and the procedures to follow if abuse was suspected or alleged. Safeguarding procedures and incidents were discussed at team meetings. The Trust's target was for 95% of staff to attend training in safeguarding vulnerable adults every two years. This target had not been met in all areas, and overall 90% of staff had accessed the required training.

There were proper procedures for child protection planning, investigations and following up outcomes of safeguarding concerns. Learning from these incidents, including the outcomes of serious case reviews, was shared across staff teams who were supported by the Trust's Safeguarding Children Team. There was a designated doctor and lead nurse for safeguarding available to staff should they require support and guidance. On adult inpatient wards, the safeguarding procedure was on display and each ward had a folder containing relevant information and a designated safeguarding lead.

Records

Most teams and services used an electronic patient record system, but paper records were also used. Records were kept securely and electronic records were password protected. Most, but not all, teams were able to access the electronic records. In general, staff were able to share records with other providers such as GPs, the 111 service, the ambulance services and A&E departments in acute hospitals. There were systems and protocols in place for sharing information with others, such as with GPs or with medical staff from other NHS trusts. Staff could describe how people's confidentiality was protected.

Some community teams reported difficulties with remote internet access for electronic records; patients treated at home had paper records with essential care plans and risk assessments that were kept at the person's home. The 'Releasing Time to Care' programme was working on streamlining processes including documentation.

Between April 2013 and March 2014 the Trust reported five incidents where confidential information was unintentionally disclosed. One of the Trust's measures to reduce the risk of this happening again was for staff to attend training in information governance. However, the staff attendance for this training was low, at 49%. This meant that staff may lack awareness of how to prevent further unwanted disclosures of confidential information. We found regular records and documentation audits were carried out.

Are services safe?

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Lone and remote working

Community staff took appropriate steps to keep themselves safe when working alone in the community. The Trust had a lone working policy and local arrangements were in place in each area, although not all teams felt arrangements were adequate. The computerised record system had an alert system so that staff were aware of any potential risks when carrying out visits. Staff told us sharing information on risks with partner organisations was generally effective.

Adaptation of safety systems for care in different settings

Teams operated local risk assessment protocols to reflect the type of service and where care was being delivered. People using the services were aware of support systems in place. Staffing levels and skills mix supported safe practice in most areas we inspected, and various changes were made to environments and procedures to provide safe care. The Trust had implemented a Quality Early Warning Trigger Tool (QEWTT) in 2012. This was used by the community units to report emerging issues of concern at clinical team level each month. The tool uses an escalation matrix to highlight concerns in teams which could affect the delivery of safe patient care. The data were considered as part of the integrated governance at clinical operational boards in order to gain a comprehensive assessment of risk and to support teams to effectively implement actions to prevent adverse outcomes for patients. We saw in clinical operational board meeting minutes and quality reports to the Board that a range of strategies were in place to reduce the identified risks.

Assessing and responding to patient risk

There were systems in place to monitor safety and respond to risks. The Trust's Quality Improvement and Safety Committee was the formal sub-committee of the Board through which issues relating to quality and safety were reported. The committee met every two months and was chaired by a non-executive director; the Chief Nurse and Medical Director attended the committee together with general managers and other clinical staff. We saw in the minutes of the last three meetings that clinical risks were reviewed and discussed. The committee had delegated authority from the Board to mitigate certain risks and there were clear instructions listed in the terms of reference to escalate high level risks to Board. We noted that these escalations were included in the Quality Report which was presented regularly at the Trust Board.

The Quality Improvement and Safety Committee had eight sub groups including emergency planning, infection prevention and control, medicines safety and safeguarding. The chair acknowledged that work was in progress to improve the quality and format of reporting to the committee. The newly appointed assistant director for governance would support this development.

There were three clinical operational boards that met monthly and were full sub-committees of the Board. Their role was to provide the Board with assurance in relation to standards of quality, finance, performance and workforce, through integrated governance analysis (reviewing the interrelationships between quality, finance, workforce and performance). Community units maintained risk registers using the Trust-wide electronic risk management and incident reporting system. Risks were escalated using a scoring framework, through the clinical operational boards and reported by exception to the Trust Board monthly.

Within the wards we visited, we saw there was NHS safety thermometer information. This provided up-to-date information about the ward's current status relating to harm free care. This information was presented in a format that could be easily understood by the general public.

Staffing levels and caseload

We saw management plans were in place to address concerns about staffing levels. We found that areas of risk were reported to the Board using the QEWTT for each team in the service. The Trust recognised the ongoing risks related to staffing levels and recruitment was continuing The Trust had identified 'hot spots' or areas where there were staff vacancies that were difficult to fill. It had invested in the district nursing service in Cambridgeshire and Peterborough, with support from the Clinical Commissioning Group, and had recruited some staff in these areas. Funding had been agreed for some additional posts in community teams where caseloads were increasing in size and complexity. This meant that there would be less reliance on locum and bank or agency staff in the future. The Trust had introduced a variety of recruitment approaches, as well as new models of mentoring and rotations in order to attract applicants.

On adult inpatient wards there were mostly sufficient staff, of an appropriate skill mix, to enable the effective delivery of care and treatment. Nursing numbers were assessed using a recognised tool. Staffing levels were clearly identified and displayed. Staff reported that although they

Are services safe?

By safe, we mean that people are protected from abuse * and avoidable harm

were busy they were rarely short staffed; we saw that some advertised vacancies had been filled. Staffing levels were reviewed by the ward sister on a daily basis and escalated as necessary. The Trust Board had an ongoing awareness of staffing levels throughout inpatient services. Staff who worked in community teams told us staffing levels and skill mix were generally appropriate. District and community nurses from one area said that weekend cover was not sufficient, and staff did not have enough time for each patient. The Trust was aware of 'hot spots' of community staff vacancies that were difficult to fill. There had been a number of initiatives to attract new appointments, and these were beginning to show results. The Trust recognised the ongoing risks related to staffing levels and recruitment was continuing.

Community teams were starting to use a workload management tool to make sure community nursing teams had manageable caseloads. The tool allowed daily review of staff levels, providing a risk rating so that managers and staff knew where staff were needed. Staff could then be allocated according to patients' needs. There was also a "Releasing Time to Care" project, helping staff manage time more effectively and ensure the correct balance with record keeping.

Deprivation of Liberty safeguards

The Mental Capacity Act 2005 (MCA) provides a statutory framework for acting and making decisions on behalf of people who lack the capacity to make decisions about and give informed consent to their care and treatment. Where this care might involve depriving vulnerable people of their liberty in hospital, extra safeguards exist. The Deprivation of Liberty Safeguards provide formal procedures to protect people who lack the capacity to consent.

Most staff we spoke with demonstrated a good understanding of their responsibilities regarding the MCA and the Deprivation of Liberty Safeguards. Staff knew what to do when patients were unable to give informed consent. Mandatory training included the MCA every two years for all clinical patient-facing staff, but less than 50% required staff had attended the training

Managing anticipated risks

Risks were reported through the electronic reporting system and the QEWTT. In the past the Trust had over reported to the National Reporting and Learning System (NRLS), particularly for pressure ulcers of all grades. They told us a member of the team had met with the NHS unit with responsibility for patient safety and they were now more consistent and reported appropriately. They told us there would be a more realistic view of the trust's reportable incidents in the next submission of data in October 2014. There were plans to recruit a further analyst to the team.

Risks were escalated to the relevant clinical operational boards and if appropriate to the Trust Board. The board assurance framework enabled the Trust to have an overview of risks affecting the safe running of services. Staff accountability and effective multi-disciplinary working within the Trust and with other agencies helped to manage anticipated risks. We looked at information relating to some risks that had been identified and could see that controls had been put in place. For example, to address the increasing incidence of pressure ulcers there was a focus on strengthening clinical leadership, with more band 7 posts providing supervision for junior staff. The impact on staff of different services being in a tendering process was being monitored by the Trust. The operational board for adults and older people clearly highlighted the need to focus on the transfer of services to another provider, and to invite a representative to the board as soon as they are known.

Major incident awareness and training

The Trust had in place appropriate policies, protocols and business continuity in case of major incidents and emergencies. Staff we spoke with across the Trust were aware of these and their individual responsibilities.

Are services effective?

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

Summary of findings

In general we found services were effectively meeting the needs of patients, families and carers through evidence based practice, guidance and care pathways. There was very good multi-disciplinary working and initiatives to support people at home and avoid admission to hospital.

Patients were sometimes admitted to the inpatient wards for rehabilitation following a stroke. In some wards, rehabilitation did not follow national guidance, staff did not have training in managing people recovering from a stroke and therapies provided were general rather than stroke-specific. The Trust had responded to the national withdrawal of the Liverpool Care Pathway and had developed their own personalised care plan to use for people during the last few days of life. There was clear staff guidance for using the care plan.

Staff demonstrated a good understanding of the social and economic factors and cultural diversity of their local communities so that sensitive and respectful care could be provided. People using the services received care, treatment and support that achieved good outcomes and promoted their well-being. Staff monitored outcomes using a range of audits, assessments and feedback mechanisms.

Staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. New staff received a comprehensive induction. Staff in general felt well supported by managers and there were systems in place for regular clinical and management supervision and appraisal in most service teams. However, Trust-wide figures for staff attendance at mandatory training and for uptake of appraisals were below the Trust's targets.

Our findings

Evidence based care and treatment

Overall care and treatment was evidence based and followed recognised and approved national guidance. Staff had developed and ratified clinical care pathways where needed for specific situations. Patients were assessed using standard clinical measurements and risk assessment screening tools. Assessments and care plans covered people's health and social care needs, and patients were involved in self-assessment where appropriate.

Patients were sometimes admitted to the inpatient wards for rehabilitation following a stroke. In some wards, rehabilitation did not follow national guidance, staff did not have training in managing people recovering from a stroke and therapies provided were general rather than stroke-specific. Staff from a community rehabilitation team also told us that the team was not following NICE guidelines and were not always able to see stroke patients within 72 hours of discharge from hospital. The team did not employ a specialist neurologist but some staff had undertaken further training to ensure they developed their skills in supporting people with neurological conditions.

The Trust did not have a Trust-wide end of life care policy or care after death policy, but care was based on the National Institute for Health and Care Excellence (NICE) quality standard. The Trust had responded to the national withdrawal of the Liverpool Care Pathway and had developed their own personalised care plan to use for people during the last few days of life. There was clear staff guidance for using the care plan.

Pain relief

Staff used recognised pain assessment tools and in general managed pain well. People using the service were supported to manage their pain and community nurses were able to adjust people's prescribed pain relief when needed. The Physio Direct service was for people to contact a physiotherapist by telephone to get advice for their symptoms, including pain. Care plans were in place for children requiring pain relief and the service had systems for ensuring the regular review of medicines by the appropriate doctor. There were clear guidelines for staff to follow regarding palliative care and staff had received appropriate training.

Nutrition and hydration

Patients were screened for malnutrition and the risk of malnutrition; care plans were in place to minimise risks from poor dietary intake as appropriate. People's nutritional needs were assessed and, where appropriate, they were referred to the dietician or speech and language therapist. Care plans were regularly evaluated and revised as appropriate as patients progressed through their care and treatment.

Are services effective?

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Patient outcomes

People using the services received care, treatment and support that achieved good outcomes and promoted their well-being. Staff demonstrated a good understanding of the social and economic factors and cultural diversity of their local communities so that sensitive and respectful care could be provided.

Staff monitored outcomes using a range of audits, assessments and feedback mechanisms. Performance dashboards were available and reported on monthly for each service area and community unit. The Trust monitored the effectiveness of care through the clinical operational boards, the quality improvement and safety committee and the Trust Board. A quality dashboard was reviewed at Board and this contained information such as how the Trust was performing against patient safety indicators such as Falls, and VTE screening. These showed the Trust generally met standards required by national programmes or local quality improvement goals set by commissioners.

The Trust had a detailed audit programme in place and staff we spoke with were aware of clinical audits taking place in their area. The planning and outcomes of audits were monitored by the Quality Improvement and Safety Committee. The Trust had taken part in all four national audits it was eligible for during 2012/13.

Performance information

Performance information about community health services was included in the Trust's quality monitoring 'dashboard' system. This included information about patient safety, incidents, infection prevention and control, and patient experience. Staff discussed the performance information at team meetings and described plans to improve patient outcomes as a result. The Trust Board had clear oversight as there was effective information sharing from the teams delivering care through to Board level

Information provided to the Board included quality and safety reports with performance and delivery against key performance indicators and outcomes of clinical audit activity. There were also reports on patient experience, including an analysis of any trends. Action plans were developed to ensure targets were met where improvements had been identified as being required.

Competent staff

Staff were appropriately qualified and competent to carry out their roles safely and effectively in line with best practice. New staff received a comprehensive induction. Staff were supported to access professional development courses, but this was variable across the Trust and not always possible due to workload in some teams.

The 2013 National NHS staff survey reported that the proportion of staff who felt they received job-relevant training, learning or development was average when compared with other community Trusts. However this was one of the Trust's three bottom ranking scores. Access to mandatory training was variable across the Trust and performance dashboards demonstrated poor levels of uptake.

Staff in general felt well supported by managers and there were systems in place for regular clinical and management supervision and appraisal in most service teams. The Trust had a Supervision Framework (January 2014), which promotes that all staff should participate in a structured conversation that enables reflection on their role, practice or activities and have a duty to seek out and participate constructively in supervision in line with this framework. However, uptake was inconsistent across the Trust.

The Trust reported in April 2014 that just over 90% of staff had had an appraisal in the last year, against the Trust wide target of 95%. Just over 70% of staff had attended mandatory training in April 2014, against the Trust target of 95%. This was monitored through the use of the QEWTT and the Quality Improvement and Safety Committee had escalated the issues to the Trust Board. There were plans in place to adapt training approaches and delivery so that staff were better able to access the modules. Induction was recently lengthened to cover mandatory training so that on completion of induction, staff could go straight to work in their ward or department.

Use of equipment and facilities

Throughout most services the facilities and equipment reflected good practice and had a positive impact on outcomes. Equipment was well maintained, serviced regularly and stored correctly. There were some areas where improvements were needed and most of these were known risks and being addressed by the Trust or commissioners. Some staff raised concerns about the IT equipment and remote working, but overall staff considered the latest IT system to be effective.

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Multi-disciplinary working and working with others

Multi-disciplinary working was evident across all services. Staff worked effectively with Trust colleagues and other health and social care providers. Specialist nurses worked effectively in the community, linking with relevant professionals as needed. Staff understood each other's roles and there were regular meetings and information sharing with appropriate professionals and people using the service.

Co-ordinated integrated care pathways

We found evidence of excellent integrated care pathways, from admission to the wards or to community teams, to discharge from the service. Community rehabilitation teams were made up of occupational therapists, physiotherapists and support staff and were based in community hospitals and health centres. They worked closely with community nurses and social services staff to coordinate provision of appropriate care and equipment patients needed at home. The community matrons acted as co-ordinators for the care of people with complex healthcare needs, including input from GPs, community nurses, therapists and social care staff.

Are services caring?

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

Summary of findings

People using the services were treated with compassion, dignity and respect. People were consistently positive about their experiences of receiving care. Staff respected people's individual preferences, culture and background. We noted that there were mutually respectful working relationships between different professional groups.

Patients were involved in planning their care and were provided with useful information. Information leaflets about the services were available, although not all of these were written in plain English. The leaflets were provided in languages other than English, or in large print if required.

Staff were responsive to people's emotional needs and included patients' friends and relatives in explanations and support where appropriate. People were supported to manage their own health and care when they could and to maintain their independence.

Our findings

Compassionate care

People using the services were treated with compassion. People were consistently positive about their experiences of receiving care from the Trust. Staff were empathic and took time to understand people's situation and how they could provide appropriate care and support. We heard many examples of staff going the extra mile to make sure patients were reassured or received effective support.

Dignity and respect

Throughout our inspection we saw patients and their families being treated with dignity and respect. In the Trust wide patient survey January to March 2014 90% of patients strongly agreed with the statement 'The person I saw treated me with respect and dignity'. We saw that each person's culture, beliefs and values had been taken into account in the assessment, planning and delivery of care. Staff always ensured that confidentiality was maintained.

We observed staff interactions with patients and their families to be positive, respectful and person-centred. Staff respected people's dignity, individual preferences, culture and background. Staff showed great sensitivity and care.

We noted that there were mutually respectful working relationships between different professional groups. Private rooms or screens were used as appropriate to provide some privacy and most inpatient units had separate rooms for private conversations or breaking bad news.

Patient understanding and involvement

Patients were involved in planning their care and understood what was happening to them. Patients and relatives were provided with useful information and told us that staff kept them informed. In the Trust wide service user survey January to March 2014, nearly all patients said they were involved as much as they wanted to be in decisions about their care /treatment. We could see that discussions were recorded that had taken place with patients and their families regarding care, treatment, prognosis and discharge. We saw where patients had been assessed as not having capacity to make decisions, best interest decisions had been made and where appropriate care options had been discussed with their next of kin.

Some people commented on poor signage in community hospitals. They said they found it difficult to find their way round. One said, "The hospital only has written signage so it's very difficult for someone who doesn't read to find their way round." Another told us, "The layout and signage is confusing. Hospitals rely on people being able to read - why can't they use colour coding?"

Information leaflets about a range of conditions and about the services provided were available. The leaflets were provided in languages other than English, or in large print if required. Staff said they had access to a telephone interpreter service if needed. Patient information leaflet for the Dental clinics did not contain essential information about access and were not written in plain English.

Emotional support

People using the services received good emotional support. Communication was largely effective and concerns were addressed quickly. Staff were knowledgeable about a range of voluntary services that people could access.

Staff developed trusting relationships with patients and their relatives by working in an open, honest and supportive way. Staff were responsive to people's

Are services caring?

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emotional needs and included patients' friends and relatives in explanations and support where appropriate. The community matrons gave people a mobile telephone number on which to contact them directly.

Promotion of self-care

People were supported to manage their own health and care when they could and to maintain their independence. End of life care plans gave guidance for staff in supporting people to remain as independent as possible for as long as possible. We saw that patients within the hospice were encouraged and enabled to look after and take their own medicines where possible.

Patients on the rehabilitation wards were encouraged to do as much as they could for themselves. Patients were supported to develop social links and take part in activities.

Are services caring?

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Summary of findings

Teams working in the community delivered care that was focused on the needs and wishes of people using the service. Multi-disciplinary teams worked flexibly to ensure joined up children's services Staff had a good understanding of the local population and initiated ways of working with different community groups.

People were able to access care and treatment close to home in local community hospitals, clinics and treatment centres. Some teams were short staffed and managing increasing workloads, so that they could not always meet waiting times targets. District and community nursing services were flexible and worked across professional and organisational boundaries. The Trust provided a small number of "step up" beds so that patients could have short term care without being admitted to an acute hospital. Community rehabilitation teams worked flexibly to avoid hospital admissions for people at risk in their own homes, such as people at risk of falling. The Trust had reviewed its minor injury unit services and, with Clinical Commissioning Group support, was testing weekend opening.

The Trust was committed to ensuring people received their end of life care in their preferred place. The specialist palliative care team could facilitate a rapid discharge home for people who had identified a wish to be cared for in their own home.

People's religious and cultural needs were assessed and treatment plans were holistic and person centred, paying attention to individual wishes and preferences. We found that Trust staff generally had good working relationships with partner organisations, such as social services and the voluntary sector.

There were systems in place within all teams for learning from experiences, concerns and complaints. We saw how the Trust had managed and responded to a number of complaints by improving the environment, changing clinic opening hours or working with volunteers to assist patients.

Our findings

Service planning and delivery to meet the needs of different people

Teams working in the community delivered care that was focussed on the needs and wishes of people using the service. Care and treatment provided in outpatient clinics promoted people's independence and self-care. Provision was made for people who did not have English as their first language, and appointment times were adapted to suit the needs of the individual patient.

Multi-disciplinary teams worked flexibly to ensure joined up children's services that met individual children's needs with minimal disruption to family routine. Staff had a good understanding of the local population and initiated ways of working with different community groups.

The community unit managers received monthly activity data to show where patients were referred from, ie which GP practice or acute hospital and the numbers of re-admissions. This included demographic details such as age, gender and ethnic group. This meant they could monitor how their services were meeting the needs of different people in the community.

Access to care as close to home as possible

People were able to access care and treatment close to home in local community hospitals, clinics and treatment centres. People told us they were offered suitable appointments in local clinics and hospitals. Minor injury units in three local hospitals provided a service to the population of north Cambridgeshire and parts of west Norfolk. Lengthy travel times across the rural areas to larger accident and emergency departments meant that patients made good use of these units and were pleased with the short waiting times. Children's services were accessible and tailored by front line professionals to meet children's individual needs, at the times and in the places to best suit their needs. These made use of local community venues and sessions at weekends and in the evenings, as well as referrals to health and social care providers and voluntary groups.

In one area there was a community rapid response service that assessed patients in their own home to determine the type of care and support they needed. A decision was then

Are services caring?

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made either to care for the patient at home or a short stay in a community hospital. This helped prevent admissions to hospital and helped staff to discharge patients earlier with support at home.

The Trust was committed to ensuring people received their end of life care in their preferred place. We saw that staff had discussed preferred place of care and preferred place of death. The specialist palliative care team could facilitate a rapid discharge home for people who had identified a wish to be cared for in their own home. The hospice also ran a hospice at home service to provide 24 hour care to patients who chose to die at home and, support for their families.

Access to the right care at the right time

Inpatients were reviewed daily by a doctor, including at weekends. Therapy services were routinely available on weekdays. People who used outpatient clinics were generally happy with their access to services and with waiting and appointment times. At one hospital musculoskeletal clinic waiting times had been reduced through a range of different approaches including working with GPs and providing patients with an online screening service. The Physio Direct service offered assessments over the telephone. Urgent appointments could be arranged within a week of the person contacting the service if necessary.

Most of the District Nurse teams had an allocated nurse to carry out any unplanned care each day to ensure that people with urgent needs were seen as soon as possible. The community matrons had a triage system where patients' needs were assessed and they were seen urgently if required.

Community dental services were provided at a number of locations and specialist treatments such as intravenous sedation were only provided at some. This meant that patients sometimes had to travel considerable distances. Some dental patients found it difficult to contact the practice to make an appointment, but patients were triaged to make sure patients were seen the same day in an emergency. There were plans to install a new telephone system to manage callers more efficiently.

Flexible community services

District and community nursing services were flexible and worked across professional and organisational boundaries. A member of staff working in the drug and alcohol service had developed links with a midwife at the local hospital who provided a weekly midwifery clinic on site. The Children's Community Nursing team had introduced an evening service designed specifically to provide intravenous antibiotic administration. Nurses were also working a flexible rota at weekends so children could receive care at home as opposed to hospital admissions.

The Trust provided a small number of "step up" beds so that patients could have short term care without being admitted to an acute hospital. Community rehabilitation teams worked flexibly to avoid hospital admissions for people at risk in their own homes, such as people at risk of falling. The Acute Geriatric Intervention Service (AGIS) was a joint project with the East of England Ambulance Service. A multidisciplinary team comprising an ambulance clinician, physiotherapist, occupational therapist and consultant geriatrician, was able to deliver an immediate response following a fall. Local defined outcomes were to reduce urgent and unplanned hospital attendance and admissions, and to improve patients' experience. For the 12 month period from April 2013, the service had exceeded its target of avoiding 264 admissions.

The Trust had reviewed its minor injury unit services and was testing weekend opening. Feedback from patients was positive. The children's service had a specialist nurse to support children and families with specific medical conditions prevalent in some ethnic groups in the community. There were flexible drop-in clinics which provided better access for the community.

Meeting the needs of individuals

The Trust had arrangements in place to meet the diverse needs of people using the service. We found consistently that staff had access to interpreters and all information was available in different languages and formats. People's religious and cultural needs were assessed and treatment plans were holistic and person centred, paying attention to individual wishes and preferences. There was integrated working between the community dental team and other health care services, social workers, care homes and public health.

Moving between services

We found that Trust staff generally had good working relationships with partner organisations, such as social services and the voluntary sector. There was appropriate information sharing when children and young people

Are services caring?

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moved between services and the new computerised record systems had improved this. Plans were developed early on to make the transition from children to adult services as smooth as possible.

At inpatient wards, we found good multidisciplinary discharge procedures, involving patients and relatives. Staff carried out home visits with patients before discharge and sometimes accompanied patients home. However, some patients told us they had not been involved and were anxious about arrangements for going home. Over the six month period preceding our inspection there were 52 delayed transfers of care from inpatient services, just under half attributable to the Trust. Delays were caused by patients waiting for additional support and equipment at home. The rapid response team pilot had tackled this by enabling people to leave hospital under their care, but the service was not provided across the Trust.

Complaints handling and learning from feedback

There were systems in place within all teams for learning from experiences, concerns and complaints. Information about making complaints or raising concerns was available in the community hospitals and clinics. It was not always prominently displayed to ensure that people using the service could easily find it. Inpatients were given a leaflet about the complaints process at the time of their admission to hospital.

We saw how the Trust had managed and responded to a number of complaints by improving the environment, changing clinic opening hours or working with volunteers to assist patients. Senior staff and team leaders emphasised the importance of good communication with patients to prevent complaints and local resolution on receipt of a complaint. Staff told us they discussed at meetings how they could improve on the negative areas.

The Trust had received 187 formal complaints between April 2013 and March 2014. The patient experience report taken to the Board in May 2014 presented a good analysis of trends, themes and lessons learnt. From January all complaints about clinical care were highlighted to the Trust clinical audit team who requested that services conducted specified clinical audits for the aspect of clinical care indicated within the complaint. Complaints, incidents and risks were presented by the Chief Nurse in their quarterly quality report to the Board.

The Trust also collected patient feedback using the friends and families test, a single question survey that asks patients “How likely is it that you would recommend this service to friends and family?” The Trust reported that it was achieving scores better than NHS Midlands and East for all but one month.

Are services well-led?

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

Summary of findings

Instructions

The Trust had a clear statement of vision and values. Staff were not consistently aware of these but we found the values reflected in many conversations with staff and observations of staff acting with sensitivity and respect. The Trust had a two year operational plan for 2014-16 that set out intentions for quality, recruitment, finance and sustainability. Overall we found staff groups were aware of the current transformation programmes.

The Trust had an effective governance system. The Trust used a range of tools to monitor quality and risk, including the Quality Early Warning Trigger Tool (QEWTT), quality dashboards, risk registers and electronic incident reporting. In most clinical teams, senior staff showed a good awareness and understanding of governance arrangements, and they maintained local performance data, risk registers and audits. Most but not all teams were benchmarking themselves against other service areas in the Trust.

Throughout our inspection we heard many examples of the visibility and commitment of executive and non-executive Board members. There was good clinical leadership throughout all units. Leadership development opportunities were available to staff through in-house and external programmes. The 2013 National NHS Staff Survey found the percentage of staff recommending the Trust as a place to work or receive treatment and who felt able to contribute to improvements at work was above average when compared with other community trusts. Staff reported an open culture at the trust which gave them confidence to report concerns. Most but not all staff we spoke with felt they were consulted about changes to services and were able to contribute to service developments.

Patient experience information was gathered through means such as feedback surveys, complaints, compliments and comment cards, external websites and service visits. Patient stories were presented at the Board meeting bi-monthly.

The Trust did not have a unified vision or strategy for end of life care. There was no Trust-wide policy on end of life care or on caring for patients after they have died. In North Cambridgeshire hospital, there was no guidance for staff responsible for transporting deceased patients to the mortuary and there were no procedures or schedules in place for cleaning and infection control. Risks in the mortuary had not been monitored and had been overlooked. We raised these concerns at the time of the inspection and the Trust took immediate action to close the mortuary and put in place alternative arrangements for the care of deceased patients. However, as a result of the concerns identified, we judged the provider was not meeting Regulation 10, Assessing and monitoring the quality of service provision in End of Life Care. We have asked the provider to send us a report that tells us what actions they are taking to meet these essential standards.

Work was ongoing to clarify and strengthen the Trust's strategic direction and to ensure the safe transfer in and out of services as a result of procurements which will take effect later in 2014 and early 2015. The Trust Board was developing plans for re-configuring governance structures in light of forthcoming changes.

Our findings

Instructions

Vision and strategy for this service

The Trust had a clear statement of vision and values. Its vision was to deliver high quality health and social care to the diverse communities it serves to make their lives better. Its values of honesty, empathy, ambition and respect ('HEAR') embodied a listening and learning organisation. Staff awareness of the vision and values was patchy across the Trust, but we found the values reflected in many conversations with staff and observations of staff acting with sensitivity and respect. Staff told us they felt valued, supported and listened to. There were plans to embed values into the formal appraisal process.

Community units each had an annual plan which set out achievements and future delivery programmes in the context of the Trust's strategic objectives and ongoing commissioning negotiations. Most teams were aware of future plans for their service to ensure consistent and

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flexible care. The Trust did not have a unified vision or strategy for end of life care. There was no Trust policy on end of life care or on caring for patients after they have died.

The Trust had a two year operational plan for 2014-16 that set out intentions for quality, recruitment, finance and sustainability. This introduced a quality objective of collaboration with organisations to improve care for people using the services. There was a Quality "5 star" Programme that aligned the Trust's ambitions with the five domains of safety, effectiveness, caring, responsiveness and leadership.

The plan included a transition work stream to ensure safe and effective transfer of services in and out of the Trust. Members of the executive team placed high importance on open communication with staff, and overall we found staff groups were aware of the current transformation programmes.

Governance, risk management and quality measurement

Overall the Trust had an effective governance system. The Trust Board had delegated authority to various committees in relation to monitoring quality and risk. There were three Clinical Operational Boards, a Quality Improvement and Safety Committee (QISC), Estates, Audit and Remuneration Committees, and a Strategic Change Board. Clear terms of reference were in place for each of these. The Board assurance and escalation framework described the systems through which the Board received assurance or escalated concerns and risks related to the Trust's performance and strategic objectives. Through the Board Assurance Framework, the Trust Board identified the key risks and the key controls in place to manage them. The Trust used a range of tools to monitor quality and risk, including the Quality Early Warning Trigger Tool (QEWTT), quality dashboards, risk registers and electronic incident reporting.

The Risk Management Strategy set out how risks were identified, assimilated into the Risk Register and reported, monitored, managed at different levels and escalated through the governance structures. Each operational unit had its own risk register on the electronic reporting system, which was reviewed at both Unit management meetings and Clinical Operational Boards. Risks identified as having Trust-wide impact were monitored by The Trust Board and its committees to ensure that appropriate escalation and/or de-escalation took place. In most clinical teams, senior staff showed a good awareness and understanding of governance arrangements, and they maintained local performance data, risk registers and audits. Most but not all teams were benchmarking themselves against other service areas in the Trust.

The Clinical Operational Boards had responsibility for the community units: Adults and Older People (Cambridgeshire and Peterborough), Children and Young People and the Luton Locality. Their role was to review quality, activity and financial data for their specific service and geographical areas, provide assurance to the Board in relation to meeting required standards and highlight areas of concern. They also supported clinical operational teams to work as self-managing teams. The boards were chaired by a Non-Executive Director (NED) and attended by executive leads, other NEDs and senior clinical and management staff. All clinical operational boards had two NEDs as members and they all attended more than one, which helped transfer learning.

We spoke with the managers and clinical leads of all the community units. We found governance arrangements were consistent, with local governance via quality dashboards, incident reporting, risk registers, and audits, and routes of escalation to the Trust Board. Each unit manager produced a monthly report which detailed key issues. For example we reviewed the monthly governance report for the Huntingdonshire Community Unit and saw that complaints, incident trends, key risks and performance data were detailed. Issues from the report were discussed at the monthly Clinical Operational Boards and any issues requiring escalation to the board were agreed.

The executive and non-executive directors we spoke with were enthusiastic about the role of the clinical operational boards in governance. Senior managers and clinical leads were more involved in strategic leadership and non-executive directors were exposed to the details of clinical delivery. We observed a clinical operational board meeting. There was effective senior clinical input, which clearly focused on performance targets, the importance of education and respect of patient choice. The Chief Nurse played an important role in making sure there was effective questioning and discussion, the data were interpreted

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correctly, themes identified and planned actions were clear. The style of reports to the board was being developed and leads were asked to reflect best practice in future.

The chair of the Quality Improvement and Safety Committee (QISC) told us that its role was to analyse issues, look at trends and drive good practice. Concerns were raised through the clinical operational boards. We noted some inconsistencies within the governance framework, particularly in relation to the completion of actions and how the sub-committees worked together. For example, we saw actions identified at the Quality Improvement and Safety Committee for monitoring by the clinical operational boards were not picked up within these board meetings. Similarly we could find no record that a recommendation for the QISC to undertake a deep dive into an issue of concern was considered or discussed.

The Trust Board did not always monitor actions arising. For example in November 2013 we saw that following a patient experience story a number of recommendations were identified. Staff we spoke with were unable to tell us how these recommendations were implemented and we found no reference to action taken listed in a Board action plan. In addition we found that an unassured paper had been sent to the Board in relation to the Trust's CQC registration. The Board was assured on the locations which had been registered with the CQC based on evidence previously submitted to CQC to amend its registration. However this paper had not been cross referenced with the Trust's Registration Certificate which meant the Board had received information which was incorrect.

In North Cambridgeshire hospital, there was no guidance for staff responsible for transporting deceased patients to the mortuary and staff told us they had received no training to prepare them to undertake this role. There were no procedures or schedules in place for cleaning and minimising the risk of infection to people who were deceased or to staff. The Trust could not provide evidence that risks had been managed, or that quality of service had been monitored in the mortuary. This meant that the Trust had overlooked the mortuary and potentially put staff and patients at risk. We raised these concerns at the time of the inspection and the Trust took immediate action to close the mortuary and put in place alternative arrangements for the care of deceased patients.

Leadership of this service

The leadership team within the trust was well established, with a recently appointed assistant director for governance shortly to come into post. The Medical Director was employed in this role for two days a week. His responsibilities were balanced with those of the Chief Nurse, with specific rather than joint areas of responsibility so as to provide clear lines of sight. The 2013 National NHS Staff Survey found the percentage of staff in the Trust reporting good communication between senior management and staff as above average when compared with other community trusts. Throughout our inspection we heard many examples of the visibility and commitment of executive and non-executive Board members.

There was good clinical leadership throughout all units There were four community unit managers to cover the five community units. They were supported by clinical leads who had a day a week allocated to the role, although this was sometimes in addition to their substantive role. The clinical leads acted as a link between staff on the ground and the unit managers, making sure the local governance systems were effective and issues were escalated swiftly. The unit managers had a strategic overview and were responsible for the quality of all services delivered in their geographical area.

There were monthly management meetings where quality, performance and risk were discussed and learning from incidents and root cause analyses was shared. One unit manager gave an example of a checklist developed to support staff in managing people living at home who rejected care and advice, and showed us how this was linked to unit risk register. Most staff said they felt respected, valued and supported by their managers. Better ways of working were shared across community units, although one district and community nursing team felt they were not properly consulted and listened to.

Leadership development opportunities were available to staff through in-house and external programmes. Staff told us they had been supported to attend management and mentorship training. Line management arrangements and regular one to one meetings were in place for senior staff. Unit managers told us they had excellent access to the executive team. One manager was attending the NHS Leadership Academy's Nye Bevan programme and was

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provided with additional opportunities to develop leadership expertise. A leadership group held quarterly meetings, involving leaders and managers in all aspects of the Trust's work.

There were monthly Wider Executive Team meetings, chaired by the Chief Executive. These were for unit leads to meet and exchange information across the Trust. We looked at action logs from meetings in March and April 2014. These included actions relating to the "back to the floor" programme, contracts and procurement, and the new risk reporting system. The Back to the Floor programme was to enable Trust Board members and members of the wider executive team to carry out visits across the Trust to hear first-hand from staff about their daily working lives. The Trust Chair and NEDs accompanied staff on these visits, and also carried out service visits separate to the Back to the Floor programme as appropriate to their clinical operational board alignments. The visits helped senior staff to understand services, value the staff and their challenges and hear from patients.

Culture within this service

The Trust's vision was referred to on its website and on the Trust's computers as a screensaver. However, the Trust had a deliberate policy of understatement in terms of its identity at sites from where services were delivered. We did not see information about the Trust's vision, values or strategy displayed prominently in community hospitals or clinics.

The 2013 National NHS Staff Survey found the percentage of staff recommending the Trust as a place to work or receive treatment was above average when compared with other community trusts. Staff reported an open culture at the trust which gave them confidence to report concerns. Staff in general felt that issues which were reported were acted upon however we were told on a number of occasions that they did not always receive feedback. A small number of staff said it was difficult to raise concerns and they felt penalised for doing so.

Overall, conversations with staff demonstrated an open and honest culture with patient safety at the forefront of practice. In response to recommendations from the Francis Report in 2013, the Trust established a real time staff survey or 'pulse check'. All of the staff we spoke with were passionate and committed to ensuring patients received the care and treatment they needed. We also found mutual respect between staff, and a strong ethos of teamwork. Staff felt informed. There were weekly communication cascades through email and regular team meetings. Most managers promoted an "open door" way of working. Following a significant whistle blowing incident, Trust policy and processes were reviewed. Other initiatives addressed training issues, staff absence and leadership.

Public and staff engagement

The Public Involvement and Patient Experience Committee that ensured involvement in planning and developing services was recently discontinued. There were no firm plans to replace it but the intention was to access people locally in existing forums and meetings

Patient experience information was gathered through feedback surveys (electronic hand-held devices, online and paper), the net promoter score or friends and family test, patient stories to the Board, feedback through Patient Advice and Liaison Service (PALS), complaints, compliments and comment cards, external websites such as NHS Choices and service visits. Staff were involved in seeking feedback from people, and were reminded to do so in the weekly 'Comms Cascade'. Some service areas used "You said we did" posters to show how patient feedback had been taken into account.

Trust-wide levels of satisfaction were high and exceeded the Trust target of 95% in five months of the 12 month period. Lower scores were achieved in areas suffering from staff shortages, or where there were problems with access or adequate information. The Trust used the net promoter friends and families test asking patients "How likely is it that you would recommend this service to friends and family?" Up until February 2014 the Trust achieved scores better than the NHS Midlands and East cluster average of 71 and better than the upper quartile of 78. However this fell in March to 76, below the Trust's benchmark of 78.

Patient stories were presented at the Board meeting bi-monthly. We found that learning from patient stories to the board was not followed up systematically. Feedback from Back to the Floor programme visits, including actions taken as a result, were fed back to the Trust's Quality Improvement and Safety Committee and shared via the Trust's communication cascade and the staff intranet.

A patient story project, involving video recording patients and relatives describing their experiences, was completed in the physiotherapy service. Information was organised into themes and the whole patient pathway was

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redesigned. Another project currently in progress used patient experiences to focus on how Trust services were working in an integrated way with other services. Patient stories and actions from them were on the Trust's public website.

Most but not all staff we spoke with felt they were consulted about changes to services and were able to contribute to service developments. The 2013 National NHS Staff Survey found the percentage of staff in the Trust who felt able to contribute to improvements at work was above average when compared with other community trusts. Staff generally understood the challenges faced by the Trust in respect of commissioning contracts and procurement. Staff told us they were aware of the information cascades within the trust and confirmed they had regular access to them.

Innovation, improvement and sustainability

The Trust serves multiple populations with different cultural and demographic contexts and significant variations in health outcomes. It works with a range of partner organisations and provides services commissioned by several clinical and specialist commissioning groups and local authorities. It has been through a challenging period but has a track record of financial stability. Work was ongoing to clarify and strengthen the Trust's strategic direction and to ensure the safe transfer in and out of services as a result of procurements which will take effect later in 2014 and early 2015. Executive and non-executive directors were developing plans for re-configuring governance structures in light of forthcoming changes. The chair planned to involve the new provider at an early stage to ensure an effective transfer.

The Deputy Chief Executive led the transformation programme which had a number of step change projects, exploring new ways of working. These included the adults and frail elderly care programme and improving organisational capacity. The Trust worked with a number of other providers on initiatives aimed at maintaining people's independence and avoiding hospital admission. This included rapid response teams and re-ablement services. We found staff were proactive in learning from patient feedback and making changes to services as a result. Trust services and individual staff had been awarded various accolades from national NHS organisations.

The Board was focused on supporting community based staff, and appreciated the challenge of providing sufficient support and mentoring to new staff recruited to an already stretched service. There was a Board away day planned for September 2014, where the Board would address the challenges ahead.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010. Assessing and monitoring the quality of service provision **How the regulation was not being met:** In relation to end of life care and care after death, the provider did not have effective systems to regularly assess and monitor the quality of services and to identify, assess and manage risks to people using the services and others at risk. Regulation 10(1)(a) & (1)(b).

Regulated activity	Regulation
Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010. Management of medicines **How the regulation was not being met:** The registered person failed to protect people using community inpatient services against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the safe recording and administration of medicines. Regulation 13.